I. Country Context

Uttar Pradesh (UP) is India’s most populous state with an estimated population of nearly 200 million (17% of the population of India)\(^1\), of which 85% lives in rural areas and about 33%\(^2\) lives below the poverty line. The per-capita income of UP was USD 410 relative to India’s average of about USD 1,000 in 2008-09. UP has been ranked in the bottom third of the states on the Human Poverty Index since 1981. The state lags behind all other states in the country on most human development indicators. The literacy rate is only 57%, with 43% female literacy\(^3\).

Uttar Pradesh will determine achievement of India’s own health goals and its health related Millennium Development Goals (MDGs), given the size of the state population and the disproportionately higher mortality and morbidity rates. Despite declines in maternal mortality, it remains the second highest in the country at 359 per 100,000 live births against a national average of 212\(^4\). Neonatal mortality (45 per 1,000 live births versus a national average of 35) and infant mortality (67 per 1000 live births whereas the national average is 53 per 1000)\(^5\) are

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1 2010; Population projections for India and States: 2001-2026, Registrar General of India
2 2004 based on a uniform recall period of 365 days; Poverty estimates for India 2004-05, Planning Commission
3 2001; Census of India
4 2007-09; Sample Registration System, Registrar General of India
5 2008; Sample Registration System, Registrar General of India
amongst the highest in the country. The total fertility rate of 3.8\(^6\) is the highest in India, although contraceptive coverage is increasing. Anemia (85% and 51% for children and women respectively) and malnutrition are significant concerns with the percentage of children underweight (42%), wasted (20%) and stunted (52%)\(^7\). Infectious diseases are still a major problem in UP, immunization rates remain very low (only 30% children are fully immunized by 12 months of age)\(^8\), and polio continues to be endemic in parts of Western UP. Of the 264 high focus districts \(^9\) identified by the central Ministry of Health, 46\(^10\) are in UP. Although there are variations between districts and substantial inequities in both burden of disease and access to services across population groups, there is no individual region or district that is either succeeding or underachieving across all indicators\(^11\).

The annual per-capita public health expenditure in UP at about USD 7 in 2008-09 is lower than the national average of USD 8. Total public health expenditure increased (in nominal terms) from USD 0.74 billion in 2005-06 to about USD 1.3 billion\(^12\), with the share of state own health spending at about 80% of the total, and the balance financed through the federal government’s National Rural Health Mission (NRHM); in 2009-10, total public health budget allocation was USD 1.8 billion. As a share of its gross state domestic product (GDSP), public health spending in UP is higher than the national average of about 1%. The share of private health expenditure in total health expenditure was higher at about 87% compared to the national average of 80%\(^13\). Eight percent of households in the state fell below the poverty line due to health related out of pocket expenditures (versus the national average of 6.2%)\(^14\).

II. Sectoral and Institutional Context

There has been some progress made in the recent years. The conditional cash transfer scheme for poor pregnant women (Janani Suraksha Yojana or JSY) has increased demand for basic services across the country, including in UP. Institutional deliveries in the state have increased by 33% in the last 5 years\(^15\). Coverage Evaluation Surveys by UNICEF in 2009 indicate that the institutional delivery rate in UP is now about 60%, and evidence improvements in ante-natal and immunization coverage. In the last five years, the percentage of 24 by 7 Primary Health Centers (PHCs open all day, every day) offering basic services has increased three fold (6% to 18%); most of these conducting more than 10 institutional deliveries per month. About 130,000 community health volunteers (Accredited Social Health Activists or ASHAs) have been recruited, trained and provided with basic kits to increase awareness and improve linkages with the community.

