Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 03-Dec-2018 | Report No: PIDA175333
## BASIC INFORMATION

### A. Basic Program Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Program Name</th>
<th>Parent Project ID (if any)</th>
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<tbody>
<tr>
<td>India</td>
<td>P167523</td>
<td>Program Towards Elimination of Tuberculosis</td>
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<th>Practice Area (Lead)</th>
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<th>Implementing Agency</th>
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<td>Republic of India</td>
<td>Ministry of Health and Family Welfare</td>
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### Proposed Program Development Objective(s)

To improve the coverage and quality of Tuberculosis control interventions in the private and public sector in targeted states of India

## COST & FINANCING

### SUMMARY (USD Millions)

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<th>Description</th>
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### FINANCING (USD Millions)

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<td>World Bank Lending</td>
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<td>Total Government Contribution</td>
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B. Introduction and Context

Country Context

1. **India is one of the fastest growing economies in the world and its achievements in improving several dimensions of human development are impressive.** Between 2005 and 2010, India’s share of global gross domestic product (GDP) increased from 1.8 percent to 2.7 percent and by 2017 it reached 7.4 percent. Based on the Government of India (GoI) official poverty line, 137 million people were lifted out of poverty between 2004–05 and 2011–12. However, the country continues to face daunting development challenges. India is still marked by disparities between urban and rural areas, as well as structural inequalities by gender, tribe, and caste. Addressing these inequalities will require increasing access, quality, and utilization of human development services, including health care.

2. **Despite substantial improvements in health outcomes since 1990, India still faces tremendous challenges in health care access, quality, and utilization.** From 1990 to 2016, infant mortality rates fell by half, deliveries in health facilities tripled, and maternal mortality ratios fell by more than 60%. However, the rate of overall progress in health remains slower than in countries of comparable income, and variations persist within and among states. Quality of care is a significant and complex challenge. India’s demographic and epidemiological transition calls for an aggressive response to persisting communicable diseases and a burgeoning burden of non-communicable diseases (NCDs).

3. **India’s steadily increasing health expenditures are dominated by regressive out-of-pocket payments by households.** From 2013 to 2015, total health expenditures per capita grew by more than 10% per year—a higher rate than the country’s GDP growth. Despite this rapid increase, India’s health expenditures are relatively low; National Health Accounts 2014-2015 indicate that India spends India Rupees (INR) 3,800 (US$56) per person, while other lower middle-income countries spend around US$233 per person on health. In addition, there is a weak correlation between per capita health expenditures and outcomes across states. Despite increases in health expenditures through central level schemes, including tuberculosis (TB) control, the private sector continues to dominate the provision of fee-based health services in rural and urban areas. For example, 80% of people with TB make first contact with the health system through private providers. Out-of-pocket expenditures—accounting for 62-63% of India’s total health expenditure—are driven by outpatient care costs, diagnostics, and drugs for TB and other diseases disproportionately affecting poor households.

Sectoral and Institutional Context

4. **TB is a prime example of a persisting communicable disease challenge for India.** TB kills approximately 480,000 people every year in India. While the coverage of publicly provided diagnostics and treatment of TB under the Revised National TB Control Program (RNTCP) expanded rapidly from 1993 to 2012, such coverage has plateaued, and overall TB outcomes have stagnated over the past five years. India contributes almost 25% of the global TB burden and this proportion has remained constant for more than 20 years.

5. **Drug-resistant TB, in particular, is a major public health threat to India.** TB is one of the world’s top anti-microbial resistant pathogens, mostly due to inadequate treatment. Resistance to first-line drugs is known as Multidrug Resistant TB (MDR-TB). Inappropriate management of MDR-TB can lead to a highly lethal form of extensively drug-resistant TB (XDR-TB). Resistant forms of TB require more expensive drugs with higher levels of toxicity, case fatality, and treatment failure.

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1 Ministry of Health and Family Welfare, National Strategic Plan for Tuberculosis Elimination, 2017-25

rates. Unfortunately, India has the world’s highest number of multi-drug resistant TB (MDR-TB) cases. India’s health systems are ill-equipped to adequately respond to drug-resistant TB (DR-TB), with DR-TB outcomes lagging global and regional trends. These resistant forms of TB threaten to erode India’s health and development gains.

