



## 1. Project Data

<b>Project ID</b> P100304	<b>Project Name</b> IN: UP Health Sys Strengthening Project		
<b>Country</b> India	<b>Practice Area(Lead)</b> Health, Nutrition & Population		
<b>L/C/TF Number(s)</b> IDA-50330	<b>Closing Date (Original)</b> 31-Mar-2017	<b>Total Project Cost (USD)</b> 129,320,207.07	
<b>Bank Approval Date</b> 20-Dec-2011	<b>Closing Date (Actual)</b> 30-Sep-2019		
	<b>IBRD/IDA (USD)</b>	<b>Grants (USD)</b>	
Original Commitment	152,000,000.00	0.00	
Revised Commitment	145,787,708.66	0.00	
Actual	129,320,207.07	0.00	
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## 2. Project Objectives and Components

### a. Objectives

The objectives of the project were to improve the efficiency, quality and accountability of health service delivery in Uttar Pradesh by strengthening its Health Department's management and systems capacity (Financing Agreement, 3/21/12, p. 4). The statements of objectives in the PAD and ICR were consistent with the Financing Agreement.



Note on the revision of an indicator definition and its associated outcome target in 2016: The original indicator on hospital accreditation encompassed three levels: entry level pre-accreditation (target 90%); progressive level pre-accreditation (target 50%); and final accreditation (target 25%). As the indicator and targets were over-ambitious (ICR, p. 21), the revision reduced the scope of the indicator by retaining the entry-level pre-accreditation and its corresponding target while dropping the other two elements (progressive pre-accreditation and final accreditation). As ambition was lowered, the revision would normally trigger a split evaluation. However, this ICR Review did not apply a split methodology only because it was clear at the outset that it would be inconsequential to the ratings, as the original indicator was relevant only to 25% of disbursements.

**b. Were the project objectives/key associated outcome targets revised during implementation?**

Yes

**Did the Board approve the revised objectives/key associated outcome targets?**

No

**c. Will a split evaluation be undertaken?**

No

**d. Components**

**1. System Strengthening (Appraisal US\$55 million; Actual provided by TTL: US\$40.95 million).**

Strengthening the management and accountability systems of the Department of Health in the State of Uttar Pradesh (UP), including:

- strengthening its strategic planning functions;
- improving use of data for program management and expanding the scope of its electronic data processing cell to function as a data resource center;
- strengthening the use of financial information for improved decision making through the existing accounting and auditing systems;
- strengthening the procurement and supply chain management systems;
- strengthening action research capacity; and
- strengthening the institutional and procurement capacity of the project support unit and coordination team to discharge their responsibilities under the project.

**2. Capacity Building (Appraisal US\$115 million; Actual provided by TTL: US\$88.37 million)**



Improving the institutional capacity of UP Health Department to perform its quality assurance role and effectively engage the private sector, including:

- strengthening the institutional capacity to ensure service quality improvement and regulation through the establishment of, and capacity building for, quality assurance, environment management and public private partnerships cells within UP Directorate of Health;
- improving the quality of service delivery at public sector hospitals to enable their accreditation under the Recipient's National Accreditation Board of Hospitals;
- contracting with the private sector for delivery of diagnostic services and nonclinical support services; and
- ensuring the availability of human resources (including health managers at each facility) required for accreditation of public sector hospitals.

#### e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

**Cost and financing.** The total cost at appraisal was estimated at US\$170 million, consisting of an IDA Credit of US\$152 million equivalent, and a contribution of US\$18 million equivalent from the Government of UP. The financing instrument consisted of a specific investment loan modality for a duration of five years (with a mix of traditional financing of about US\$102 million and results-based financing of about US\$50 million using disbursement-linked indicators). No direct Borrower contribution was recorded by the ICR, and the actual cost at closing was US\$129.3 million. US\$4 million were cancelled due to savings arising from early transition of some activities to the state budget. The remaining difference between actual and planned project costs under IDA financing was explained by XDR/USD exchange rate fluctuations (TTL clarifications, 5/1/2020).