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6 2008; Sample Registration System, Registrar General of India
7 2006; National Family Health Survey - 3
8 2007-08: District Level Household Survey - 3
9 High focus districts are districts with the worst health indicators and significant access issues that have been identified for priority action
10 Of a total of 71 districts in UP
11 For example, whereas eastern districts may be poorer, Polio is persisting in western UP
12 USD 1= INR 45
13 2004-05, National Health Accounts of India, Ministry of Health and Family Welfare.
14 2004; National Sample Survey (NSS), 60th Round
15 2005-2010: NRHM bulletin; according to District Level Household Surveys (DLHS), institutional deliveries have increased from 21% to 25% between 2003-04 to 2007-08
Some improvements in health service delivery notwithstanding, key challenges remain. However, the percentage of 24 by 7 PHCs offering basic services is 18% against a national average of 35.8%; and only 6% of First Referral Units (FRUs) offer comprehensive obstetric care, whereas the national average is 19%; and about 1% only have blood storage facilities for life saving emergencies. Even where facilities for delivery care are available, total complement of services are generally unavailable; all essential laboratory tests are available in less than 3% of the FRUs; thermal protection for babies in less than 10% of facilities and a third of the women leave within 5 hours of delivering a baby.

In order to provide health care to its population and thereby reach stated health goals/targets, the main investments by the health sector of the Government of Uttar Pradesh (GOUP) have been to establish and operate an extensive network of public sector health facilities at the primary, secondary and tertiary levels. Most of the state government health financing is focused on inputs for public sector service delivery (infrastructure (20%), supplies and human resource salaries (80%). Through the Government of India’s National Rural Health Mission (NRHM; 2005-2012), there is a focus on improving basic health services, mainly through investments in public sector infrastructure, contracting additional human resources and the provision of flexible financing to states. A Bank-financed project, the Uttar Pradesh Health Systems Development Project (UPHSDP I; 2000-2008) supported investment in secondary health care services and systems strengthening. Complementary investments for primary and preventive health service were supported through Bank investments in national programs for reproductive and child health, immunization, polio eradication and disease control (TB, vector borne diseases, HIV/AIDS, cataract, leprosy). Key achievements of the first project include strengthening of secondary level public sector facilities, introducing a system for health care waste management, piloting outreach service delivery in inaccessible areas through partnerships with non-governmental organizations (NGO), and supporting one public hospital for accreditation.

UP has also been the recipient of funding from several development partners (DP), including UNICEF, USAID, the Bill and Melinda Gates Foundation, WHO and several NGOs. Most DPs have also focused on improving service through direct point-of-service interventions, while only marginally addressing health systems and institutional issues affecting service provision.

Service delivery improvements depend on functioning health systems, including the availability of adequate and sustainable health financing and the ability of the health system organization to convert these resources into better health results for its population. While overall health

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16 2007-08: DLHS 3 facility surveys
17 FRUs are public sector facilities proving referral care for comprehensive emergency obstetric and neonatal care
18 Using the ability to provide caesarean sections as a proxy for comprehensive obstetric care
19 USAID 2008: Rapid Assessment of the Functionality of FRUs and 24x7 PHCs in Uttar Pradesh (for the Reproductive and Child Health II program)
20 USAID primarily supports family planning activities, providing and funds and implementing most of their activities through NGOs. UNICEF and WHO primarily support immunization, currently with special focus on polio eradication; UNICEF also supports child survival as well as water and sanitation related activities in a limited number of locations. The Gates Foundation has recently expanded its activities for maternal and child health in those districts with the poorest RCH indicators.
financing is still low, it is not the binding constraint. Organizational performance is a key for improved allocative and technical efficiency of available financial resources resulting in improved health outcomes. **Organizational performance** is in turn determined by the institutional capacity, governance and accountability, availability and management of human resources and an effective engagement with the private sector.

The institutional capacity of the Health Directorate is “the weak middle”. As the case in most other states in India, the Directorate of Health and Family Welfare (DOHFW) has mostly been organized for implementation of vertical disease-specific programs or for public sector clinical care delivery. However, key stewardship and public sector management functions required for a Directorate of Health to manage these programs that ensure delivery of accessible, affordable, equitable and efficient health services are weak or virtually absent. Public health and regulatory functions such as health prevention, disease surveillance, quality assurance of service delivery, food and drug regulation and healthcare waste management are also weak. There has been an attempt to infuse these capacities through parallel systems like program management units under NRHM, but capacities remain weak and the need to introduce these functions within the main Directorate remain.

