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Report No: PAD997

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON

A PROPOSED CREDIT

IN THE AMOUNT OF US$100.0 MILLION

TO THE

REPUBLIC OF INDIA

FOR A

UTTARAKHAND HEALTH SYSTEMS DEVELOPMENT PROJECT

January 3, 2017

Health, Nutrition, and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective November 30, 2016)

Currency Unit = Indian Rupees (INR)
INR 68.65 = US$1

FISCAL YEAR
April 1 – March 31

ABBREVIATIONS AND ACRONYMS

AHS	Annual Health Survey
ANC	Antenatal Care
CES	Coverage Evaluation Survey
CHC	Community Health Center
CPS	Country Partnership Strategy
CQS	Selection Based on the Consultants' Qualification
DC	Direct Contracting
DHGS	Director General Health Services
DoHFW	Department of Health and Family Welfare
EAG	Empowered Action Group
ESMP	Environmental and Social Management Plan
FBS	Selection under Fixed Budget
FC	Finance Controller
FM	Financial Management
GDP	Gross Domestic Product
GoI	Government of India
GoUK	Government of Uttarakhand
GPN	General Procurement Notice
HMIS	Health Management Information System
ICB	International Competitive Bidding
IFC	International Finance Corporation
IMR	Infant Mortality Rate
ISA	Implementation Support Agency
IUFR	Interim Unaudited Financial Report
JSY	Janani Suraksha Yojana
LCS	Least-Cost Selection
M&E	Monitoring and Evaluation
MCTS	Mother and Child Tracking System
MHV	Mobile Health Van
MIS	Management Information System
MMR	Maternal Mortality Ratio

MSBY	Mukhyamantri Swasthya Bima Yojana
NABH	National Accreditation Board for Hospitals and Healthcare Providers
NCB	National Competitive Bidding
NCDs	Noncommunicable Diseases
NGO	Nongovernmental Organization
NHM	National Health Mission
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organization
OOP	Out-of-Pocket
PD	Project Director
PDO	Project Development Objective
PFS	Project Financial Statement
PGB	Project Governing Board
PHC	Primary Health Center
PIT	Project Implementation Team
PMU	Project Management Unit
PPP	Public-Private Partnership
PPR	Procurement Post Review
PRAMS	Procurement Risk Assessment Management System
PSC	Project Steering Committee
QBS	Quality-Based Selection
QCBS	Quality- and Cost-Based Selection
RF	Results Framework
RSBY	Rashtriya Swasthya Bima Yojna
SBD	Standard Bidding Document
SSS	Single-Source Selection
STEP	Systematic Tracking of Exchanges in Procurement
ToR	Terms of Reference
THE	Total Health Expenditure
TPA	Third-party Administrator
UAHSDP	Uttar Pradesh and Uttarakhand Health System Development Project
UKHFWS	Uttarakhand Health and Family Welfare Society
UKHSDP	Uttarakhand Health System Development Project
VHSC	Village Health Sanitation and Nutrition Committee

Regional Vice President:	Annette Dixon
Country Director:	Junaid Kamal Ahmad
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Rekha Menon
Task Team Leader:	Somil Nagpal

INDIA

Uttarakhand Health Systems Development Project

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PAD DATA SHEET

India

Uttarakhand Health Systems Development Project (P148531)

PROJECT APPRAISAL DOCUMENT

SOUTH ASIA

GHN06

Report No.: PAD997

Basic Information			
Project ID P148531	EA Category B - Partial Assessment	Team Leader(s) Somil Nagpal	
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date 01-Apr-2017	Project Implementation End Date 31-Mar-2023		
Expected Effectiveness Date 01-Apr-2017	Expected Closing Date 30-Sep-2023		
Joint IFC Yes	Joint Level Complementary or Interdependent project requiring active coordination		
Practice Manager/Manager	Senior Global Practice Director	Country Director	Regional Vice President
Rekha Menon	Timothy Grant Evans	Junaid Kamal Ahmad	Annette Dixon

Borrower: Republic of India			
Responsible Agency: Department of Medical Health and Family Welfare, Government of Uttarakhand			
Contact:	Dr. Neeraj Kharwal	Title:	Mission Director- NHM, DoHFW
Telephone No.:	91-8979002222	Email:	neeraj.kharwal@gmail.com

Project Financing Data (in US$, millions)		
[ ] Loan	[ ] IDA	[ ] Guarantee

[X] Credit	[ ] Grant	[ ] Other

Total Project Cost:	125.00	Total Bank Financing:	100.00
Financing Gap:	0.00		

Financing Source	**Amount**
BORROWER/RECIPIENT	25.00
International Development Association (IDA)	100.00
Total	125.00

Expected Disbursements (in US$, million)

Fiscal Year	2017	2018	2019	2020	2021	2022	2023	2024
Annual	1.10	10.10	13.20	18.60	21.00	21.00	11.60	3.40
Cumulative	1.10	11.20	24.40	43.00	64.00	85.00	96.60	100.00

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Areas

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[X] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	75		
Finance	Non-compulsory health finance	15		
Public Administration, Law, and Justice	Sanitation	10		

Total	100

(X) I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	50
Human development	Child health	20
Human development	Injuries and non-communicable diseases	20
Finance and private sector development	Other Financial Sector Development	10
Total		100

Proposed Development Objective(s)

The Project Development Objective (PDO) is to improve access to quality health services, particularly in the hilly districts of the state, and to expand health financial risk protection for the residents of Uttarakhand.

Components

Component Name	**Cost (US$, millions)**
Innovations in Engaging the Private Sector	80.00
Stewardship and System Improvement	45.00

Systematic Operations Risk-Rating Tool (SORT)

Risk Category	**Rating**
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Substantial
9. Other	

OVERALL	Substantial

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	**X**	
Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10	**X**	
Involuntary Resettlement OP/BP 4.12		**X**
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Staffing	**X**		Continuous

Description of Covenant

Uttarakhand shall ensure that, at all times during project implementation, the project team shall be headed by a project director, an additional PD and adequately staffed with professional and administrative staff (including procurement, financial management, environmental, social, and project related technical staff), with the necessary experience and qualifications acceptable to Association.

Name	**Recurrent**	**Due Date**	**Frequency**
Budget Allocation	X		Continuous

Description of Covenant

Uttarakhand, shall take necessary and appropriate actions to ensure that adequate budgetary allocations are: (a) included in its budget for annual counterpart funds and (b) transferred to the Uttarakhand Health and Family Welfare Society (UKHFWS) in a timely manner in accordance with the project's annual work plans.

Name	Recurrent	Due Date	Frequency
Timely Payment	X		Continuous

Description of Covenant

Uttarakhand shall ensure that all payments due for private-partnership partnership (PPP) contracts under Part 1 of the project are fully paid within ninety (90) days from the date said payment become eligible.

Name	Recurrent	Due Date	Frequency
Steering Committee	X		Continuous

Description of Covenant

UKHFWS shall maintain, at all times during project implementation, a project steering committee, headed by either the principal secretary or secretary of medical, health and family welfare, which shall comprise secretaries and deputy secretaries from stakeholder departments, vested with the responsibility of, among others, providing strategic direction to the project.

Name	Recurrent	Due Date	Frequency
Monitoring agent		12 months from effectiveness	

Description of Covenant

UKHFWS shall not later than twelve (12) months after the effective date, employ, and maintain throughout project implementation, an independent monitoring and verification agent, under terms of reference and with qualifications and experience acceptable to the Association to assist the UKHFWS to carry out verification of medical insurance claims and related performance audits on a quarterly basis for purposes of the project.

Name	Recurrent	Due Date	Frequency
Project financial audit	X	9 months after the end of the fiscal year	Annually

Description of Covenant

The Recipient shall, or shall cause the State of Uttarakhand to, have the Project's Financial Statements audited in accordance with the provisions of Section 4.09 (b) of the General Conditions. Each audit shall cover the period of one (1) fiscal year of the Recipient, and shall be furnished to the Association not later than nine (9) months after the end of such period.

Name	Recurrent	Due Date	Frequency
Safeguards	X		continuous

Description of Covenant
Uttarakhand shall carry out the project in accordance with the Environmental and Social Management Plan, as detailed in Section I.D of the Schedule to the Project Agreement.

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Somil Nagpal	Team Leader (ADM Responsible)	Senior Health Specialist		GHN02
Jurminla Jurminla	Procurement Specialist (ADM Responsible)	Procurement Specialist		GGO06
Krishnamurthy Sankaranarayanan	Financial Management Specialist	Sr Financial Management Specialist		GGO24
Abeyah A. Al-Omair	Team Member	Public Health Spec.		GHN19
Federica Secci	Team Member	Health Specialist		GHNGE
Jorge A. Coarasa	Team Member	Sr Economist (Health)		GHN06
Juan Carlos Alvarez	Counsel	Senior Counsel		LEGES
Lucy S. Lotha	Team Member	Program Assistant		SACIN
Martha P. Vargas	Team Member	Program Assistant		GHN06
Matthew H. Morton	Team Member	Social Protection Specialist		GSP06
Naoko Ohno	Team Member	Senior Operations Officer		GHN19
Owen K. Smith	Team Member	Senior Economist		GHN06
Pranav Mohan	Team Member	Investment Officer		CASPS
Rahul Pandey	Team Member	Operations Officer		GHN06
Ruma Tavorath	Safeguards Specialist	Environmental Specialist		GEN07
Shafali Rajora	Team Member	Program Assistant		GHN07
Victor Manuel Ordoñez	Senior Finance Officer	Senior Finance Officer		WFALA
Vikram Sundara Rajan	Team Member	Senior Health Specialist		GHN02

Extended Team

Name	Title	Office Phone	Location
Dr. A. Venkat Raman	Consultant , PPP		

Shreelata Rao Seshadri	Consultant, Social Development Specialist		
Angad Karande	Consultant		Dehradun

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
India	Uttarakhand	Uttarakhand	**X**		

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? Yes

I. STRATEGIC CONTEXT

A. Country Context

1. India's population is 1.25 billion, with a per capita gross domestic product (GDP) of US$1,489 in 2012, which has increased by nearly 35 percent during 2007–2012. The relatively high growth of GDP (average 8.2 percent per year during 2007–2012), supported by high rates of investment and savings and strong export growth, has generated substantial public and private resources for large investment in education, health, transportation and communication, and development programs to benefit the poor, as the country positions itself as an emerging middle income economy. The key challenge facing India is to ensure that its economic growth is rapid and inclusive and leads to significant rural poverty reduction—the Government's 12th Five Year Plan (2012–2017) puts emphasis on "development of human capabilities". However, more than 400 million people still live under US$1.25 per day, with the majority living in rural areas and dependent on agriculture or other land-based resources.