**Dates.** Project appraisal was completed on 11/18/11, and the project became effective on 5/25/12. A Mid-Term Review was undertaken on 6/13/14. A first restructuring on 6/3/16 revised the implementation schedule, disbursement arrangements, and results framework. It extended the closing date by two years. A second restructuring on 3/18/19 extended the closing date by six months, and a third restructuring cancelled US\$4 million on 9/30/19, at which date the project closed, 2.5 years beyond the original closing date of 3/31/17.

### 3. Relevance of Objectives

#### Rationale

The design focusing on institutional capacity, management systems, and the secondary level of health care was responsive to state needs as these were considered the “weak middle” of the health system (ICR, p. 18 and PAD, p. 10). At appraisal, project objectives were aligned to the goals of the Five-Year Plans for India and UP (2007-12) and the National Rural Health Mission 2005-12 (PAD, p. 12) in terms of improving



systems to achieve Millennium Development Goals and sustainable health outcomes. Being a low-income state with some of the lowest health indicators in India, UP was considered to be a high focus state for health sector improvement. A previous bank-supported project (UP Health Systems Development Project, 2000-2008) initiated investments in secondary health care services and systems strengthening. The objectives were in general alignment with the third pillar of the Country Assistance Strategy, 2009-2012, aiming to support improvements in the organization and delivery of publicly financed services that would enhance development effectiveness of public spending, including in the health sector.

At project closing, one of the stated objectives (to improve the quality of health service delivery) was aligned with Objective 3.4 -- improve the quality of health service delivery and financing as well as access to quality healthcare -- of the Country Partnership Framework for India, FY18–FY22, under Focus Area 3: Investing in Human Capital that includes the following: enhance investment in the early years of children’s development, improve the quality of education in schools and colleges, increase access to improved rural water supply and sanitation services, improve the quality of health service delivery and financing as well as access to quality healthcare, and improve the coverage and coordination of social protection systems.

## **Rating**

Substantial

## **4. Achievement of Objectives (Efficacy)**

### **OBJECTIVE 1**

#### **Objective**

Improve the efficiency of health service delivery in Uttar Pradesh

#### **Rationale**

The theory of change illustrated by the ICR (p. 6) and the PAD (p. 21) was based on the premise that strengthening institutional capacity of the Health Department’s management and systems capacity would improve institutional performance, that would in turn contribute to improving overall service delivery performance. The theory of change did not explicitly illustrate a separate pathway for each of the stated objectives (efficiency, quality and accountability), but assumed that improved overall institutional performance would contribute to the achievement of stated objectives, as overall service delivery performance encompasses these objectives. Hence, the ICR’s theory of change reasonably expected that:

- capacity development for strategic planning, data resource center, quality assurance, environmental management, and public private partnerships;
- building staff capacity for monitoring results, financial management and procurement;



- designing and providing technical support for the implementation of social accountability interventions;
- making available essential manpower, infrastructure, goods and supplies;
- adopting processes for warranting quality of care in selected district hospitals leading to external certification; and
- performance-based outsourcing of service contracts;

would generate the following outputs: improved planning, data generation and use; trained staff in financial management, procurement and supply chain management; creation of community platforms for planning and monitoring service delivery; improved monitoring of service delivery and quality of care at hospitals; and improved bio-medical waste management.

The above outputs would be reasonably expected to lead to the following intermediate results reflecting improved institutional performance:

- effective management functions in planning, budgeting, procurement, financial management, and human resources management;
- strong monitoring and performance reporting;
- sound regulatory systems;
- strategic purchasing and contract management;
- entry level certification of hospitals; and
- responsiveness to communities.

In turn, the above results were plausibly assumed to contribute to improved health service delivery performance, including efficiency, quality and accountability of health service delivery.

## **Outputs**

- 51 hospitals produced data on performance every year.
- The Data Resource Center developed 20 software applications, such as for data collection and analysis and information about program activities.
- The Strategic Planning Cell and Data Resource Center produced eight policy documents, including state health policy; five state action plans; five manuals; eight guidelines; research studies; and information, education and communication documentary films.
- Salaries of health workers in all 75 districts were paid electronically.
- All districts used the UP Health Management Information System to report on national health program indicators by district and facility level.
- 52 hospitals used performance-based contracts for non-clinical services: cleaning and gardening, high-end laboratory services, and mechanized laundry services, all provided through Public-Private Partnerships.