6. Many TB cases remain undiagnosed and/or inadequately treated. Despite increases in total new TB cases reported to the RNTCP by providers, India still accounts for approximately one third of the world’s three million people with TB each year who are not diagnosed, treated, or officially registered by a national TB program. Most of these people are in their economic prime. In India, cases not notified in the public system remain either undiagnosed or inadequately diagnosed and treated in the private sector. As such, delayed diagnosis and incomplete treatment are the greatest challenges to TB control in India—particularly among private providers, who are ill-equipped or unmotivated to sustain patients on prolonged, complex, and costly regimens.

7. Evidence suggests that strategic engagement between the public and private sectors could be a game changer in India’s TB control. The Government of India (GOI) has long recognized the challenges in TB control and the need to engage the private sector. While the RNTCP has articulated guidelines and schemes for private sector engagement since 1999, most engagement and pilots were confined to Maharashtra and Gujarat and several reviews of the earlier years of the RNTCP pointed to the government’s lack of attention to private sector engagement. In 2012, however, the GOI: (i) approved a new National Strategic Plan (NSP) (2012-17) that endorsed contracting Private Provider Interface Agencies to engage private providers on behalf of the government; (ii) made TB a notifiable disease and provided a regulatory mechanism to mandate private providers to report TB cases to the RNTCP; and (iii) launched a large scale effort to roll out the Nikshay information system to enable TB case notification by all providers. Following these policy actions, the GOI appointed dedicated Public Private Mix (PPM) Coordinators and worked with partners—USAID, the Global Fund to Fight AIDS, TB and Malaria, and the Bill and Melinda Gates Foundation (BMGF)—to test and roll out implementation models to engage the private sector in TB control. RNCTP data show that while public sector notifications have plateaued since 2012, early efforts to engage private providers has yielded promising results. India’s private TB notifications had increased significantly to 14% of estimated incidence, approaching the levels achieved by regional peers. However, India’s treatment success rate among privately notified patients was just 14% because of the absence of adherence support and monitoring systems for these patients.

8. A combination of household and health system factors account for India’s persistently high levels of TB:
   i. Poor coordination in TB care: The TB burden is exacerbated by fragmented health care provision through diverse providers, including the unregulated private sector that accounts for over half of TB cases treated in India. Convoluted patient pathways, especially in the private sector, prolong waiting times between onset of symptoms, diagnosis, and initiation of treatment.
   ii. Quality Gaps: Evidence points to quality gaps in diagnosing and managing TB in both public and private sector. Especially, there are varying levels of adherence to India Standards of TB Care. A standardized patient study among Bachelor of Medicine and other providers in two cities of India found only: (i) 35% compliance with care standards; (ii) 31% of interactions with a microbiological diagnostic test ordered; and (iii) only 5% of cases with anti-TB medications prescribed. This represents substantive quality gaps in the private sector.

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3 Undiagnosed TB represents a major public health failure given that an undiagnosed person with TB can infect 10-15 people. (Stop TB Partnership, 2015).

5 Studies found low adherence to case specific checklists of TB care, inappropriate treatment and overuse of unnecessary treatment such as steroids and anti-biotics. See McDowell, A. Pai, M. 2016. “Treatment as diagnosis and diagnosis as treatment: empirical management of presumptive tuberculosis in India” IJTLD 20(4)

6 World Health Partners (WHP), World Vision India, Lepra, Mamta, Alert, Karnataka Health Promotion Trust (KHPT) and Maharashtra Janvikas Kendra (MVK).
iii. Delayed care-seeking and leakages in care cascade: Household delays in seeking care and lack of adherence to treatment result from various behavioral and socio-economic factors. Transportation costs is a well-known barrier to TB care. While under-nutrition is one of the major risk factors for TB, emerging evidence shows that it also contributes to unfavorable treatment outcomes.

iv. Diagnostic laboratory network limitations: In 2017, an external Diagnostic Laboratory Assessment revealed substantial human resource deficiencies. Closing these gaps requires: (i) improving specimen referral and transport systems, (ii) engaging private providers and laboratories; (iii) deploying a centralized laboratory information system; and (iv) enhanced quality assurance and monitoring and evaluation, as well as more regular supportive supervision. To diagnose the estimated 2.8 million cases of TB and 150,000 cases of MDR-TB a year, laboratory capacity needs to be further expanded.

v. TB can result in catastrophic medical expenditures. A systematic review of low- and middle-income countries shows that the total cost of TB ranges from 5-40% of the annual household income of the patient. This percentage can be over 200% among poorer households and those with MDR-TB. A staggering 70% of patients took loans for TB treatment. High out-of-pocket costs related to TB also reduce medication adherence, which was associated with poor TB treatment outcomes, development of drug resistance, and continued spread of the disease.