2. Uttarakhand is the 27th state of the Republic of India and was carved out of the state of Uttar Pradesh in 2000 with the primary objective of bringing development to the hill region of the state. Uttarakhand's population of 10.1 million in 2011 (most recent census in India) has increased by 19.2 percent over the previous decade. It borders Himachal Pradesh in the north-west and Uttar Pradesh in the south and has international borders with Nepal and China. The state is divided into 13 districts, located in three geographical regions, the high mountain, the mid-mountain, and the terai (the low-lying area and plains at the Himalayan foothills). Hills account for over 90 percent of its area and forests cover two-thirds, with numerous, small, scattered communities (almost 17,000 settlements, most comprising less than 500 persons)—which makes inaccessibility a crucial, cross-cutting issue in Uttarakhand and a formidable challenge for service delivery in the state. The density of population varies across districts, with Haridwar, Udham Singh Nagar, and Dehradun having above 500 persons per km^2 while Uttarkashi and Chamoli have less than 50 persons.

3. Uttarakhand is one of the fastest growing economies in the country with GDP growth in 2012 at 8.8 percent, much of it coming from services and manufacturing, with a smaller contribution from agriculture. Emphasis has been placed on stimulating these sectors to their fullest potential, considering the limitations owing to the state's geographic profile. The service sector has particularly benefited from the availability of quality human resources because of the high level of literacy compared to the national average.

4. Given its location, the state is prone to natural disasters, especially landslides, earthquakes, cloudbursts, and floods, which can cause severe disruption to transportation and basic service provision for prolonged periods. Moreover, it is an important destination for pilgrimage and tourism, hosting about 30 million tourists per year, often concentrated in specific time periods. However, the state needs to improve its ability to generate systematic evidence and timely information to formulate plans and better prepare itself for such expected tourist arrivals and unexpected natural calamities.

B. Sectoral and Institutional Context

5. **Uttarakhand faces persisting challenges in improving maternal and child health.** The state's under-5 mortality rate is 47 per 1,000, infant mortality rate (IMR) is 33 per 1,000, neonatal mortality rate is 29 per 1,000, and the maternal mortality ratio (MMR) now stands at 162 per 100,000 (National Family Health Survey 2015–2016, Sample Registration System Bulletin June 2016). While all these indicators are slightly better than national averages (Annual Health Survey [AHS] II 2011–2012), variations between districts are significant, with districts as diverse in their topography as Haridwar, Pauri Garhwal, and Tehri Garhwal reporting some of the poorest indicators in the state. The low rate of institutional deliveries, may be suggestive of access constraints for maternal and child health services. An additional concern is a rapid decline of the child sex ratio (0–6 years) in some districts of the state.

6. **The state is facing a growing burden of noncommunicable diseases (NCDs)** as it undergoes an epidemiological and demographic transition. A recent survey revealed a high prevalence of risk factors for NCDs in Uttarakhand's population, including smoking, overweight, and low level of consumption of fruit and vegetables (Annual Health Survey, 2014). The same survey, commissioned by the Ministry of Health and Family Welfare, also showed that diabetes affects as much as 6 percent of the hilly population, while hypertension affected over 8 percent, challenging the widely held perception that people living in the hills were generally active and healthy. The emergence of NCDs poses a renewed threat to the financial protection of the state's population, which is related not only to the high costs of treatment, but also compounded by the long duration of treatment for what are often chronic illnesses or long-term disabilities.

7. **Uttarakhand's health system faces severe human resources constraints, contributing to limited access, inequity, and the highly variable quality of health services.** The population in the remote areas of the state continues to be unserved and/or underserved, as public and private providers are concentrated in urban and plain areas. Most public health facilities in the middle and upper mountainous areas are either non-functional or provide poor services because of large-scale vacancies of health staff, as deployment and retention in such geographically remote areas has proven to be extremely difficult. The presence of qualified private providers is negligible in the remote areas of the state, because of low population density and limited income opportunities. In 2013, 48 percent of the posts of general duty medical officers and 75 percent of the specialists' posts were vacant, despite a liberal government policy to hire contractual doctors and to pay them incentives for remote area postings. Private operators were managing a total of 12 community health centers (CHCs) in the state, out of which only 5 are currently operational. One of the major reasons, which led to the termination of some privately operated CHCs, was the private sector's inability to man the CHCs with the requisite number of medical specialists. Furthermore, the frequent occurrence of natural calamities and the large number of pilgrims and tourists visiting the state pose additional challenges to the health system, with an increased and more diversified demand for health services. The state's difficult terrain and its susceptibility to natural disasters further hampers the response capability of health facilities to cater to disasters and trauma.

8. **The private sector plays an important role in the provision of services**, accounting for 82 percent and 65 percent of outpatient care and for 57 percent and 66 percent of inpatient care for rural and urban areas respectively (National Health Accounts, 2004–2005 and National Sample Survey Organization [NSSO], 57th Round). Individual physicians constitute 63.4 percent and

inpatient establishments 15.3 percent of the 9,956 private health care providers in the state, with others including diagnostic facilities, ambulance and other services constituting the balance 21.3 percent (as of 2002) (National Commission on Macro Economics and Health, 2005). Uttarakhand has the second highest proportion (11.7 percent) of nonprofit health care providers among all Indian states.

9. **Service utilization has been compromised by the limited service availability and health-seeking behavior is influenced by geographical access and costs of care.** In addition to differences in service provision and utilization between plain and hilly districts, huge variations are reported even across districts with similar geographical terrain. For example, the average rate of institutional deliveries in Uttarakhand is low at 68.6 percent (National Family Health Survey-4 2015–2016), but rural areas of Haridwar, a populated district in the plains, have a rate of institutional delivery at 54.7 percent (out of expected deliveries) which is one-third below that of rural Dehradun, at 81.7 percent. This suggests that additional barriers to access beyond the geographical configuration of the districts may exist. The NSSO data show that the household utilization rate of inpatient care reduces to 0.67 percent in the rural areas from a state average of 0.95 percent (a rate already significantly lower than the national average of 2.5 percent). While the poorest population is not seeking/spending on inpatient care (monthly per capita expenditure is about INR 36), their household health expenditure is concentrated on outpatient care (INR 114 per month).

10. **Uttarakhand needs to address the financial burden in accessing health care and the risk of catastrophic health expenditures.** In 2004–2005, India's total health expenditure (THE) as a share of GDP was 4.2 percent, of which 69 percent was private out-of-pocket (OOP) expenditure (World Health Organization National Health Accounts statistics and Ministry of Health and Family Welfare 2009). In 2012, while THE as a percentage of GDP continued to be in the same range at 4 percent, the share of OOP expenditure witnessed a rapid decline to 58 percent (though still high compared to the country's income level), and the share of public expenditure rose to 33 percent. Formal, detailed sub-national numbers available for Uttarakhand (2004–2005) indicate that THE was higher than the national average at over 5 percent of state GDP. The NSSO data also reveal that private OOP expenditure in the state is directed mostly to outpatient care as opposed to inpatient services (75 percent of households spent OOP on outpatient care, in line with the national average of 76.5 percent). In 2008, the Government of India (GoI) introduced a national health insurance scheme called Rashtriya Swasthya Bima Yojna (RSBY), which covers most inpatient care costs in public and private facilities for those living below the poverty line. In February 2014, the Government of Uttarakhand (GoUK) also announced a similar state initiative called Mukhyamantri Swasthya Bima Yojana (MSBY), the first phase of which was launched in April 2015. MSBY extends the inpatient coverage of RSBY to all the remaining citizens of Uttarakhand (except certain higher income categories) and also complements RSBY in covering certain high cost illnesses not covered under RSBY. The second phase of MSBY was launched in August 2016 with further enhanced financial coverage for high-cost inpatient care. Plans to further enhance the coverage of RSBY and MSBY to include additional services, such as primary care, are also on the agenda. Despite these initiatives, the risk of catastrophic health expenditure in Uttarakhand, though slightly less than the national average, is still high and is possibly preventing households from seeking care. A preliminary analysis of household survey data suggests that 5.3 percent of households spent more than 25 percent of their non-food expenses on health in 2011–2012, indicating very high risks of impoverishment. An increasing number of these at-risk

households were families with high outpatient care expenses, adding to the importance of ensuring greater focus on primary care services in the state.

C. Higher Level Objectives to which the Project Contributes

11. The proposed project supports the goals (economic growth, poverty reduction, and shared prosperity) of the current Country Partnership Strategy (CPS) for India 2013–2017 (Report No. 76176-IN), particularly in its engagement area on inclusion and a more pronounced shift to low-income and special category states, like Uttarakhand. The project's key focus, improved access to health services for some of the most remote population groups in the country, will further enhance inclusion of the underserved population. The project will also support strengthened engagement with private health care providers, expanding their role in meeting the unmet health access needs of the state's population. This engagement will also contribute to "promoting greater private investment in a low-income state", which is a stated outcome of the India CPS, and to the state's own economic development. Lastly, the project supports the CPS outcome of "strengthened public and private health-delivery systems", by strengthening health facilities and accountability arrangements in service delivery through the development of greater stewardship and managerial capacity in the state directorate, improved information systems, and a focus on monitoring and research.

12. The project also directly supports the national and global efforts toward ensuring Universal Health Coverage, expanding financial protection, and strengthening the performance of the public health system. The project's focus on access, quality, and financial protection in a low-income state directly contributes to the World Bank Health Nutrition and Population Global Practice goals of supporting progress towards UHC and ensuring financial protection and service delivery.

II. PROJECT DEVELOPMENT OBJECTIVES

A. Project Development Objective (PDO)

13. The PDO is to improve access to quality health services, particularly in the hilly districts of the state, and to expand health financial risk protection for the residents of Uttarakhand.

Project Beneficiaries

14. The project will benefit the residents of the entire state of Uttarakhand, in particular those residing in the hilly districts and remote areas of other districts with poor availability of health services and large vacancies in positions for medical professionals. Successful implementation of the project will have a particularly positive impact on the underserved population (women, elderly, and communities living in remote areas). The strengthened availability of primary care services and improved disaster response capabilities in the hilly districts will also support the very large floating population that visits the state for business, pilgrimage, and tourism.

PDO Level Results Indicators

15. The following outcome indicators will be used to measure progress toward the achievement of the PDO, with information collection and analysis being done in a disaggregated manner by gender and by geographical area:

- Number of outpatient visits to Primary Health Centers (PHCs), CHCs, and mobile vans per year, disaggregated by districts

- Number of persons who used the Health Helpline to receive information or lodge grievances, disaggregated by gender

- Patients contacted by the Health Helpline that are satisfied with the health services provided to them (per year, disaggregated by gender)

- Number of government and non-government healthcare facilities in the state issued with an entry (or higher) level certification by the National Accreditation Board for Hospitals

- Number of hospital admissions and outpatient consultations covered by any form of health insurance supported by the project (RSBY and MSBY), disaggregated by gender

16. Intermediate outcome indicators for access to quality health care and financial protection will also be used to track project progress (see annex 1).