- 51 district hospitals pursued quality care improvements beyond the originally envisaged 40 district hospitals under the accreditation program.

### **Intermediate results**

The percentage of districts that completed staff training in financial management reached 100%, exceeding the target of 90%.

The percentage of districts that completed procurement and supply chain management staff training reached 100%, exceeding the target of 90%.

### **Outcomes**

The ICR highlighted the following outcomes:

- The number of facilities using performance-based contracts for non-clinical services in laboratory services and housekeeping to improve the quality and efficiency of service delivery increased from a baseline of zero in 2012 to 52 facilities in 2019, exceeding the target of 50 facilities. However, the ICR did not offer data that would substantiate related efficiency gains.
- The number of hospitals under the accreditation program (i.e., 40 hospitals) that annually produced data and monitored service productivity (number of inpatients, surgeries), efficiency (average length of stay, bed occupancy rate), quality (surgical site infection, needle stick injuries), patient satisfaction, and accountability (number of complaints and Right to Information requests) increased from a baseline of zero in 2012 to 51 hospitals in 2019, exceeding the target of 36 hospitals.
- The percentage of districts with completed and published facility-based report cards detailing national health program indicators and facility-level performance data increased from a zero baseline in 2012 to 100% in 2019, exceeding the target of 90%.

The above outcomes on data reporting and monitoring, as well as the intermediate results on staff training, do not provide sufficient evidence on improved efficiency of health service delivery in UP.



While the ICR presented multiyear data on average monthly metrics (2014 and 2019) showing average increases for in-patient admissions and surgeries (ICR, p. 14), it noted that attribution conclusions could not be made due to non-availability of relevant data from other hospitals to allow comparisons. The ICR concluded that improvements could also have been due to secular upward trends in service utilization.

The ICR (p. 15) stated that, excluding social accountability interventions, the low emphasis on stimulating demand and the lack of addressing referral issues may have reduced efficiency. Promoting demand would have contributed to increased service utilization and the uptake of promotive health behavior. The lack of addressing referral chain issues may have brought unwanted traffic to district hospitals and reduced efficiency. The analysis of the patient satisfaction survey, conducted in 23 district hospitals in February 2019, showed that only 13% of in-patients and 4% of out-patients were referred from any medical facility, as the majority of patients came directly to district hospitals. This implied that resources meant for secondary facilities were likely used for unsophisticated basic care treatments.

**Rating**  
Modest

## **OBJECTIVE 2**

### **Objective**

Improve the quality of health service delivery in Uttar Pradesh

### **Rationale**

The discussion of the theory of change above (Objective 1) also applies to this objective.

**Outputs:** The outputs described above (Objective 1) also apply to this objective. In addition, the project introduced best practices for improving the clinical quality of care, namely, infection prevention programs; standard operating procedures for different departments; in-service training to hospital staff; standardized forms and formats, including for outpatients, and bed head tickets for inpatient admissions; and mock drills for fire, cardiac emergencies and external disasters. The project provided for the accreditation needs of district level hospitals to facilitate accreditation by the National Accreditation Board for Hospitals. The accreditation process was to ensure that hospitals were adhering to quality standards for patient care and management systems for human resources and data management. The enhancement of service quality was supported by the provision of medical equipment, technical support, additional human resources (including hospital managers), and contracting the private sector for provision of non-clinical services through performance-based contracts. The technical cells, notably for quality assurance, contributed to oversight and to the accreditation process.

### **Intermediate results**



The project filled critical gaps in human resources in hospitals: against a shortage of 5,636 staff, including medical officers, specialist doctors, staff nurses, dieticians, operation theatre and laboratory technicians, X-Ray technicians, medical records clerks, computer operators and hospital managers, the project posted 3,689 staff on a contractual basis.

The project recruited hospital managers in 51 district hospitals and provided them with training and support.

The project revamped hospital infrastructure, redesigned layouts, ensured compliance to mandatory licenses, calibrated equipment, condemned discarded items and introduced mechanized laundry, cleaning and gardening services on a contractual basis.

The percentage of hospitals that prepared Action Plans, based on facility surveys and agreed with the state government, reached 100%.