**Weak governance and regulatory mechanisms in UP represent major challenges to improved service delivery.** Decision-making is highly centralized in the state health authorities, and subject to political patronage which further impedes the already weak institutional mechanisms to deliver results. There also appears to be a gap between de jure and de facto rules applied to key managerial functions conducted at the state level such as human resource management. Accountability is diffuse between elected officials and local administrators/providers, between elected officials and citizens, and between citizens and local administrators/providers. Absenteeism, high staff turnover, lack of appropriate training/skills, absence of citizen grievance redressal, and monitoring failures combine to undermine sector performance. Community driven accountability mechanisms for improved service delivery, and community led approaches to improving health promoting and health seeking behavior are limited in the state.

**Systematic planning and investment in improving quality of service delivery and its supportive regulatory environment is weak.** While considerable investment to upgrade health facilities is being provided under NRHM and through the state budget, the lack of adoption of a standard framework and procedures, rational planning of human resources (quantity and skill mix), the absence of facility based health managers, and Continuous Quality Improvement (CQI) programs, results in poor quality of service delivery. The recent introduction in the country of both the National Clinical Establishment Act and National Board of Accreditation of Hospitals (NABH), now provide a framework to develop a set of uniform standards that can be adopted to enable health facilities, both in the public and private sectors, to deliver quality health services. GOUP is also cognizant of, and is addressing the human resource gaps in the state.

**Private sector partnerships in order to purchase services from the private sector have not been fully exploited.** While the state has been exploring and has piloted some Private Sector Partnerships (PPPs), there is enormous potential (in areas of service delivery as well as human resource training and production) which has not been expanded due to low capacities in the
Health Directorate to design and manage PPPs. With over 60% of provision of inpatient care and over 90% of outpatient care being delivered through the private sector and investments required in enhancing HR production, harnessing technical, managerial and financial resources of the private sector is key for expanding quality services. The quality of the private sector is variable and improved regulation by the state will be key in shaping quality private sector services.

Thus, despite government, donor and private investments in the health sector in Uttar Pradesh, the main challenges that are undermining the full impact of the inputs are centered around inadequate organizational performance. The Bank through its project is expected to leverage its resources to support GOUP to improve efficiency of the health system, and enhance effectiveness of total public investments going into the health sector.

III. Project Development Objectives

To improve the efficiency, quality and accountability of health service delivery in Uttar Pradesh by strengthening the State Health Department’s management and systems capacity.

IV. Project Description

Given that weak institutional capacities and systems are key challenges (described above) to improve access to quality of health care services delivery in UP, the proposed project therefore represents a departure from the traditional “incremental inputs for service delivery” projects towards institutional development, strengthening local systems and accountability, generating demand side accountability, introducing incentives for performance and piloting alternative delivery models, including public private partnerships (PPPs). The project would consist of the following two components under the first phase of the project: (i) strengthening management and accountability system; and (ii) improving quality of service delivery and private sector engagement.

Component 1: Strengthening management and accountability systems (total estimated costs USD 51 million) will support: (i) strategic planning functions in the Health Department, working closely with the recently established Health and Knowledge Resource Center (HKRC) in the Family Welfare Department. This would undertake selected, need-based analytical work and action research to provide necessary evidence for policy decision making, to enable holistic planning, budgeting and evaluation; (ii) improved use of data for program management in collaboration with the existing Electronic Data Processing (EDP) Cell in the Department and expanding its scope to function as a Data Resource Center. An important objective would be to ensure that data collected at each level is utilized for improved management of health programs, improvement of service delivery quality and health outcomes, focusing on equity and reducing disparities in access to health care; (iii) strengthening the use of financial information for improved decision making through the existing accounting and auditing systems for treasury and society funds and over time enable the State to move to a unified financial management control system; and in undertaking the necessary procurement reform and strengthening of procurement and supply chain management systems; and (iv) introducing and strengthening social

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21 2004; National Sample Survey (NSS), 60th Round
accountability action research to introduce community assessment of health and health care at the local level and use assessment information to stimulate community action to demand better services, enhance positive health behaviors and promote community audits of service delivery; and introducing provider incentives in the public sector. This would also include the services of the procurement agent, technical assistance provider and the project support unit which would support institutional capacity building and project implementation.