III. PROJECT DESCRIPTION

17. The project will be implemented over six years, wherein the first year will be a 'startup year' with a focus on commencing the revised design of public-private partnership (PPP) service delivery, setting up its performance measurement system, and undertaking evidence-based design of the integrated networked model, the Health Helpline system, and RSBY primary care packages. This will be concurrent with strengthening the state's capacity to implement the project. The initial rollout of the innovations in Years 1 and 2 will be undertaken in a limited geographical area, with a scale-up planned by Year 4.

A. Project Components

18. The project will have two components: (a) Innovations in Engaging the Private Sector (for integrated service delivery and for health financing) and (b) Stewardship and System Improvement. A description of the activities under the two project components is provided below.

Component 1. Innovations in Engaging the Private Sector (Total estimated amount: US$80 million, including IDA US$64 million and GoUK US$16 million)

19. Innovations in engaging the private sector will finance engagement with the private sector in the delivery of health care services, as well as in health care financing. This component will expand access to services by creating integrated, technology-enabled health system architecture with enhanced focus and availability of primary care, emergency care, and necessary referral services (See figure 2.1 in annex 2 for more details). It will also expand financial protection by defining a benefit package of primary care services for child and adolescent care and for the management of NCDs. Component 1 includes two subcomponents.

Subcomponent 1.1. Innovations in integrated delivery of healthcare services (primary, referral, and emergency care) (Total estimated amount: US$47.5 million)

20. The objective of this subcomponent is to improve access to an integrated network of primary care, referral services, and emergency care in the state by engaging the private sector through financing the following activities (see figure 2.2 in annex 2): (i) the development of a conducive institutional environment to support ongoing and new PPPs; (ii) telephonic health information and telemedicine services; and (iii) the development of new PPPs such as integrated networks of mobile health vans, outsourced CHCs as well as government-run CHCs, and specialist services and defined clinical and diagnostic services at the district hospitals. These will be phased, starting in two to three selected districts and backed up by the development of an information network promoting a patient centric health system, to help patients navigate across different levels of care across public and private providers, as well as create linkages to financing entities such as RSBY/MSBY. The subcomponent will also provide technical assistance and finance improvements and integration of the toll-free Health Helpline to help patients navigate through the health system and access appropriate health facilities according to their location and medical need, receive and track patient grievances, undertake collection of patient feedback, and support the health facilities in the state through various telemedicine services, together facilitating technology-enabled integration and coordination of services offered by the health system.

Subcomponent 1.2. Innovations in healthcare financing (Total estimated amount: US$32.5 million)

21. This subcomponent will finance the expansion of primary care coverage into the state's health insurance programs (RSBY and MSBY) by i) designing, implementing, and evaluating benefit packages around childhood and adolescent health, as well as case management of NCDs in primary care settings; and ii) financing the purchase of health care services from public as well as private providers.

22. This subcomponent will provide technical assistance and finance the required evidence and global knowledge to make key decisions on the specifics of expanded benefit packages, provider payment mechanisms, payment rates, provider empanelment criteria (including the balance between access, quality, and other provider characteristics), and interface with the existing hospital coverage. It will finance the costs of an implementation support agency (ISA), reimburse the claims paid for primary care services, and, subsequently, finance the competitively determined premium paid for the primary care coverage provided under the state's health insurance programs.

23. Achieving this expansion will begin by addressing bottlenecks facing the current implementation of RSBY/MSBY, enrollment challenges, and shortcomings on the supply side. The state's expansion of RSBY/MSBY into primary care will also be necessarily phased. The expanded packages will be piloted in a small number of districts. The first phase coverage expansion will start with child health services, with a plan to expand in the next phase to NCDs.

Component 2. Stewardship and System Improvement (Total estimated amount: US$45 million, including IDA US$36 million and GoUK US$9 million)

24. This component will strengthen the Government's capacity to engage effectively with the private sector, and therefore, enable the Government to provide effective stewardship to improve the quality of services in the entire health system, particularly in its capacity to effectively pursue the innovations being planned under this project. The component will focus on strengthening the institutional structures for stewardship and service delivery and augmenting the state's human resource capacity, so that the necessary skillsets required for effective implementation of the project and the state's health programs are available. The strengthened capacity will serve beyond the activities of this project, as it will contribute to the Government's stewardship role for the health system as a whole. This component will finance research and evidence generation, use of evidence for strategic planning, and improved information systems for data generation and management, including timely feedback to providers. An independent monitoring and verification agency will also be hired to support the state in field-level monitoring and performance validation of the contracted entities. It will also finance an assessment of existing facilities, as well as contracting of agencies on a turnkey basis to support the attainment of National Accreditation Board for Hospitals and Healthcare Providers (NABH) quality standards in identified public health facilities in the state. The scope of such turnkey contracts may include training of staff, creation of standard manuals and other quality documentation, and some minor refurbishments, among others. Finally, the component will promote a multidisciplinary approach that will strengthen the ability of the health system to respond to seasonal and context-specific needs. For instance, specific activities financed under the project will include detailed planning for the potential redeployment of MHVs as trauma and medical relief centers in case of natural disasters, in close coordination with the disaster response mechanisms being strengthened under an existing World Bank-financed project. The project management costs including salaries of full time staff assigned to the project, hiring of consultants, training, office rent and utilities, office maintenance and repair, vehicle hiring, communication and other administrative costs will also be financed from this component.

B. Project Financing

25. The estimated total cost is US$125 million (see table 1). This will be financed by an IDA-17 transitional financing credit of US$100 million equivalent, along with the Government counterpart financing of US$25 million.

Project Cost and Financing

Project Components	Government US$, million	IDA US$, million	Total US$, million
Component 1.Innovations in Engaging the Private Sector Subcomponent 1.1. Innovations in integrated delivery of health care services	9.5	38	47.5
Subcomponent 1.2. Innovations in healthcare financing	6.5	26	32.5
Component 2. Stewardship and System Improvement	9	36	45
Total	25	100	125

C. Lessons Learned and Reflected in the Project Design

26. Drawing on the experience gained from the implementation of the previous World Bank-financed health sector project in Uttarakhand,[1] the ongoing projects in the state focused on disaster recovery and on rural water supply and sanitation, the findings from over a decade of World Bank financed state-level health lending operations in about ten Indian states, and the World Bank's global experience, the following key lessons are reflected in the project design:

(a) The Government's ownership and continuity of project leadership are crucial to successful projects' implementation; the project will follow the successful implementation arrangement adopted by the Uttarakhand Health and Family Welfare Society (UKHFWS) in the previous project, under the overall direction of the principle secretary (Health). To ensure continuity of leadership and avoid disruption of implementation, the state government agreed to ensure a fixed tenure of at least three years for key project staff.

(b) Adequate human resource management and development policies, including public health planning and management capabilities are critical variables for quality health service delivery; the stewardship and system improvement component of this project aims to strengthen the institutional structure and the management capacity, as well as establish a governance structure and regulatory system to improve the quality of care. Building upon the foundations of the previous World Bank project in the state, this project will focus on system wide capacity challenges such as in strategic planning, data generation and management, health communication, and human resources management.

(c) Investment in norm-based inputs, including infrastructure, drugs, equipment, and training does not necessarily lead to increased access or quality of services especially for the poor. This project supports innovative interventions to improve access to an integrated network of primary care, emergency care, and necessary referral services to benefit, particularly, the remote population through engaging the private sector and creating an integrated technology-enabled health system such as MHVs.

(d) It is important to invest time and energy in building state capacity and in an evidence-based design and also use lessons from initial implementation experience in scaling up the innovations. Learning from the Rural and Water Sanitation Support Project in the state and as also advised by the Quality Enhancement Review, the time frame for the project is six years, allowing for adequate time for mid-course corrections and scale-up based on initial implementation experience.

(e) PPP should effectively harness the private sector to improve the access to and quality of health services, utilizing the relative advantages that each partner brings to the

[1] The World Bank was formerly engaged in the state through the Uttar Pradesh and Uttaranchal Health System Development Project (the state was then called Uttaranchal), which closed in December 2008. Although approved in April 2000, in November, after the bifurcation of Uttar Pradesh state into Uttar Pradesh and Uttaranchal, a separate Development Credit Agreement and Project Agreement were signed with the new state in November 2001. The objective (PDO) of this project was to establish a well-managed health system that delivers more effective services through policy reforms, institutional and human resource development, and investments in health sector.

table, as learned from the analytical tasks recently undertaken in India and Africa. This project aims to support the scale-up of partnerships with the private sector to ensure a sustained and mutually beneficial engagement and improve health care investment and the PPP system.

(f) Strong capacity and transparent system in procurement and financial management (FM) are essential for a well-functioning health service delivery system. The directorate of health services is already using an e-procurement platform, a special financial arrangement for timely payments to private partners through an empowered committee, and the provision of interest to the provider in case of delayed payments has already been agreed with the state government.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

27. The planned institutional arrangements are based on the implementation experience of the previous World Bank-supported health project in the state and the ongoing implementation of the National Health Mission (NHM) in the state. The implementing agency for the project is the UKHFWS constituted under the Department of Medical, Health and Family Welfare (DoMHFW), GoUK. The Mission Director of the NHM is serving as the Project Director (PD) for the UKHSDP, who leads project implementation under the overall guidance and supervision of the Principal Secretary/Secretary, DoMHFW, who is also the Chairman of the Uttarakhand Health and Family Welfare Society (UKHFWS). Each of the key implementation areas is coordinated by a focal point within the UKHFWS and supported by a core project team as detailed in annex 3. The project will be implemented over a six-year period by the GoUK and use the standard onlending arrangements from the GoI to the state. As detailed in annex 3, the project will be administered and monitored at various levels: (a) Project Governing Board (PGB) of the UKHSDP at the apex level, headed by the Chief Secretary, GoUK; (b) Project Steering Committee (PSC) of the UKHSDP headed by Principal Secretary/Secretary, Medical, Health, and Family Welfare; and (c) Project Implementation Team (PIT) under the PD. Implementation support agencies for RSBY/MSBY, as well as independent monitoring and verification agencies for the performance-based contracts under the project, will additionally contribute to appropriate internal controls and validated information emanating from the project.

B. Results Monitoring and Evaluation

28. The project has a Results Framework (RF) and monitoring and evaluation (M&E) system that will enable effective tracking of indicators, results, and implementation progress. The progress of the project toward achieving its targets will be monitored against the set of indicators described in the RF in annex 1. In addition to using the existing state administrative systems for data compilation and reporting, the UKHSDP will prepare annual reports on the status of the performance indicators listed in the RF to track the overall implementation progress toward achieving the PDO (see annex 2 for more details on the description of the links between activities under the project and the PDO-level result indicators).