51 hospitals that were in the accreditation program had health care waste management monitoring mechanisms and staff trained in waste management, and were connected with a common treatment facility service, exceeding the target of 40 hospitals.

The number of research studies completed and results disseminated to key stakeholders reached 15 studies, exceeding the target of four studies.

## **Outcomes**

The number of hospitals that achieved quality certification (entry-level pre-accreditation) increased from a baseline of zero in 2012 to 40 district hospitals in 2019, exceeding the target of 36 hospitals. As noted in Section 2a and M&E Section 9b, the original indicator definition was revised in 2016. While it did not affect the above entry-level element of the indicator or its target, the revision dropped other accreditation levels (progressive pre-accreditation and final accreditation), thus reducing ambition.



A 2019 survey showed that 94% of inpatients and 93% of outpatients had waiting times less than 30 minutes, and 99% of the patients perceived doctor behavior as good or fair. Also, 90% of patients who had previous visits indicated that that the hospitals were cleaner than on previous visits.

The number of hospitals under the accreditation program that annually produced data and monitored service productivity (number of inpatients, surgeries), efficiency (average length of stay, bed occupancy rate), quality (surgical site infection, needle stick injuries), patient satisfaction, and accountability (number of complaints and Right to Information requests) increased from a baseline of zero in 2012 to 51 hospitals in 2019, exceeding the target of 36 hospitals.

### **Rating**

Substantial

## **OBJECTIVE 3**

### **Objective**

Improve the accountability of health service delivery in Uttar Pradesh

### **Rationale**

**Rationale:** the same as under Objective 1, above.

**Outputs:** The same as under Objective 1 above. In addition, all of the targeted 72 Block Primary Health Centers participated in social accountability interventions, which were meant as a pilot. Village Health Sanitation and Nutrition Committees in 4,238 Gram Panchayats across 72 Blocks in 12 project districts were activated. About 48,000 committee members and front-line workers associated with health and nutrition services were trained and active in supervision. 34,807 Village Health and Nutrition Days sessions were facilitated by the project team. 51 Jan-Samvads (public hearings on health services) for reporting service delivery issues and grievances to relevant authorities were organized at the block level in the project districts. The scheme included the provision of information on healthy behaviors and the strengthening of Village Health Sanitation and Nutrition Committees for providing community-level services (ICR, p. 20).

All districts used the UP Health Management Information System to report on national health program indicators by district and facility level.

### **Intermediate results**



Annual validation of the Data Resource Center Report for health programs was achieved.

Social accountability interventions created mechanisms for community assessment of health service delivery at the local level and empowered the community to use these mechanisms to: (i) demand better services; (ii) enhance positive health behaviors and community actions that improved health and nutrition; and (iii) promote community audits of service delivery and drug and human resource availability. Findings from the impact evaluation carried out in 120 villages in two districts showed increased service utilization, especially in maternal and child health services, and better outcomes for stunting and underweight among children less than two years of age. Also, the impact evaluation suggested that the interventions had a positive contributory impact on nutritional outcomes, as there was a reduction in stunting of 5.6% in children less than 2 years and 2.6% in the age cohort of 2-5 years; 6.5% reduction of underweight children 2-5 years; improved full immunization by 11.8%; and increased institutional deliveries by 5.6%.

## **Outcomes**

The percentage of Primary Health Centers participating in social accountability interventions for which a service delivery assessment has been completed, and at least one corrective action by government was verified by the community, increased from a baseline of zero in 2012 to 100% in 2019, exceeding the target of 80%.

The percentage of districts with completed and published facility-based report cards detailing national health program indicators and facility-level performance data increased from a baseline of zero in 2012 to 100% in 2019, exceeding the target of 90%.

The number of hospitals under the accreditation program that annually produced data and monitored service productivity (number of inpatients, surgeries), efficiency (average length of stay, bed occupancy rate), quality (surgical site infection, needle stick injuries), patient satisfaction, and accountability (number of complaints and Right to Information requests) increased from a baseline of zero in 2012 to 51 hospitals in 2019, exceeding the target of 36 hospitals.

The percentage of districts using the personnel information system for paying salaries of health workers increased from a zero baseline in 2012 to 100% in 2019, exceeding the target of 75%.