**Component 2: Improving quality of service delivery and private sector engagement (total estimated costs USD 119 million)** will support: (i) strengthening the institutional capacity for service quality improvement and supportive regulatory environment, which would include establishment and capacity building of the Quality Assurance (QA), Environment Management (EM) and Public Private Partnerships (PPP) Cells in the Directorate of Health. This would enable strengthening capacity of the Health Department/Directorate to introduce systematic QA mechanisms, further strengthening healthcare waste management, and design, manage and monitor performance based contracting and PPPs, and support the State to implement the recently introduced National Clinical Establishment Act whereby the government would need to regulate the quality in the private sector; (ii) improvement of quality of service delivery at public sector hospitals to enable accreditation under the National Accreditation Board of Hospitals (NABH); (iii) contracting with private sector for improving quality of service delivery, which would include diagnostic services, non-clinical support services; (iv) and availability of the full complement of human resources required for accreditation at each selected facility, and health managers at the facility level.

V. Financing (USD million)

<table>
<thead>
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<th>Source</th>
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<tr>
<td>IBRD</td>
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</tr>
<tr>
<td>IDA</td>
<td>152</td>
</tr>
<tr>
<td>Others (specify)</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>170</strong></td>
</tr>
</tbody>
</table>

VI. Implementation

There will be a three tier structure for the implementation of this project, the Project Coordination Team (PCT) headed by the Project Director (PD), specialist support cells located within the Directorate of Medical Health and a Project Support Unit (PSU) which will provide dedicated support to the PCT, the specialist support cells and other TA needs of the Directorate and the Department. A society will be established under the project to support project implementation. This society will be headed by the PD and will consist of the PCT and the PSU, which will support implementation of other project activities through the Directorate of Medical Health. The Directorate of Medical Health will be responsible for implementing or managing project activities in coordination with the Directorates of Family Welfare and Training, other sectors (such as the State Pollution Board for environment management) and other related non-state institutions (such as NABH, NGOs and the private sector).
The PCT will be responsible for overseeing the timely and effective implementation of the project. It will be led by the PD, who will be supported by an additional project director (APD), who will be responsible for the overall day to day activities and supervision of the project. In addition, the PCT will have team members drawn from the Departments of Medical Health and Family welfare (MH&FW) and their respective Directorates.

Specialist support cells located within the Directorate of Medical Health will support institutional strengthening. The support cells which will be Quality Assurance, Public Private Partnership, EDP-Data Resource Centre and Environment Management. These support cells would be responsible for implementing and managing activities supported under the project, related to their respective areas.

A Project Support Unit (PSU) will be located in the project office of current UPHSDP-PMU. It will consist of staff specialized in areas relevant to the core needs of the project. The structure and specialists will reflect the need to support the specialist cells, implement innovative pilots and manage the fiduciary requirements of the project. Depending on the skills required, either medical staff would be seconded from the Directorates of Medical & Health and Family Welfare or where there is a lack of capacity within the department, consultants will be hired. A procurement agent (PA) will be contracted to carry out the procurement of hospital equipment, furniture, vehicles, hospital and office supplies for the project. This PA would also be responsible for building procurement capacity and developing procurement systems within the Central Medical Stores Department (CMSD). A Technical Assistance Provider (TAP) to provide TA consultancy support as well as contract and manage external TA as required. Both the PA and the TAP will be supervised by the PSU under the oversight of the PCT.

VII. Safeguard Policies (including public consultation)

<table>
<thead>
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<th>Safeguard Policies Triggered by the Project</th>
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<tbody>
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<td>Environmental Assessment (OP/BP 4.01)</td>
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<td>Projects in Disputed Areas (OP/BP 7.60)*</td>
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<tr>
<td>Projects on International Waterways (OP/BP 7.50)</td>
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<td>X</td>
</tr>
</tbody>
</table>

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas
ENVIRONMENT: The project, as envisaged does not have any immediate safeguard impacts, given that the focus is on the establishment of an institutional framework for a coordinated and multi-sectoral management of environmental issues related to health sector.

SOCIAL: The purpose of the Equity Plan is to ensure that the systems strengthening carried out under the project takes into account inequalities in access and use of health care, and in health outcomes.

Further details are available in the Integrated Safeguard Data Sheet (ISDS)

VIII. Contact point at World Bank and Borrower

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