29. The project builds on existing health information systems currently used for reporting, including the Health Management Information System (HMIS), the Integrated Disease Surveillance Program, and the Mother and Child Tracking System (MCTS). RSBY/MSBY has its own data flows, involving the hospital network and the insurance company, which are aggregated at the state nodal agency level. Many challenges exist with the current health information system, such as delays in reporting, incomplete coverage (for example, data on private hospitals is not available, with a few exceptions), and duplication. The problems are encountered at different levels: data collection, filling up of forms, transportation by carriers, transcription at CHC level, and report generation at the headquarters level. In general, therefore, integration of data sources is inadequate and its analysis and use at the state level also leaves much to be desired.

30. Therefore, the project will finance the strengthening of the state's M&E systems by supporting capacity building and streamlining of M&E systems in the health sector in Uttarakhand. The project will also promote stronger integration of existing data sources and the use of evidence for decision making. New activities under the project, such as the Health Helpline, will also generate substantial amounts of data that will be very helpful.

31. During implementation, the impact of investments will be accessed through selected evaluations. A central aspect of the project design is to subject the core activities to rigorous evaluations, to help create an evidence base to inform future implementation of the health system reform agenda both in Uttarakhand and beyond. Random assignment of interventions at the facility and district level and the phased rollout of activities, will be used to help establish causality of interventions on key outcomes of interest.

C. Sustainability

32. The activities being supported under the project have wide acceptance and buy-in at all levels of the state government, and some of these, such as the Health Helpline, have already been initiated using the state's own resources. The project attempts to further rationalize and optimize the design of these activities and further enhance their allocative and technical efficiency (such as increased focus on primary care and through rationalizing the design and distribution of medical specialists in outsourced CHCs and MHVs), whereby it should be possible to further reduce the recurring cost needs.

33. The state has a good record of sustaining World Bank investments. For example, it has 13 MHVs acquired under the previous World Bank project, which have continued to be operational and much in demand, and are being scaled up under this project as part of the integrated district-level network. The project design focuses on institutional strengthening and creating a robust health stewardship function, which should provide the technical and operational expertise to sustain these demanding modalities of service delivery being rolled out by the state. Finally, the implementation arrangements for the project also do not create a separate or parallel structure, and instead work through existing state systems, strengthening and supporting them as needed, and also bridging the gaps wherever required. This further 'mainstreams' the project activities and makes them an integral part of the health system, which augurs well for their sustenance.

V. KEY RISKS AND MITIGATION MEASURES

A. Overall Risk Rating and Explanation of Key Risks

34. The overall risk is rated as **Substantial.** The project faces significant risks in (a) institutional capacity for implementation and sustainability, (b) technical design of the project, (c) fiduciary, and (d) stakeholders. The key risks, which may impair the effective implementation of the project, are related to the highly innovative nature of the activities being undertaken, to the limited institutional capacity and ongoing human resource constraints faced by the state, and to possible resistance from government service providers in the health sector as the project involves changes which may affect their status quo.

35. **Institutional capacity risk is Substantial.** Given that Uttarakhand is a relatively new state, the GoUK in general has limited institutional capacity which may affect planning, management, and monitoring of efficient service delivery. Furthermore, due to a long-standing inadequacy in the allocation of human resources and their capacity, especially in the management of PPP, major risks to project implementation exist. The proposed mitigation measures to the risks are identified as follows: (a) the project will focus on strengthening the institutional capacity through capacity building of existing human resources and hiring the necessary skills contracted from the market; (b) required capacities identified during project preparation will be closely monitored; (c) the project design prioritizes addressing human resource constraints for clinical, public health, and program management cadres, and (d) training will be provided on PPP mechanisms and contract management.

36. **Technical design risk is Substantial.** Several of the activities planned under the project, such as the integrated district level operators and the expansion of health insurance to primary care, are highly innovative and unprecedented. In addition, the newly introduced contracting models with a results-based element may also be perceived as too complex. Furthermore, the topography of the state might make it difficult to reach the scattered population that lives in deep hill and forest areas. The proposed mitigation measures to the risks are identified as follows: (a) the provision of technical support to the DoMHFW during design and implementation of new/innovative activities; (b) the lessons learned for the state from the innovative activities which have been already initiated in a limited way in the state; (c) phased roll-out of innovations and a longer project implementation period in light of the innovative nature of the project activities and the state's limited capacity,; and (d) collaboration between the MHVs and local health workers from these communities for better outreach to the underserved population.

37. **Fiduciary risk is Substantial.** The FM risk rating is Moderate which reflects the single implementing entity with simplified implementation arrangements, for the most part based on existing government systems. However, the procurement rating is Substantial due to a prior history of challenges with contract management in PPP contracts, especially because PPP contracts are a large part of this project. The previous generation of PPP contracts had issues with their design as well as gaps in the bidding documents, and the team is relatively inexperienced in the World Bank's procurement procedures. The risks and mitigation measures are outlined in section V and detailed in annex 3.

38. **Stakeholders' risk is Substantial.** With the introduction of new modes of service delivery, such as outsourcing, there may be some resistance from government health workers and other government officials working in the state health sector. A series of changes will affect their status quo, which may make government employees feel vulnerable. The proposed mitigation measures to the risks are identified as follows: (a) strengthening the communications to stakeholders to help enhance the understanding of the benefits of the project to the state as well as to government employees, and (b) enhancing proactive information disclosure and communication by the GoUK as well as by the World Bank, especially on the new initiatives involving peripheral users such as RSBY and outsourcing and its advantages to different stakeholders.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

39. The economic analysis focused on the following aspects: recurrent costs and budgetary implications, efficiency gains, cost-effectiveness of key project interventions, cost-benefit considerations and equity aspects of the project. Project components include programmatic initiatives that imply additional *recurrent costs* that will continue beyond project completion. However, the project costs are only slightly over 5 percent of the annual state health budget. As Uttarakhand has had one of the fastest growing economies in the country in recent years, if current growth patterns persist, sustainability of the recurring costs will not pose a challenge to the state. Further, while project activities may lead to a slight increase in overall operating costs, this is a result of investing in new modes of financing and delivering care and as such, benefits will rise more than proportionately, implying an *efficiency gain*. Overall, however, the project is fundamentally about incurring additional cost in exchange for benefits that are well worth those costs and more – and not a pursuit of efficiency gains per se.

40. The project has a strong focus on primary care in its various incarnations—CHCs, expanding the RSBY/MSBY package to include primary care, and MHVs—all of which offer very favorable *cost-effectiveness ratios* based on global evidence (for example, immunization, oral rehydration therapy, and access to contraceptives all offer "very cost effective" ratios as defined by a major recent global research project; see Annex 5 for details). This is also true of certain Component 2 activities related to stewardship, and though these are less amenable to undergoing cost-effectiveness analysis, such investments can leverage improved results from a much larger investment in the health sector by the Government.

41. In principle, the project's activities could contribute to a healthier workforce that raises economic growth and productivity in Uttarakhand. But the "intrinsic" value of health improvements are likely to be even greater. *Cost-benefit analysis* studies from around the world suggest that the value of a statistical life year is at least five times higher than GDP per capita, which translates into about US$8,500 in Uttarakhand. With this value and if project spending (including recurrent costs) is about US$25 million per year at peak implementation, the project would only have to achieve an average of about 3,000 additional life years annually to 'break even'. The relative ease of surpassing this threshold – through the strengthening of primary care interventions as noted above – implies very high benefits vis-à-vis the investments made, consistent with recent economic research in this area.

42. The project also contributes to *equity* by addressing the issues of access denied and/or sick patients not seeking appropriate care when needed, which are common occurrences in the state. The focus on geographic access and primary care interventions are naturally well-suited to ensure that activities will benefit poor households. In addition, financial protection would be improved by the innovation of expanding RSBY/MSBY to include outpatient expenditures—a major source of OOP and catastrophic episodes in the state. A more detailed economic analysis is presented in annex 5.

B. Technical

43. The technical design for the project is a result of extensive review of the state data, primary quantitative, qualitative, and geospatial research undertaken in the state, and wide stakeholder consultations, drawing on international expertise and global experiences of the invited experts and the World Bank team. The state's context with regard to the scarcity of qualified human resources (particularly specialists), geographical access issues, and ongoing innovations in the PPP space have informed the design.

44. The review of previously existing PPP contracts identified several design and operational issues in the existing PPPs. To meet the state government's needs, the PPPs must be organic and integral to the health system of the state, integrated with both the existing and planned health system entities and services, and also the health insurance system, RSBY/ MSBY. Learning from these lessons of the past, due diligence has been undertaken in the design of PPPs in UKHSDP, which has also been strengthened further by extensive consultation with the beneficiaries, the private health sector, and other stakeholders.

45. The planned design consists of multiple self-contained clusters of clinical services backed by a robust oversight and monitoring mechanism and fully integrated with the expanded RSBY/MSBY in the state. The new system aims at enlarging the scale to allow PPP operators to realize significant operational and technical efficiencies and synergies.

46. The project design has been informed by very robust evidence-generation initiatives. The census and geospatial mapping of all formal health providers in the state, public and private, as well as qualitative research on patient perceptions on access, costs, and availability of health services in remote districts has been undertaken. Several international experts and practitioners[2] participated in a stakeholders' workshop in Delhi to discuss options for expansion of health insurance to include primary care (February 24–26, 2014) and also conducted a one day discussion on the project in Dehradun. A consultation workshop was co-organized by the GoUK and the World Bank in September 2014 with more than 40 participants representing various private sector groups to discuss the proposed innovative models for collaborating with the private sector and contributing to the project design. Such consultations and studies have ensured that all the planned activities are well grounded and evidence based, taking into account the contextual challenges, and yet progressive and transformative enough to bring about the much necessary expansion of access and quality of health services, as well as financial protection needed in the state.

[2] The participants were from Turkey, Thailand, Costa Rica, and Kaiser Permanente.

C. Financial Management

47. The UKHFWS implementing the NHM in the state will also be the implementing agency for this project, and it has successfully implemented the earlier World Bank-supported Uttar Pradesh and Uttaranchal Health System Development Project (UAHSDP). The UKHFWS has functioning FM systems which meet the requirements of the project and the World Bank.

48. The project FM arrangements are summarized as follows:

(a) A budget head has been created by the GoUK for the project along with an initial allocation of funds. The current system of transferring financial resources from the budget to the bank account of UKHFWS will be followed by the project. A separate project bank account will be opened by the UKHFWS, which will be handled jointly by the PD and Finance Controller (FC) who will be the joint signatories. All payments and procurements will be carried out by the UKHFWS.