vi. Institutional Capacity Gaps: There are substantial staffing gaps and institutional capacity challenges that impact TB control efforts at state and central levels. These include high vacancy rates in some high burden TB states and a mismatch between the skills mix proposed under the NSP 2017-25 and the current staff complement of the RNTCP. Key areas in which the RNTCP is yet to strengthen its staff capacity include private sector contracting, Direct Benefit Transfer for TB patients and information systems. To add to this, the performance-based management system between CTD and states needs to be reviewed in line with national and international best practices for federal states of comparable income.

9. Although India’s National TB Program was initiated in 1962, significant progress in TB control was only made after the establishment of the RNTCP in 1992. This included improvements in critical infrastructure for TB prevention and care, closing the diagnostic gap, and rolling out interventions to improve programmatic and clinical management of drug susceptible and drug-resistant TB. The Central TB Division (CTD) in the Ministry of Health and Family Welfare (MOHFW) carries out national-level policy and financing, program planning, implementation, and quality assurance functions. State TB Officers provide guidance and oversight to districts and other implementation units. The RNTCP has service delivery and administrative structures in 632 districts in 35 states and union territories.

10. The GOI has demonstrated a strong and growing commitment to tackling TB over the past ten years. The GOI launched an ambitious new National Strategic Plan (NSP) for 2017-2025, which encompasses several high impact interventions and implementation reforms to accelerate the country’s progress toward elimination of TB. These include switching to a more effective treatment regimen for drug-susceptible TB and introducing shorter regimens for drug resistant TB in a bid to improve TB outcomes. In addition to strengthening the RNTCP to improve services and outcomes for the 1.5 million patients in the public system, the NSP sets out a bold roadmap for improved diagnosis and treatment of the millions of private sector patients. Building on the promising pilot results, the NSP plans to provide incentives to private providers to follow standard protocols for diagnosis and treatment; and notify cases to the government. Public and private patients notified to the government will in turn receive a cash transfer to incentivize them to complete treatment. Notification will enable the government to provide home visits and counseling and to implement preventive interventions. Most importantly, the GOI is matching its strong commitment to end TB with financial and technical resources; India almost doubled its 2016 budget envelope for TB to US$525 million in 2017.

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11. **The ambitious NSP 2017-25 constitutes the government program.** It lays out the GOI’s ambitious strategic approaches and priority interventions to eliminate TB, which is aligned with the global End TB Strategy and Sustainable Development Goal targets. Moreover, the NSP sets the End TB goals five years ahead of the global timeline of 2030. Organized around four pillars of ‘Detect’, ‘Treat’, ‘Prevent’ and ‘Build’, the US$8 billion NSP 2017-25 strategically prioritizes expanding private provider engagement, improving the coverage and quality of TB and DR-TB detection and treatment, and building stronger and more harmonized surveillance systems and public health management. The NSP also begins to address the more complicated challenges of social support and TB prevention.

**PforR Program Scope**

12. **The proposed Program Towards Elimination of TB (PTETB) is a well-defined subset of the government program.** The PTETB was carved out of the NSP by: (a) results area; (b) geographical area with the selection of priority states; and (c) timeframe. Of several NSP result areas, the Program focuses on four: (i) scaling up private sector engagement; (ii) rolling out TB patient management and support interventions; (iii) strengthening diagnostics and management of DR-TB; and (iv) strengthening program management capacity and information systems. These results areas are inter-linked and mutually reinforcing.

13. **In terms of geographical area, taking into account both the estimated TB burden and the gap between private notification and the estimated TB burden, the GOI selected nine states for the Program:** Uttar Pradesh, Maharashtra, Bihar, Rajasthan, Madhya Pradesh, Karnataka, West Bengal, Assam, and Tamil Nadu. Together, these nine states account for:

   - 60% of the public-sector notification in the country
   - 62% of the existing gap in private sector notification (based on NSP targets)
   - 70% of all private TB treatment nationwide (or 12 out of 19 million patient-months of anti-TB treatment distributed via private chemists)

14. **As mentioned above, the PTETB PforR will support four result areas which are inter-linked and mutually reinforcing.**

**Result Area # 1: Scaling up Private-Provider Engagement:**

15. **The PTETB PforR aims to scale up private sector engagement to ensure timely diagnosis and notification and effective management of TB among patients in line with Standards of TB Care in India.** The NSP envisages an initial doubling of the number of patients detected and treated, with most of the increase coming from engagement of private healthcare providers.