The above outcomes indicate a significant level of achievement in transparency and accountability, including the empowerment of communities in the governance of health service delivery in UP.

**Rating**  
High

## **OVERALL EFFICACY**

### **Rationale**

The project contributed to increased quality of health service delivery, including through accreditation, and to increased accountability, including through the involvement of communities, but there was insufficient evidence to validate the achievement of increased efficiency in service delivery. The aggregation of one fully achieved objective (accountability) and an almost fully achieved objective (quality) with a partly achieved objective (efficiency) is consistent with a substantial rating for overall efficacy.

### **Overall Efficacy Rating**

Substantial

## **5. Efficiency**

The PAD's economic analysis used general arguments in discussing efficiency. Its key argument was that further health gains would be difficult to achieve in the presence of system bottlenecks and weak public sector management functions that cannot be addressed by funding alone, and that an external stimulus along with the necessary technical guidance was needed. The analysis stated that the project was designed to address such institutional constraints, and although the financial envelope of the project, bringing an average of US\$34 million per year for 5 years, was relatively small at 1.7% of the overall annual health budget of US\$2 billion, it would be expected to have disproportionate value in improving the efficiency and effectiveness of overall public health spending.

The ICR's economic analysis focused on the allocative and technical efficiency of the project and its design. It noted that the interventions consisting of strategic planning, strong M&E, financial management, human resources, procurement, supply chain management, quality and social accountability were key governance pillars. The ICR referred to global literature suggesting that systems-level interventions usually provide higher and longer-term value for money compared with piecemeal service-delivery improvements. Weak health systems in low and middle-income countries usually prevent optimal deployment of technical service delivery interventions. The focus on institutional strengthening and district hospitals constituted a complementary role rather than a duplicative one to the National Health Mission (national health sector strategy initiative to meet health needs), whose resources are largely directed towards primary health care. Also, rather than spreading



project resources too thinly, the project limited the number of targeted hospitals. Outsourcing the recruitment of human resources expedited the filling of vacancies in district hospitals (ICR, p. 21).

The ICR reasonably postulated that, even if only 2% of state annual budgets were better utilized over the next 10 years, starting in 2017, the project would represent value for money with a Net Present Value of US\$94 million and an estimated Internal Rate of Return of 30% assuming a discount rate of 8.3% (ICR, p. 13).

There were some shortcomings in the efficiency of implementation. A lack of coherent information technology (IT) strategy and piecemeal approaches to IT deployment reduced related efficiency (ICR, p. 15). Numerous softwares were developed by the Data Resource Center, of which several fell into disuse (ICR, p. 15). Frequent changes in leadership and capacity constraints in the initial years contributed to a slow project start. During the first three years of implementation, the project was led by nine different Project Directors, with an average tenure of four to five months, thus affecting quick decision-making and oversight, and contributing to a low disbursement of 20% during that period. The issue was rectified by the state government on the fourth year when it committed to ensuring steady project leadership with tenures of at least two years. According to the ICR, two subsequent Project Directors were instrumental in expediting project implementation, as reflected by favorable assessments in the ISRs since 2017. In 2016, the project was extended by two years to compensate for the initial delays and to complete the implementation of project activities. The 6-month extension in 2019 aimed at facilitating the funding transition of project activities to regular state budget.

## Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	30.00	100.00 <input type="checkbox"/> Not Applicable

\* Refers to percent of total project cost for which ERR/FRR was calculated.

## 6. Outcome

Relevance of objectives is rated substantial, as the objectives were in general alignment with the Country Partnership Framework for India (FY18–FY22) at project closing and with UP State health strategies. Efficacy is rated substantial, consistent with almost fully achieving project objectives. Efficiency is rated substantial, as the



project offered good value for money, but with moderate shortcomings in the efficiency of implementation. These findings are consistent with an outcome rating of satisfactory.

**a. Outcome Rating**  
Satisfactory

## 7. Risk to Development Outcome

The risk to development outcome appears to be limited in view of favorable technical and financial sustainability aspects. The project represented 1% of the total state funding for health, and project support to hospitals represented 1 to 2% of annual allocations for each (ICR, p. 26). The state government budgeted the continuation of key activities beyond the project, notably for human resources. Institutional strengthening was extensive and the institutional cells created by the project were continued, while the quality assurance cell was transferred to the National Health Mission. The National Health Mission included social accountability interventions in its future implementation plans. Information, education and communication materials and training manuals are used by the National Health Mission, and the training modules for accountability are used by other sectors.