(b) Currently, the UKHFWS follows double entry cash basis of accounting according to NHM rules. As a part of the computerized accounting system of UKHFWS, project accounts will be maintained separately. The Accounts Department is managed by the FC, who is deputed from the state's Finance Department. It was agreed that the FC will be supported by key staff who will be employed on a contract basis. Currently the FC is supported by contract staff from NHM, including an accounts manager and Tally accountant and an audit officer.

(c) All financial controls applicable to routine expenditures will also apply to the expenditures under the project. All payments will be approved/vetted in accordance with the schedule of powers in place for the UKHFWS. All project related receipts and payments/withdrawals will be reconciled with periodic World Bank statements.

(d) An internal audit will cover all activities under the project and could be carried out by a chartered accountancy firm according to the terms of reference (ToR) agreed with the World Bank. The auditor will be appointed within one year of project effectiveness. The audit reports along with the compliance will be shared with the World Bank. The project's financial statements, to be audited by the chartered accountancy firm, will need to be submitted to the World Bank within nine months from the end of each fiscal year.

(e) Interim unaudited financial reports (IUFRs)-based disbursement will be used for the project which is to be submitted to the World Bank on a half-yearly basis within 45 days from the end of the half year. The IUFRs will disclose receipt and utilization of project funds (both World Bank share and counterpart contribution).

49. **Disbursements**. Disbursement will be on reimbursable basis, as the state will provide the budget for project expenditure. Table 2 shows the disbursement categories envisaged for the project.

Table 1. Disbursement Categories

Category	Amount of Financing Allocated (US$, million)	Percentage of Expenditures to be Financed (inclusive of taxes)
(1) Goods, non-consulting services, and consultants' services, incremental operating costs, and training for the project	74	80
(2) Medical insurance claims and medical insurance premiums for Subcomponent 1.2 of the project	26	80
Total Amount	100	

50. **Contract management.** Due to the nature of PPP projects being planned in the project, contract management is very essential for this project. The project will hire suitable persons with financial, legal, and technical backgrounds to manage the contracts. The project will also build a management information system (MIS) to track these contracts during the project period. Contract and variation management will be one of the key challenges for the project.

D. Procurement

51. The procurement of goods and non-consulting services required for the project and to be financed out of the proceeds of this financing shall be done in accordance with the requirements set forth or referred to in the 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers', dated January 2011, revised July 2014. Selection of consulting services required for the project and to be financed out of the proceeds of the financing shall be done in accordance with the requirements set forth or referred to in the 'Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers', dated January 2011, revised July 2014; and the provisions stipulated in the Financing Agreement.

52. As a part of preparation process, a procurement capacity assessment was carried out using Procurement Risk Assessment Management System (PRAMS) and accordingly, the risk mitigation measures were proposed. The initial overall risk rating for the project is High. However, the residual risk rating after taking proposed mitigation measures is Substantial.

53. The procurement of goods and services shall be carried out using an e-procurement platform. The UKHFWS is already using an e-procurement platform (https://uktenders.gov.in) developed by the National Informatics Centre. The portal system has been assessed by the World Bank and was cleared for its adoption for World Bank-funded projects in 2013. It is foreseen that the procurement of health service such as CHCs, MHVs, and expansion of the existing RSBY/MSBY, and so on shall be outsourced to private health service providers and operated through PPP contracts. The PPP contracts shall be formulated based on the existing PPP policies of the state government.

54. During project preparation, the use of procurement plan execution software system called Systematic Tracking of Exchanges in Procurement (STEP) for execution of procurement plans for

the project to strengthen the procurement monitoring was confirmed. The World Bank will arrange training on use of STEP when the focal persons are identified and put in place. Trainings (study tours, workshops, training for staff, and so on) and operational costs will be met from the incremental operating cost, following borrower's procedures.

E. Social (including Safeguards)

55. No negative social safeguard issues and impacts on the project are expected because the proposed project activities do not involve any construction works, land acquisition, or involuntary resettlement. However, as the state has about 3 percent of tribal population, many of whom reside in the hilly and remote areas of the state OP/BP 4.10 is triggered. The state has developed an integrated Environmental and Social Management Plan (ESMP), which includes a tribal action plan, and was disclosed on September 2, 2014. The ESMP, including the tribal action plan therein, was updated and re-disclosed by the state on December 1st, 2016. A social assessment was also conducted and is summarized in annex 6.

56. **Gender.** Difficult geographical terrain contributes to low utilization of health services and undesirable health outcomes, which disproportionally affect women who are constrained in their mobility. The '108' ambulances deployed across the state have significantly enhanced availability of emergency transport, yet communities that live deep in hills and forests are unable to use this facility. Low awareness of health issues among communities is yet another issue that needs to be addressed. The project aims to enhance access and equity of health services to all underserved populations of the state through innovative interventions that will improve access as well as strengthen state health systems to expand health coverage, contributing to affordable and quality health care for all. As such, the project should make a positive contribution by improving women's access to health services, by connecting remote populations to improved health services, and by focusing on awareness, communication, and equity. Disaggregated analysis by gender is envisaged throughout the implementation period to guide project activities as noted in the RF.

57. **Citizens' engagement.** Citizens' engagement is integral to the project, particularly through implementation of Subcomponent 1.1. The contracts for integrated district-level operators under this subcomponent provide for kiosk-based collection of patient feedback, which is closely monitored and constitutes part of the performance criteria. The toll-free Health Helpline, under the same component, is also designed to help patients navigate the health system and access appropriate health facilities according to location and medical need, receive and track patients' grievances toward services provided, and undertake collection of patient feedback. The project's RF includes two citizen engagement indicators, (a) Number of persons who used the Health Helpline to receive health information/advice (disaggregated by gender) and (b) Patients who used the Health Helpline that are satisfied with the health services provided to them (per year, disaggregated by gender) (see annex 1).

F. Environment (including Safeguards)

58. An integrated approach toward better sanitation, hygiene, infection control, and waste management is essential to support the project's objective of providing cleaner health facilities and high quality of health services to the state of Uttarakhand. The nature of this project provides

tremendous opportunities to enhance these systems in the state so as to further promote sound public health outcomes, while also ensuring that there are no adverse impacts to the environment.

59. Due to the nature of environmental impacts of the project, which are well identifiable and manageable, the project has been categorized as 'B' in accordance with the World Bank safeguards policies. The UKHFWS has completed a sample survey and a situational analysis, based on which the ESMP was developed and disclosed on their website on September 2, 2014 which was further updated and re-disclosed by the state on December 1st 2016. The project has been screened for short- and long-term climate and disaster risks on December 20, 2016. Risks and appropriate resilience measures are recognized during project preparation, which have been integrated in project design as needed.

60. Environmental aspects will be an integral part of both components of this project, which focus on institutional and skill strengthening and multi-sectoral coordination, along with private sector engagement. Since waste management and provision of utility services require involvement of multiple stakeholders, the project will support engagement with related sectors, which include the Department of Environment, Uttarakhand Pollution Control Board, urban authorities, and municipalities for better monitoring and enforcement of sound systems for waste transportation, treatment, and disposal. Based on the facilities assessment, if there is need for physical improvements to meet quality and patient safety requirements to meet NABH standards in the identified facilities, the client will inform the World Bank of site-specific environmental due diligence and mitigation measures to be implemented by the contractor.

61. The earlier World Bank-funded UAHSDP initiated sound health care waste management systems. The current project needs to build and improve upon those existing systems, while taking into account emerging environmental issues and the new legislations and policies promulgated by the GoI, including the BioMedical Waste Management Rules and the Infection Management and Environment Plan instituted under the NHM.[3]

G. World Bank Grievance Redress

62. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

[3] http://nrhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines/infection-management-and-environment-plan-imep.html

Annex 1: Results Framework and Monitoring

India: Uttarakhand Health Systems Development Project (P148531)

Project Development Objectives								
PDO Statement								
The PDO is to improve access to quality health services, particularly in the hilly districts of the state, and to expand health financial risk protection for the residents of Uttarakhand.								
These results are at	Project Level							
Project Development Objective Indicators								
		Cumulative Target Values						
Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	YR6	End Target
Number of outpatient visits to Primary Health Centers (PHCs), CHCs, and mobile vans per year, disaggregated by districts (Number)	774,926 For Financial Year 2015–2016: Uttarakhand HMIS (All PHCs and CHCs) 670,804 + DoHFW MHVs 64,762 + NHM MHVs 39,360 = Total 774,926	800,000	900,000	1,000,000	1,050,000	1,100,000	1,150,000	1,150,000
Number of persons who used the Health Helpline to receive	81,192	100,000	100,000	120,000	120,000	150,000	160,000	160,000

information or lodge grievances, disaggregated by gender. (Number)	(From May 2016 to November 25, 2016)							
Patients contacted by the Health Helpline that are satisfied with the health services provided to them (per year, disaggregated by gender) (Percentage)	n.a.	n.a.	n.a.	55.00	60.00	65.00	70.00	70.00
Number of government and non-government healthcare facilities in the state issued with an entry (or higher) level certification by the National Accreditation Board for Hospitals (Number)	2.00	2.00	2.00	2.00	4.00	6.00	8.00	8.00
Number of hospital admissions and outpatient consultations covered by any form of health insurance supported by the project (RSBY and MSBY), disaggregated by gender (Number)	46,040 (MSBY Phase I: April 1, 2015–July 2016)	50,000	50,000	60,000	60,000	80,000	100,000	100,000

Intermediate Results Indicators								
		Cumulative Target Values						
Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	YR6	End Target
People with access to any form of health insurance in the state during the year, disaggregated by gender (Number)	921,584 (male:544,357, female:377,227) (RSBY 2014)	900,000	2,000,000	2,000,000	3,000,000	3,000,000	5,000,000	5,000,000
Number of children covered under the expanded health insurance program who received an annual health assessment during the year, disaggregated by gender (Number)	n.a.	n.a.	50,000	100,000	200,000	200,000	200,000	200,000
Number of children immunized during the year (Number)	140,631 (FY15–FY16)	145,000	150,000	160,000	170,000	180,000	180,000	180,000
Number of patients who use the services provided by the mobile health vans, disaggregated by gender (Number)	104,122 (DoMHFW MHVs: 64,762 + NHM MHVs 39,360 = Total 104,122)	120,000	150,000	200,000	200,000	300,000	300,000	300,000
Number of mobile medical units	0	3	3	6	6	6	9	9

complying with the requirement of having at least one female doctor with sonology certification (>90% compliance on a day-to-day basis) (Number)	(No MHVs with ultrasound are operational)							
Number of outsourced CHCs with utilization of emergency services reported during each month (Number)	0	2	2	4	6	8	8	8
Number of outsourced CHCs where at least one emergency caesarean section was reported during each quarter (Number)	0	2	2	2	4	6	6	6
Benefit package of child health services finalized and piloted (Text)	n.a.	n.a.	Yes					'yes' from Year 2.
Benefit package of NCDs services finalized and piloted (Text)	n.a.	n.a.	n.a.	Benefit package finalized	Benefit package piloted	Benefit package rolled-out state wide	Benefit package rolled-out state wide	Benefit package rolled-out state wide
Share of eligible households successfully enrolled under	45.70 (RSBY 2014)	46.00	50.00	50.00	50.00	50.00	50.00	50.00

RSBY/MSBY during the year (Percentage)								
Number of specialists working in the outsourced health facilities (and augmenting the positions functionally vacant in the public system) (Number)	25	25	35	35	50	50	50	50
Health personnel receiving training financed by the project-cumulative (Number)	0	500	1,000	2,000	3,000	4,000	5,000	5,000
Development and periodical update of a comprehensive disaster response plan at the state level (1= in process, 2= complete, 3 = updated and revised)	n.a.	n.a.	Comprehensive disaster response plan drafted				Comprehensive disaster response plan revised and updated	Drafted by Year 2 and revised by Year 6.