**Result Area # 2: Rolling out TB Patient Management and Support Interventions:**

16. **It is well recognized that TB control outcomes depend on the extent to which patients seek early care, adhere to treatment and complete the treatment course.** It is for this purpose that the GOI is rolling out TB patient support as one of its strategic interventions to eliminate TB. To meet these twin objectives of adherence and treatment support, the GOI is rolling out a DBT scheme to directly transfer incentives for nutritional support to TB patients called Nikshay Poshan Yojana (NPY). The PTETB PforR will support NPY for three different categories of beneficiaries with different levels of incentive payments, namely TB patients both from public and private sector with drug susceptible TB, private providers who notify TB cases and tribal TB patients.

17. **To implement NPY, RNTCP will use Nikshay, a web-based TB case monitoring system already utilized by health...**
workers at various levels across India. In the current state, the Nikshay application has different modules, wherein one of the modules enables staff of district level TB units to record “notified or diagnosed” TB patients. Further, the Nikshay platform is being integrated with the Public Financial Management System (PFMS) of the GOI to undertake payments to beneficiaries electronically.

Result Area # 3: Strengthening Detection, Treatment and Monitoring of Drug Resistant TB:

18. The proposed PTETB PforR directs efforts at the key bottlenecks for drug resistant TB (DR-TB) control. The key proposed activities under the program involve incentivizing achievement of universal drug sensitivity testing (DST). Testing is the most essential activity for DR-TB control to succeed. While private laboratory services have well established specimen collection and transportation systems, such efforts have been sporadically successful across RNTCP. Developing robust sputum transportation to the growing number of public laboratories with molecular diagnostics capabilities for rifampicin susceptibility testing is a key activity of the program. Once detected, the RNTCP has previously achieved >85% linkage to treatment, substantially higher than other TB programs worldwide. Similarly, poor treatment outcomes in DR-TB have been associated with fluoroquinolone resistance and poor adherence, and the program accordingly tracks progress in detection of additional drug resistance and completion of treatment.

Results Area # 4: Strengthening RNTCP Institutional Capacity and Information Systems:

19. The PTETB PforR will help the GOI build the many institutional capacities on both the public and the private sides of the partnership—that will be required to succeed. The management of the TB program is embedded within the MOHFW and the National Health Mission (NHM), as well as the general health system at the state and district levels. The CTD is the nodal agency for the TB program nationally. The RNTCP institutional staffing structure and information systems have been evolving with the expanding TB program. However, substantial gaps remain in human resource staffing and skills mix to match the goals of the NSP at central and state levels, particularly in the nine states supported by the PTETB PforR. The PTETB will support the MOHFW to develop and implement a human resource plan to enable the TB program to staff to match the scope and implementation needs of the NSP.

20. Strengthening of Nikshay information system will be another area of key support under the PTETB PforR. The Nikshay system supports TB patient management and adherence monitoring, drugs, and inventory management, DBT for providers and patients, and public finance management. In September 2018, this system was upgraded from Nikshay 1.0 to Nikshay 2.0, which has several advanced features that will support implementation of the wider NSP and the four results areas of the PTETB PforR. However, there are still concerns about authentication of cases and duplication in case notification. Improvements can also be made in quality of data as well as data analytics for users at all levels. It is also felt that features for private sector interface and forecasting and supply chain management can be enhanced. Strengthening of the Nikshay 2 platform on the above-mentioned lines will be an essential component of the PTETB PforR.

C. Proposed Program Development Objective(s)

Program Development Objective(s)

To improve the coverage and quality of Tuberculosis control interventions in the private and public sector in targeted states of India

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21. Program Key Results

Coverage of TB interventions
- The number of private notifications, net of any decrease in public notifications in targeted states (Annually)
- Proportion of beneficiaries receiving financial support through DBT in targeted states (Annually, by category of DBT scheme)
  (i) Notified Public TB patients
  (ii) Notified Private TB patients

Quality of TB interventions
- Treatment success rate of private sector notified TB patients in targeted states (Annually, based on prior cohort)
- Proportion of notified pulmonary TB patients with known Rifampicin-susceptibility status in targeted states

D. Environmental and Social Effects

22. The Environmental and Social Systems Assessment (ESSA) was carried out in line with the World Bank policy and procedure for PforR financing for the identified Program. The ESSA provides a comprehensive review of relevant environmental and social management systems and procedures in India pertaining to detection and treatment of TB care. The ESSA also identifies the extent to which the country/local systems are consistent with the World Bank’s PforR Policy and Directive, and recommends necessary actions to address potential gaps, as well as opportunities to enhance performance during program implementation. The program’s overall environmental and social risk rating is Moderate and can be effectively mitigated within the existing environmental and social management systems.