## 8. Assessment of Bank Performance

**a. Quality-at-Entry**

Preparation started during a difficult political environment related to concerns about possible fraud and corruption in procurement in several health sector projects in India, as was raised by the Bank's Detailed Implementation Review or DIR that was released in 2008. Early preparation of the project along with other health sector projects in India was initially put on hold (ICR, p. 18). When preparation proceeded, it was informed by the experience and lessons gained from the implementation of the first Health Systems Development Project (2000-2008) and state-level health operations in 10 other states. Lessons reflected in the project design (PAD, p.18) included implementation and coordination by the directorates of health departments rather than parallel bodies, shifting attention to systems, and alignment with overall sector strategies.

Institutional and implementation arrangements were well defined and included a Project Governing Board chaired by the Chief Secretary of the state government, a Project Steering Committee, and a Project Director (PAD, p. 19). Fiduciary aspects were well prepared, and financial management arrangements used the treasury system to ensure that the project was mainstreamed financially and operationally within existing state systems (PAD, p. 21). Environmental aspects were adequately addressed. The preparation team facilitated implementation readiness (ICR, p. 19), and the budget for the first year of the project was approved and released. A Quality Enhancement Review was conducted during project preparation (ICR, p. 25), resulting in further fine-tuning of preparatory arrangements.



Quality-at-Entry had some shortcomings. M&E planning left gaps in the planned measurement of efficiency and quality of health service delivery (see M&E Section 9a). The project design did not address demand-side aspects or patient referral issues that affect service delivery performance. While important risks were well identified, mitigation measures were at times insufficient. For example, maintaining a dialogue with government stakeholders was stated to be the risk management measure for frequent changes in leadership (PAD, p. 75). Subsequently, following a turnover of nine Project Directors in the first three years of implementation, the project secured at mid-course a commitment from the state government for continuity, with tenures of at least two years for Project Directors. A similar commitment arguably could have been established at entry.

### **Quality-at-Entry Rating**

Moderately Satisfactory

#### **b. Quality of supervision**

According to the ICR (25), the implementation support team was committed and proactive. Most team members were based in the country office. They provided continuity and developed an effective working relationship with state government counterparts. Additional expertise was provided as needed. According to the ICR, the quality of the professional relationship was reflected in the mission Aide-Memoires and positive feedback received from the state government.

To compensate for the slow start of the project, the task team visited state sites every month for the first 4.5 years, resulting in 54 field visits, in addition to the regular six-monthly implementation support missions. Supervision was reportedly systematic, and the Mid-Term Review was intensive and productive. The team's support to procurement processes was notable and contributed to procurement effectiveness. The team monitored and facilitated fiduciary compliance throughout the project period, and, according to the ICR, p. 19), the project fully complied with its legal covenants, including financial management and audit requirements. The team was reportedly diligent in monitoring safeguards, where compliance was assessed as satisfactory. The team was proactive in project restructurings to facilitate the attainment of objectives. In addition, the team applied for a UK Department for International Development technical assistance grant to support the client in designing public-private health partnerships, and organized training programs for government staff working on such partnerships. During the last year of implementation, the team assisted government counterparts in the funding transition of project activities to the regular state budget.

### **Quality of Supervision Rating**

Highly Satisfactory



## Overall Bank Performance Rating

Moderately Satisfactory

## 9. M&E Design, Implementation, & Utilization

### a. M&E Design

The objectives were clearly specified. The results chain was pertinent in explaining a pathway to improve overall institutional capacity performance. Hence, marker indicators were planned by the project to assist in measuring the achievement of the stated objectives on improved efficiency, quality and accountability in health service delivery (ICR, p. 21). But this resulted in measurement gaps, notably for efficiency of service delivery, and to a lesser extent for quality. According to the ICR (p. 21), no comprehensive evaluation of the quality of care interventions at district hospitals was built into the design, and this was described by the ICR as a potential missed opportunity for documenting the effects of different processes that were introduced for strengthening service delivery and quality of care (ICR, p. 21). However, this ICR Review deems that the accreditation achievements that were documented under a thorough and systematic external process ensuring compliance with qualitative aspects, and other findings documenting quality improvements, compensated for the original assessment gap for the objective to improve service delivery. An impact evaluation by an external agency was planned for social accountability interventions on key maternal & child health and nutrition services and outcomes in two districts. Data for project indicators and DLIs were to be collected by the project and the Department of Health and Family Welfare. DLI were to be verified by an Independent Verification Agency.