Indicator Description

Project Development Objective Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Number of outpatient visits to PHCs, CHCs, and mobile vans per year, disaggregated by districts	Indicator of access to quality health services. Measures annual number of visits to PHCs, CHCs, and MHVs in each district of the state.	Annual	Administrative data	UKHFWS
Number of persons who used the Health Helpline to receive health information or lodge grievances, disaggregated by gender.	Indicator of access to quality health advice and a guide to available health services Separate analysis will be performed by gender, by geographical areas. This is also an indicator for measuring the level of citizen's engagement.	Annual	Administrative data	Health Helpline operator and the UKHFWS
Patients contacted by the Health Helpline that are satisfied with the health services provided to them (per year, disaggregated by gender)	Indicator of quality health services as well as for measuring the level of citizen's engagement. Numerator: number of people who used the Health Helpline and were satisfied with the services when surveyed using an outbound call. Denominator: Total number of people who responded to the outbound call survey of the Health Helpline. Separate analysis will be performed by gender. The outbound call will be established in year 3, and level of satisfaction is	Annual	Administrative data	Health Helpline operator and the UKHFWS

	estimated based on similar methods of gauging patient satisfaction.			
Number of government and non-government healthcare facilities issued with an entry (or higher) level certification by the National Accreditation Board for Hospitals	Indicator of access to quality health services.	Annual	Administrative data/ Reports from National Accreditation Board for Hospitals and Healthcare Providers	NABH and the UKHFWS
Number of hospital admissions and outpatient consultations covered by any form of health insurance supported by the project (RSBY and MSBY), disaggregated by gender	Indicator of financial protection against health events, as a proxy for reduction in OOP expenditure. Records will be disaggregated for hospital admissions and for outpatient consultations. Analysis will be disaggregated by gender.	Annual	Administrative data	Insurers and the UKHFWS

Intermediate Results Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
People with access to any form of health insurance in the state during the year, disaggregated by gender (Number)	Indicator of financial protection against health events, as a proxy for reduction in OOP expenditure. Records will be disaggregated by gender.	Annual	Administrative data	Insurers and the UKHFWS
Number of children covered under the expanded health insurance program who received an annual health	Indicator of financial protection. Measures coverage for preventive child health checks.	Annual	Administrative data	Insurers and the UKHFWS

assessment during the year, disaggregated by gender				
Number of children immunized during the year	Based on state government HMIS data, measuring number of children vaccinated with BCG during the year as proxy for any immunization.	Annual	Administrative data	UKHFWS
Number of patients who use the services provided by the mobile health vans, disaggregated by gender	Based on state's administrative data including the aggregate number of services provided by all types of MHVs including state, NHM and PPP MHVs. Data is disaggregated by gender as available.	Annual	Administrative data	PPP operators and the UKHFWS
Number of mobile medical units complying with the requirement of having at least one female doctor with sonology certification (>90% compliance on a day-to-day basis)	Based on state's administrative data for all types of MHVs including state, NHM and PPP MHVs.	Annual	Administrative data	PPP operators and the UKHFWS
Number of outsourced CHCs with utilization of emergency services reported during each month	Based on administrative data reported by outsourced CHCs	Annual	Administrative data	PPP operators and the UKHFWS
Number of outsourced CHCs where at least one emergency caesarean section was reported during each quarter	Based on administrative data reported by outsourced CHCs	Annual	Administrative data	PPP operators and the UKHFWS
Benefit package of child health services finalized and piloted (Text)	Process indicator for progress on Subcomponent 1.2. Compliance confirmed by implementation support mission.	Annual	Administrative data	UKHFWS

Benefit package of NCDs services finalized and piloted (Text)	Process indicator for progress on Subcomponent 1.2. Compliance confirmed by implementation support mission	Annual	Administrative data	UKHFWS
Share of eligible households successfully enrolled under RSBY/MSBY during the year (Percentage)	Process indicator for financial protection. Based on administrative data from the respective insurance program. Denominator is the complete list of eligible households for the respective program.	Annual	Administrative data	Insurers and the UKHFWS
Number of specialists working in the outsourced health facilities (and augmenting the positions functionally vacant in the public system)	Indicator of access to quality health services. Based on administrative data reported by outsourced CHCs	Annual	Administrative data	PPP operators and the UKHFWS
Health personnel receiving training financed by the project- cumulative (Number)	Process indicator for Component 2. Based on state's own HR information system.	Annual	Administrative data	UKHFWS
Development and periodical update of a comprehensive disaster response plan at the state level(1= in process, 2= complete, 3 = updated and revised)	Process indicator for Component 2. Compliance confirmed by implementation support mission.	Annual	Administrative data	UKHFWS

Annex 2: Detailed Project Description

India: Uttarakhand Health Systems Development Project

1. Taking into account the evidence around the shifting trends in morbidity and mortality, the project will support the stewardship role and capacity of the state's DoHFW for improving health outcomes through innovations in developing and engaging the private sector, institutional strengthening, and improved management of health services. Interventions will support the state's plans for scaling up health system reform initiatives and making progress toward universal health coverage. Special focus will be on improving access to quality health services for the geographically dispersed and remote populations in the state and finding innovative ways to engage with the private sector. The project also aims to reduce financial risk and make affordable, quality health care available to all citizens of the state.

2. The project will have two components: (a) Innovations in Engaging the Private Sector (for integrated service delivery and for health financing) and (b) Stewardship and System Improvement (to enable innovations in engaging the private sector). The total project cost is US$125 million, of which the IDA component is US$100 million and the state's share is US$25 million. A description of the activities under the two project components is provided in the following paragraphs.

Component 1. Innovations in Engaging the Private Sector (Total amount: US$80 million, including IDA US$64 million and GoUK US$16 million)

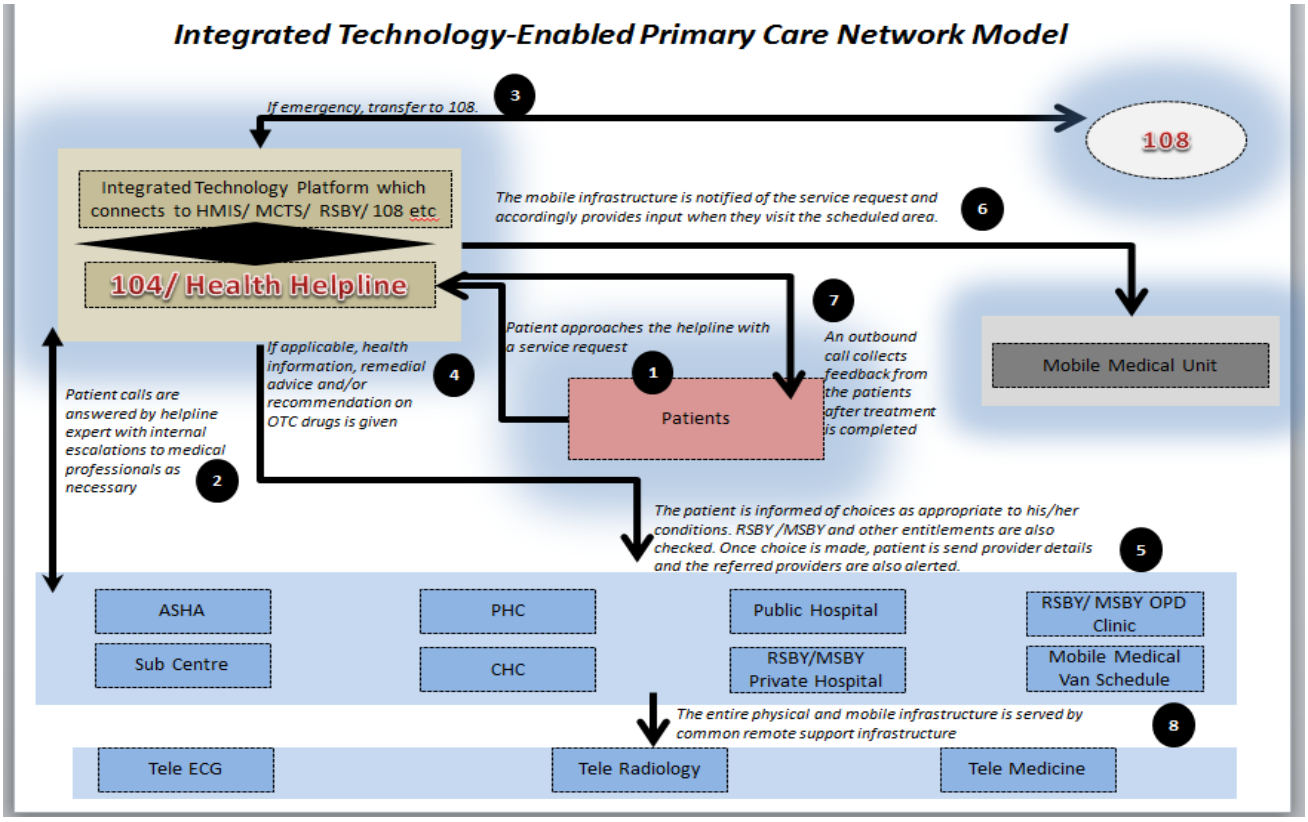
3. Innovations in engaging the private sector is the main project component that aims to stimulate and finance innovative engagement with the private sector in the delivery of health care services as well as in health care financing. This component will expand access to services by creating an integrated, technology-enabled health system architecture with enhanced focus and availability of primary care, emergency care, and necessary referral services (figure 2.1). It will also expand financial protection by defining a benefit package of primary care services for child and adolescent care and for the management of NCDs.