23. The ESSA relied primarily on desk review and was complemented by field visits to health care facilities, drug-resistant TB (DR-TB) and (antiretroviral treatment) ART centers, common bio-medical waste treatment facilities (CBMWTFs), IRLs, and private laboratories. The visits and discussion with staff managing and working within facilities created the basis for the development of this ESSA. Consultations, interviews, and discussions were held with key program stakeholders, experts, government officials, and community groups. A free and prior informed consultation (FPIC) with tribal communities was conducted in tribal blocks of Pune and Udaipur districts belonging to Schedule-V areas under the constitution of India. Primary data collection also included interviews and discussions with: Central TB Division (CTD) officials in charge of environmental and social aspects, state TB officers, development partners during the program preparation workshop in Delhi, Lucknow, Mumbai, Pune, Hyderabad, and Udaipur, and NGOs and academia currently engaged in the Revised National TB Control Program (RNTCP). The desk review included all available guidance documents and data provided by the CTD, and past reports from bank-funded engagements.

24. Environmental Benefits: The program seeks to introduce positive environmental, health, and safety provisions for workers in high risk settings including those engaged in the laboratories and handling and transportation of infectious substances. The program will also build capacity for implementation of airborne infection control (AIC) measures as an integral component of infection control for DR-TB treatment.

25. Environmental Impacts and Risks include: (i) infection control associated with TB services, including safe handling of clinical and infectious waste, sputum, sharps (slides) generated from diagnosis and treatment services (ii) high risk settings such as DR-TB carries, DST testing and ART facilities require high adherence to AIC measures and use of PPE to ensure health service providers’ health and safety, patient and public safety; and (iii) adequate disposal of all waste streams including bio-medical waste, solid wastes (e-waste, plastics and pharmaceuticals) and liquid waste (chemical reagents, effluents) streams so that there is no contamination to soil and water bodies associated with their disposal, (iv) Ensuring all lab safety equipment would need to be serviced and kept in good working condition, and (v)
decommissioning of medical imaging equipment, and radiation contaminated wastes. These risks are well defined, site-specific and easily mitigated. However, with inadequate attention and poor management, these issues can pose greater risk to worker and public health and safety. The PfDR will not include large scale construction, there may be minor renovations works required for upgradation of diagnostic facilities and implementation of AIC measures. These will be confined to existing HCF premises. These impacts are envisaged to be moderate and temporary or site-specific and can be mitigated within the current systems for environmental management. There are no anticipated adverse impacts to natural habitats, physical cultural property, natural resources.

26. **Consultations and information disclosure:** During the preparation of the ESSA, the World Bank team carried out meetings with CTD staff, experts, development partners and research groups in Delhi. Stakeholder consultations were also carried out with State TB officials in Mumbai, Pune, Udaipur, and Lucknow, and NGOs/academics engaged in the RNTCP. A free and prior informed consultation with tribal communities was carried out in tribal blocks of Pune and Udaipur districts belonging to Schedule-V areas under the constitution of India. In addition, the World Bank team undertook field visits to central biomedical waste treatment facilities; TB diagnostic facilities such as designated microscopic centers and intermediate reference laboratories; DR-TB centers; ART facilities; and health care facilities with airborne infection control infrastructure. The discussions and visits were held with staff managing and working within these facilities and created the basis for the development of this ESSA. Following preparation and disclosure of the draft ESSA, a national level multi-stakeholder consultation workshop is being conducted in Delhi based on the draft ESSA, to receive feedback on the proposed program action plan, and agree on measures for monitoring environmental and social management.