### b. M&E Implementation

The project used the existing information system as well as new arrangements created by the Directorate of Medical and Health Services for reporting annual performance of hospitals (ICR, p. 22). Health facility report cards were designed to monitor progress on service delivery performance at the facility level. Software applications for the Management Information System were designed to support monitoring and reporting of project activities. These included several applications such as the Health Facility Data Collection, Quality Management Information System, contract management for laundry, cleaning and gardening, bio-medical management system, and drug procurement. The Data Resource Center provided technical support and training for the applications. The consulting agency that was recruited to provide technical assistance, named as Technical Assistance Provider, also contributed to monitoring activities led by the project support unit.

The project restructuring in 2016 revised the definition of four PDO-level indicators. The revision of three of these indicators reflected the result they aimed to measure rather than the activity or platform through which they were to be realized (ICR, p. 9). The fourth indicator on hospital accreditation originally encompassed the following levels (PAD, p. 36): (i) entry level pre-accreditation (with a target set at 36 hospitals, i.e., 90% of the 40 hospitals under the accreditation program); (ii) progressive level pre-accreditation (target 50%); and (iii) final accreditation (target 25%). As the scope of the indicator was over-ambitious, the revision retained the entry-level pre-accreditation and its original target of 36 hospitals, and dropped the other two elements of the indicator (progressive pre-accreditation and final



accreditation). As stated in Section 2a, lowered ambition would normally trigger a split evaluation, but this ICR Review did not apply a split evaluation methodology only because it was clear at the outset that it would be inconsequential to the ratings, as the original indicator was relevant only to 25% of disbursements (US\$32.4 million out of US\$129.3 million).

Overall, M&E implementation was adequate, and the impact evaluation of the social accountability scheme was completed as planned.

### **c. M&E Utilization**

M&E data were used for regular project monitoring and for determining performance-based payments. Several software systems designed by the project were extensively used by the Department of Health and Family Welfare and subsequently transitioned to routine data management systems, where they were used across the state, such as the facility-based Health Report Card and the Personnel Information System. The Health Report Card was integrated with other information portals to create a state-specific health management information system, and was scaled up to the entire state in 2016-17. The Quality Management Information System was used as a routine management tool to monitor progress of district hospitals and to identify gaps in service delivery (ICR, p. 22). The results of the impact evaluation for social accountability interventions were widely disseminated, and several agencies in other sectors adopted a similar model as the one designed by the project.

### **M&E Quality Rating**

Substantial

## **10. Other Issues**

### **a. Safeguards**

The project was classified under Environmental Assessment Category B because of medical waste risks. The ICR (p. 23) indicated compliance with safeguards policies, and the safeguards rating was assessed as satisfactory at project closing.

The project established an Environment Management Cell for coordinating related activities across the state and with other sectors. The project developed an Environment Management Plan that was disclosed (PAD, p. 22). An android-based biomedical waste management information system included 129 district hospitals and 140 Community Health Centers. 14,000 personnel, including data entry operators and pharmacists, received training on data entry. Division-level sensitization workshops on biomedical waste were conducted. Interactive information and education material, training modules, and short films on biomedical waste were developed and distributed across the state (ICR, p. 24).



## **b. Fiduciary Compliance**

**Financial management.** Related arrangements and performance were adequate. Project funds were released by the state in a timely manner by the state Treasury. The State Financial Controller chaired the project support unit, supported by an experienced chartered accountant. Financial management staff at district hospitals received additional training. Documentation, including vouchers and bills, were well maintained. Interim Financial Reports were submitted regularly to the Bank (ICR, p. 24). Internal audits were conducted by a firm of chartered accountants, and the annual external audit was conducted by the Comptroller and Auditor General of India. The audit reports were submitted on time, except for minor delays in the initial years of implementation. When there were audit findings or observations, the project support unit promptly took corrective actions. According to the ICR (p. 19), the project fully complied with its legal covenants, including financial management and audit requirements.