4. The state has already acquired some experience with PPPs for service delivery. However, existing contracts are posing challenges due to (a) poor contract design, lack of supervision and monitoring, lack of incentives, and penalties and (b) lack of institutional capacity to design, procure, manage, and monitor the PPPs. This project aims to support the Government in overcoming such challenges, the first set of which is addressed by this component, while the second is addressed by Component 2 of the project. Component 1 will have two subcomponents.

Subcomponent 1.1. Innovations in integrated delivery of healthcare services (primary, referral, and emergency care) (US$47.5 million)

5. This subcomponent aims to improve access to an integrated network of primary care, referral services and emergency care in the state through engaging the private sector (figure 2.2). It is designed to particularly benefit the remote populations. This subcomponent will improve the current PPP practices in the state to enhance the reach and quality of health care service delivery.

Figure 2.1. Integrated Technology-Enabled Primary Care Network Model

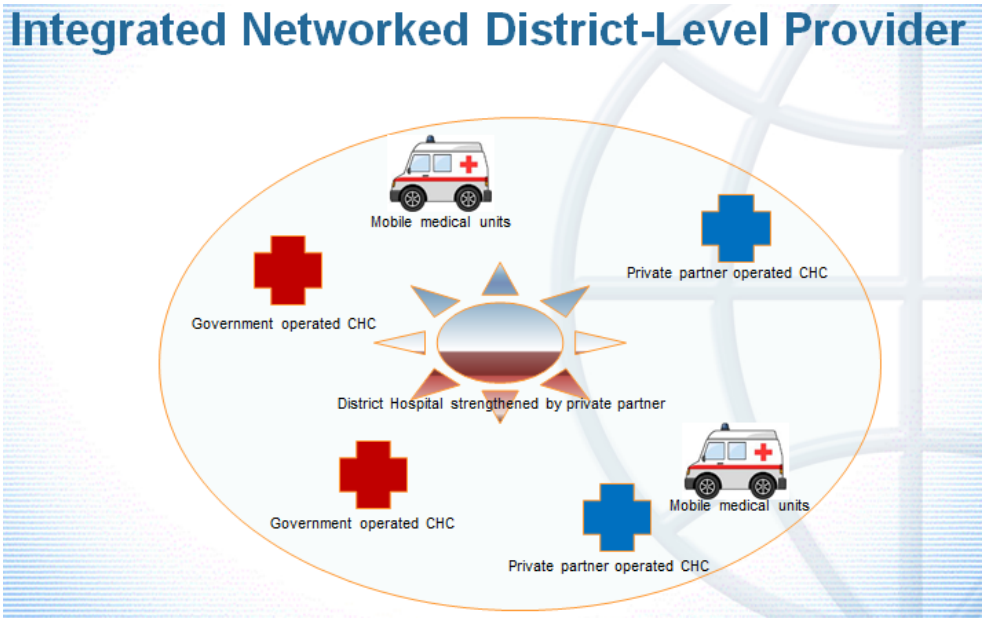


6. This will be achieved by (a) supporting the development of a conducive regulatory, policy, and institutional environment to support ongoing and new PPPs; (b) reviewing and restructuring ongoing PPPs for CHCs and MHVs; and (c) supporting the development of new PPPs as integrated networks of MHVs, outsourced CHCs, as well as government-run CHCs, and specialist services and diagnostic services at the district hospitals. This will be taken up in selected districts and backed by the development of an information network promoting a patient centric health system, which will help patients navigate across different levels of care and across public and private providers, as well as create linkages to financing entities such as RSBY/MSBY. The project will support a health information and telemedicine service available across the state.

7. The previous PPP model involved outsourcing the management of remote CHCs, offered together in clusters of four each, to private operators selected on a competitive basis. Instead, under the integrated district-level network approach, it is envisaged that the management contracts for the CHCs and the MHVs will be combined (within a geographical area), to one private provider, along with the contract for a referral center at the district level, to optimize the service delivery and allow better integration of care, also making it possible to redeploy or reassign existing public sector human resources to other areas that face scarcity of human resources. This more integrated and comprehensive approach allows better coordination, management control, and monitoring, as well as provides a complete chain of services to patients. This will also optimize the Health Helpline as a first point of contact or the health network gateway, which helps patients navigate the health system and approach health facilities appropriate to their needs, as well as proactively collects patient feedback. It is suggested that the MHVs (under PPP) could act as the primary care

community level access point, in which outpatient consultation, basic diagnostic services, ANCs and other preventive services, as well as supply of medicines could be provided. If the patient needs additional clinical services or diagnosis, the CHCs could act as the first referral unit. However, if the CHCs are managed by the same private provider who operates the MHV, then the referral linkage could help optimize the primary care service delivery system. In case patients need advanced diagnostics (for example, CT Scan) and (specific) specialty care services (for example, surgical wards), the CHCs could refer the patients to district hospitals, where some of the specialist and diagnostic services could be managed and operated by the same integrated provider.

Figure 2.2. Integrated Networked District-level Provider



Sub-component 1.2. Innovations in healthcare financing (US$32.5 million)

8. This subcomponent supports the expansion of primary care coverage into the state's health insurance programs (RSBY and MSBY) and addresses the bottlenecks that these programs have been facing. This subcomponent will focus on designing, implementing, and evaluating benefit packages around childhood and adolescent health, as well as case management of NCDs in primary care settings, purchasing care from public as well as private providers.

9. The current RSBY/MSBY benefit covers hospitalization expenses for medical and/or surgical procedures on a floater basis. However, it is increasingly evident that impoverishing OOP spending on health by households, particularly the poor and vulnerable, is often due to outpatient care expenses. Therefore, integrating primary care into RSBY is being explored by the program at the central and state levels, with Uttarakhand being the key pilot state for this initiative. In addition, in February 2014, the state announced the expansion of similar coverage for the families not below the poverty line in the state, christened as MSBY. Thus, every resident of Uttarakhand (excluding certain higher-income categories) is now eligible for health insurance coverage for hospital services, making an expansion into a primary care program even more viable in remote areas of the state. Despite such commitment, the current implementation of RSBY and MSBY face several

challenges and bottlenecks, including enrollment challenges, as well as shortcomings from the supply side.

10. The state's expansion of RSBY and MSBY into primary care will be necessarily phased and achieving this expansion will need to begin with addressing the bottlenecks facing the current implementation of RSBY and MSBY. Expanded packages will be piloted in a small number of districts. The first phase coverage expansion is proposed to start with child health services, with a plan to expand in the next phase to NCDs. The project will support the state with evidence and global knowledge to make key decisions on the specifics of expanded benefit packages, provider payment mechanisms, payment rates, provider empanelment criteria (including the balance between access, quality, and other provider characteristics), and interface with the existing hospital coverage. It will finance the costs of an ISA, reimburse the claims paid for primary care services, and, subsequently, finance the competitively determined premium paid for the primary care coverage provided under the state's health insurance programs.

Component 2. Stewardship and System Improvement (Total amount: US$45 million, including IDA US$36 million and GoUK US$9 million)

11. This component aims to strengthen the Government's ability to engage effectively with the private sector and therefore enable the Government to provide effective stewardship to the entire health system, particularly in its capacity to effectively pursue the innovations being planned under this project. The component will focus on strengthening the institutional structures for stewardship and service delivery and augmenting the state's human resource capacity, so that the necessary skillsets required for effective implementation of the project and the state's health programs are available. The strengthened capacity will serve beyond the activities of this project, as it will contribute to the Government's stewardship role for the health system as a whole.

12. This component will finance research and evidence generation, use of evidence for strategic planning, and improved information systems for data generation and management, including timely feedback to providers. An independent monitoring and verification agency will also be hired to support the state in field-level monitoring and performance validation of the contracted entities. It will also finance an assessment of existing facilities, as well as contracting of agencies on a turnkey basis to support the attainment of National Accreditation Board for Hospitals and Healthcare Providers (NABH) quality standards in identified public health facilities in the state. The scope of such turnkey contracts may include training of staff, creation of standard manuals and other quality documentation, and some minor refurbishments, among others. Finally, the component will promote a multidisciplinary approach that will strengthen the ability of the health system to respond to seasonal and context-specific needs. For instance, specific activities financed under the project will include detailed planning for the potential redeployment of MHVs as trauma and medical relief centers in case of natural disasters, in close coordination with the disaster response mechanisms being strengthened under an existing World Bank-financed project. The project management costs including salaries of full time staff assigned to the project, hiring of consultants, training, office rent and utilities, office maintenance and repair, vehicle hiring, communication and other administrative costs will also be financed from this component.

13. The component will build upon the foundations of the previous World Bank project in the state. It will work closely with the present structure of the NHM, which is the flagship initiative of

the national government, providing additional financial resources to strengthen the state's health delivery infrastructure, with a focus on public health, maternal and immunization services, and disease control programs. The project will maximize the use of available human resources and expand the available manpower to provide health services by engaging the private sector, as described in Component 1. The aim of this component is to strengthen the Government's program management capacity to effectively engage the private sector. This capacity will serve beyond the activities of this project, as it will support the development of the Government's stewardship role for the health system as a whole.