**Assessment of Environment Systems**

27. The RNTCP is a part of the National Health Mission (NHM), and TB diagnostic and treatment services are integrated in the government health system nationwide. CTD has already implemented three Bank funded projects for Tuberculosis care and management. While these projects are now closed, the institutional setup is still functional and active, and the environment management framework for biomedical waste management and capacity building remains relevant. The CTD has an existing Environmental and Bio-medical Waste Management (BMWM) Plan which was prepared under the earlier Bank supported projects. This Plan is aligned with the Government of India’s Biomedical Waste Management Rules, the Infection Management and Environment Plan (IMEP) and the Indian Public Health Standards (IPHS). Over the years, BMW has seen considerable improvement at all levels of healthcare facilities. This is indicative of good borrower capacity to deal with the environmental aspects of the proposed program. As such, biomedical waste management is managed under the public health system. The medical wastes are collected, segregated by medical workers and temporarily stored at designated places. BMW committees are responsible for providing technical guidance to the facilities. The collection, transport and disposal of medical wastes are carried out by specialized agencies in the private sector that also operate the treatment and disposal facilities.

28. The applicable environmental and social management systems is generally adequate to address underlying environmental and social risks, and noteworthy strengths are having national regulations and guidelines in place for biomedical and other waste management (which are consistent with the WBG EHS guidelines on Health Care Facilities), guidelines for laboratory biosafety, general infection control and airborne infection control in particular, though efforts are required to improve the monitoring and capacity for the management of different kinds of waste streams. The RNTCP is also following international standards for packaging, labelling and transport of infectious substances prescribed by the WHO.

29. Ensuring worker health and safety is also inextricably linked to the component of DR-TB control. RNTCP technical and operational guidelines include appropriate health surveillance of TB workers in high risk settings, however, these should be strengthened to include greater vigilance in TB surveillance and after any accident/biohazard incident,
including appropriate record keeping. Although there are comprehensive national guidelines covering institutional, administrative and infrastructure needs, implementation has been limited to a few pilot centers, and each health facility is responsible for how they implement the provisions in guidelines, with different capacity resulting in varied practice. The program results framework includes an audit of healthcare facilities in the select states, to support implementation of AIC measures in high risk settings. If managed well the measures in place will cover environmental performance on the concerns identified in the ESSA.

30. The ESSA finds that, the existing legal and regulatory framework of environmental, health, and safety in India is consistent with the World Bank’s PforR Policy and Directive relevant to the sector. The provisions of the existing environmental legal and regulatory framework are adequate but require enabling institutional and technical capacity to comply with. The program will support staffing under RNTCP at its full capacity. Hence, the manpower gap at IRL/C&DST laboratory networks, availability of biomedical engineers and lab staff will be addressed which will ensure uninterrupted service. AIC audits will also provide the platform to strengthen institutional capacity of AIC committees and ensure they are operational.

31. In general, the environmental and social management systems to manage the identified environmental and social risks related to the activities to be supported under the PforR are in place, but some improvements should be made to ensure their proper implementation which are recommended in the programme action plan.

32. **Assessment of social systems:** Overall the program has no adverse social impact. The program does not intend to do any land acquisition or resettlement, does not support any major construction, and is limited to minor renovation and repairs within the existing footprint of the health facilities and laboratories. The legislative framework to ensure social sustainability and the interest of marginalized and vulnerable populations, including SC and ST populations, is already aligned with World Bank’s safeguard policies. The focus states account for 51.5 million tribal population (49% of the India’ tribal population) and have both scheduled V and Scheduled VI areas as defined under the Constitution of India with special legislative and judicial provision including customary rights in scheduled-VI areas. The NSP 2017-25 also recognizes that there has been limited progress in the form of special action plans for tribal populations. It is even more important to strengthen the TB control activities in these difficult areas, given some of these areas have been reporting a high incidence of not only drug sensitive but also DR-TB cases. To extend the incentives designed for tribal populations and for tribal areas, the CTD shall follow the designated tribal areas (tribal districts and blocks and scheduled areas) as per Ministry of Tribal Affairs, as well as strengthen data collection and monitoring of the tribal population transport reimbursement and other incentives. The key social risk emerges from capacity gaps to deal with tribal issues, ACSM, and the program’s gender responsiveness. The risks identified will be mitigated by (a) Updating /preparing a coherent social and behavior change communication (SBCC) strategy and action plan and adopting the same, (b) Strengthens data collection and monitoring of tribal population transport reimbursements and annual CTD report to capture coverage and trends in DBT for tribal populations, (c) Develop and adopt framework for TB among women, and which will include design specific programmatic interventions (such as outreach strategies to enable early reporting) towards addressing socio-cultural barriers, and (d) Update ‘Partnership guidelines,’ ‘Technical and Operational Guidelines for TB Control in India’ and monitoring mechanisms and tools such as CIE and State Level Internal Evaluation (SIE) for specific areas such as outreach in tribal and hilly areas, ACSM (with revised financial norms), Gender responsiveness and SBCC.