**Procurement.** In view of weak capacities at the decentralized level, procurement was undertaken centrally by the state through the project support unit and a procurement agent. After an early delay, procurement functions proceeded adequately. Procurement post reviews identified areas for improvement such for delayed release of payments, lax monitoring, and the need to strengthen complaint handling. The project adopted technology processes for increasing transparency and efficiency in procurement, as demonstrated by the use of the portal for eProcurement for national open competitive procurement in 2017 and by the adoption of Government e-Marketplace for commonly used items (ICR, p. 24). All 16 project ISRs rated procurement as moderately satisfactory (ICR, p. 25).

## **c. Unintended impacts (Positive or Negative)**

The ICR reported several positive unintended impacts. The State Institute of Rural Development adopted the project's training modules for social accountability for training in other sectors (ICR, p. 18), and several agencies in other sectors adopted a similar model of social accountability (ICR, p. 22).

The 2019 Performance Audit of district hospitals, undertaken by the Comptroller and Auditor General, recognized improvements in district hospitals and recommended replication of the project's good practices. The State of UP became a key contributor to national guidelines that are being revised by the National Health Systems Resource Center for improving district-level hospitals in the whole country (ICR, p. 16).

Apart from accreditation received by project hospitals from the National Accreditation Board of Hospitals, 22 hospitals received the Kayakalp award for patient safety bestowed by the National Health Mission, and two hospitals obtained certification from the National Quality Accreditation System of the Union Ministry of Health & Family Welfare (ICR, p. 18).



**d. Other**

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**11. Ratings**

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Moderately Satisfactory	This ICR Review rated Quality-at-Entry as moderately satisfactory because of moderate shortcomings consisting of gaps in M&E, design, and risk mitigation. This ICR Review rated the Quality of Supervision as highly satisfactory, and the aggregation of both sub-ratings is consistent with a moderately satisfactory rating for overall Bank Performance.
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Substantial	

**12. Lessons**

The ICR (pp. 27-29) offered lessons and recommendations, including the following lessons restated by IEG:

**The design and implementation of social accountability schemes empower communities to monitor and demand better services, and ultimately contribute to improving the quality and utilization of health services,** as was observed under the project.

**Better synchronization of supply-side and demand-side initiatives could result in greater community ownership of quality of care interventions.** Apart from social accountability interventions, and given the context of UP’s health system, the primary approach was focused on



improving supply-side factors. A more targeted approach to involve the community, especially for beneficiaries utilizing district hospital services, and measuring patient experiences, could have further strengthened the bottom-up approach to quality enhancement.

**Institutional capacity building and the establishment of specialized technical cells within the Department of Health promote evidence-based approaches, support strategic planning, and enhance preparedness to tackle health systems challenges in the future.** Under the project, added technical expertise at the Directorate of Medical and Health Services strengthened informed decision-making and planning, and improved institutional processes and guidelines.

**The quality of service delivery at district hospitals can be improved through a decentralized and tailored approach.** Under the project, and in addition to conforming with quality standards for accreditation, the hospitals undertook tactical revamping of their infrastructure, redesigned facility layout for better patient flow and equipment condemnation, deployed capable hospital managers, and secured safety certification.

### 13. Assessment Recommended?

No

### 14. Comments on Quality of ICR

The ICR was clearly written in a concise manner. It illustrated a theory of change that reflected the project design focusing on improved institutional performance that would contribute to overall service delivery performance, encompassing the three stated objectives. The ICR's narrative and findings generally supported its principal conclusions. The quality of evidence was robust for the accountability objective and adequate for the quality objective, but there was insufficient evidence on improved efficiency for health service delivery. The ICR offered useful lessons that were directly derived from project experience. The review was internally consistent overall, although its cost tables were inconsistent (Annex 3, p. 42 versus Financing Table, p. 2), and actual costs by component were not reported, but these were promptly provided by the TTL.

#### a. Quality of ICR Rating

Substantial