33. **Gender:** Women and girls make up nearly one million of the estimated 2.8 million TB cases in India each year; TB is the fifth leading cause of death among women in the country, accounting for nearly 5 percent of fatalities in women aged 30–69. Although more men are affected by TB, women experience the disease differently and also experience the impact of stigma disproportionately. The rapid assessment of gender and TB in India reveals the differential aspects of TB among women—including that women may be diagnosed late or not at all due to added socio-cultural barriers. This includes women delaying seeking care for TB ailments because of a high household work burden combined with
deprivation of health awareness, mobility, access to resources, and decision-making power. These factors considerably influence TB case detection and adherence to treatment. In addition, more than half of all women in India are anemic and one in five are underweight; both of these factors increase risk to TB. To address this, a technical expert group is being constituted by the CTD to develop a collaborative framework for TB and women in India, including developing interventions to address socio-cultural barriers. The key program action—the development and adoption of a framework for TB among women—is further detailed under the proposed PAP actions.

34. Citizen Engagement: The CTD aims to enhance community engagement in the TB response under the RNTCP, including by creating TB forums at state and district levels. These TB forums will work collaboratively with and through communities to address issues affecting their well-being, including engaging communities to influence systems and catalyze policy change—such as to improve programs and practices and make services more patient sensitive. The scope of community engagement envisaged as: (a) Providing patient support services through community participation—including awareness creation and stigma reduction, screening for TB and TB-related morbidity, referring for diagnosis of TB and related diseases, providing treatment adherence support, linking social support to patients, and helping address equity and non-discrimination issues; and (b) community empowerment activities for sustainable community engagement—by informing, empowering and institutionalizing, and building accountability platform by creating mechanism of feedback on TB care services to providers at all levels using community monitoring tools. The scope of community engagement is much wider than the current terms of reference developed for the state and district TB forums—which alone do not fulfill the gaps in community empowerment and accountability. The key program action required is to further review and fill these gaps between the scope of community engagement possible, and the current terms of reference of the TB forums. The results of this action will strengthen the community empowerment and accountability mechanism and will inform the Program Action Plan.

35. The ESSA concludes that the program has a moderate environmental and social risk.

36. Based on the assessment of the environmental and social management system applicable to the proposed PforR, it is concluded that GoI have established a comprehensive set of environmental and social management systems. Such systems are in line with the core principles and key planning elements as defined in the Bank Policy for PforR. The overall potential environmental and social risks of this PforR is rated as moderate and can be effectively mitigated within the existing environmental and social management systems. The key environmental risks also emerge from (i) lack fully operational BMW and AIC committees (ii) shortage in laboratory staff, dedicated biomedical engineers (iii) Management of infection control associated with TB related diagnostic and treatment services (iv) public and worker health and safety which are manageable within the country systems. There are no high impact activities associated with the PforR boundaries such construction of large buildings, central bio-medical waste treatment facilities, and effluent treatment plants (these activities are not eligible for including under the Program). The key social risk emerges from capacity gaps to deal with tribal issues, ACSM, communication, and the program being gender responsive. In addition, the social risk emerges from the program not having adequate and dedicated human resources.

E. Financing

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<th>Sources</th>
<th>Amount (USD Million)</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counterpart Funding</td>
<td>934.00</td>
<td>70.01</td>
</tr>
<tr>
<td>Borrower</td>
<td>934.00</td>
<td>70.01</td>
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<tr>
<td>International Bank for Reconstruction and Development (IBRD)</td>
<td>400.00</td>
<td>29.99</td>
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</tbody>
</table>
The World Bank
Program Towards Elimination of Tuberculosis (P167523)

| Total Program Financing | 1334.00 |

CONTACT POINT

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Role: Team Leader (ADM Responsible)
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Borrower/Client/Recipient
Borrower: Republic of India
Contact: Bandana Preyashi
Title: Director (MI)
Telephone No: 911123092345
Email: bandana.preyashi@gov.in

Implementing Agencies
Implementing Agency: Ministry of Health and Family Welfare
Contact: Dr. Kuldeep Singh Sachdeva
Title: Deputy Director General, Head, CTD
Telephone No: 9111-23063226
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Implementing Agency:
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