Annex 3: Implementation Arrangements

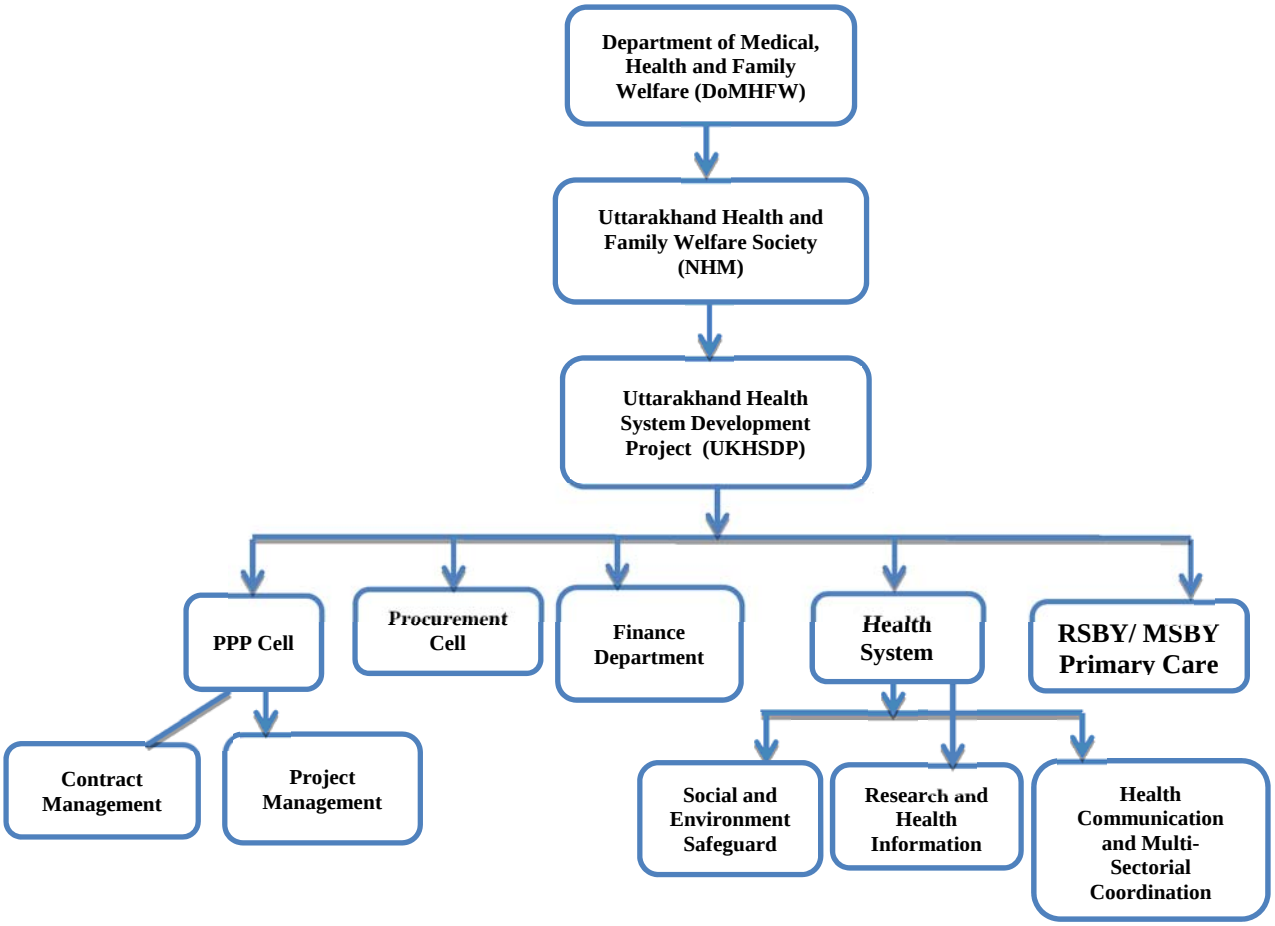
India: Uttarakhand Health Systems Development Project

Project Institutional and Implementation Arrangements

1. The proposed institutional arrangements are based on the implementation experience of the previous World Bank-supported health project in the state and the ongoing implementation of the NHM in the state. The implementing agency for the project will be the UKHFWS constituted under the Department of Medical, Health and Family Welfare (DoMHFW), GoUK. The Mission Director of the NHM will also be the PD for the UKHSDP and will lead the project implementation under the overall guidance and supervision of the principal secretary/secretary, DoMHFW, who is also the chairman of the UKHFWS. Each of the key implementation areas will be coordinated by a focal point and supported by a core group. The project will be implemented over a six-year period by the GoUK and use the standard on lending arrangements from the GoI to the state.

Implementation Arrangement

Figure 3.1. Functional Structure of UKHSDP



2. The project will be administered and monitored at various levels.

(a) **PGB.** This will be constituted under the chairmanship of the chief secretary, GoUK to provide overall direction, approval of posts, and financial and legal sanctions. The PGB can delegate powers to the PSC and the PD in the interest of efficiency in the execution of project activities.

(b) **PSC.** The PSC will be constituted under the chairmanship of the principal secretary/secretary medical, health and family welfare under the UKHSDP. He/she will have delegation of financial and procurement authority from the PGB for hospital equipment, supplies, and consultancy contracts, as well as constituting selection committees to select staff/consultants for project. The PSC will consider all proposals—administrative, financial, and project components—placed before it by the PD and accord sanction. The PSC will meet at least once in quarter.

(c) **PIT.** The team will be based at the UKHFWS and will be responsible for managing the timely and effective implementation of the project. It will be led by the PD, who will be supported by an additional PD. In addition, the PIT will have team members drawn from the Departments of Medical Health and Family Welfare and their respective directorates.

3. The PIT will be based in five different departments/cells under which the PPP cell and the health system strengthening are the two major departments/cells, which will be responsible for the implementation of Subcomponent 1.1 and Component 2 of the UKHSDP. The procurement cell and the finance cell will be responsible for the procurement and financial activities of the project, respectively, while the RSBY/MSBY cell will be responsible for the implementation of Subcomponent 1.2 of the project. The PIT is also equipped with a quality assurance and coordination cell responsible for the day-to-day monitoring and supervision of the project.

4. The department/cell head will be responsible for all the activities carried out by the respective department and all the support staff under each department will report to the department/cell head on a daily basis, who in turn will report to the additional PD, UKHSDP, on a daily/weekly basis. The PD will be updated by the additional PD on a daily basis. Within the PIT, routine review meetings will be held at least once a month to review the progress of the project, chaired by the PD.

5. Detailed compositions of department/cells are as below.

(a) **Procurement cell.** The procurement of goods and services including non-consulting services shall be conducted by the procurement cell. The procurement cell will be headed by a full-time, Assistant Director-level official who is supported by a procurement expert (contractual) and a program assistant (contractual).

(b) **Finance Department.** The Finance Department of the project is responsible for all project-related financial transactions, accounting, audit, and other FM functions. This department is headed by the FC from NHM. The FC will be supported by a finance expert (contractual) and an accounts manager (contractual).

(c) **Health communication and multisectoral coordination cell.** This cell is responsible for the activities, which involve health communication, as well as improved coordination with other departments that have linkages with health. This cell will develop the mechanism for effective sectoral integration for better coordination between departments. The cell will be headed by a full time deputed Communication officer who will be supported by one full-time contractual expert for health communication and multisectoral coordination.

(d) **Social and environmental safeguards cell.** The social and environmental safeguards cell is responsible for all activities of the project focusing on social and environmental aspects, as well as indigenous people, and is responsible for the implementation of the ESMP. This cell will be handled by a full-time deputed person from the Director General Health Services (DGHS) to the UKHSDP and will be supported by contractual experts and other support staff.

(e) **RSBY/MSBY cell.** The RSBY/MSBY primary care component of the project will be handled by the RSBY/MSBY cell. This cell will be headed by a program officer (joint director level) and supported by a health-financing expert. For effective implementation of the project activities the staff already involved in the RSBY/MSBY implementation at the state level will also be involved in the day-to-day activities of this cell.

(f) **PPP cell.** The PPP cell will be responsible for the implementation of Subcomponent 1.1 of the project. A joint director-level official from the DGHS, on full-time deputation to the UKHFWS, will head the PPP cell and will also be responsible for all PPP activities of the project. The PPP cell will be divided into two categories for managing the PPP project efficiently. The contract management unit of the cell is headed by an assistant director-level official who will be a full-time official on deputation from the DGHS to the UKHFWS for efficient management of the PPP projects. The assistant director of the contract management unit will be supported by at least two experts—one for MIS and other one for monitoring and supervision of the project activities. This unit is also responsible for coordinating timely payments to the private partner that will be processed by the accounts manager in the Finance Department. The PPP cell is responsible for development and planning of PPP projects which involves development of the transaction structure, bid evaluation, project management, and so on. A full-time, assistant director-rank official on deputation from the DGHS to the UKHFWS will head this department. This unit is also supported by two contractual experts—one for transaction and planning and another a legal expert, who will look after legal matters in the PPP contracts. The PPP cell will also be supported by program assistants who will be responsible for day–to-day documentation and reporting. For effective coordination and monitoring, a few field coordinators will also be appointed in the PPP cell with the main responsibility of monitoring of private partner and coordination in its day to day activities.

PGB

Table 3.1. Project Governing Body Members

Sr. No.	Office	Member
1	Chief Secretary, GoUK	Chairman
2	Principal Secretary/Secretary (Finance)	Member
3	Principal Secretary/Secretary (Law)	Member
4	Principal Secretary/Secretary (Planning)	Member
5	Principal Secretary/Secretary (DoMHFW)	Member
6	Principal Secretary/Secretary (Pollution control)	Member
7	Principal Secretary/Secretary (Disaster management)	Member
8	PD (UKHSDP)	Member secretary
9	DGHS, DoMHFW	Member
10	Special invitee members (2 to 4)	Member

PSC

Table 3.2. PSC Members

Sr. No.	Office	Member
1	Principal Secretary/Secretary (DoMHFW)	Chairman
2	Secretary/Additional Secretary, Medical and Health	Member
3	Secretary/Special Secretary, Finance, GoUK	Member
4	PD (UKHSDP)	Member
5	DGHS, DoMHFW	Member
6	DG Family Welfare, DoMHFW	Member
7	Additional PD, UKHSDP	Member secretary
8	Special invitee member(s)	Member

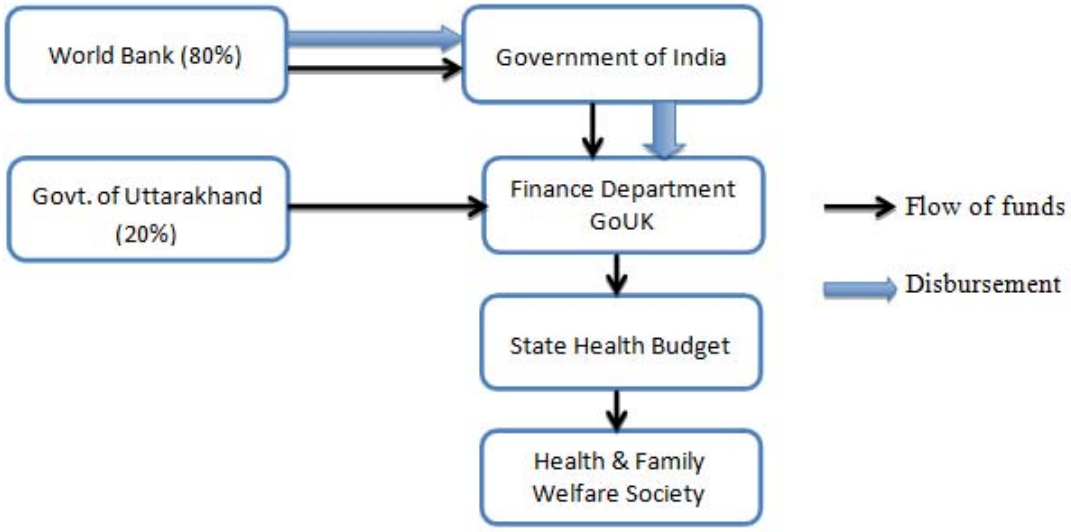
PIT

Table 3.3. PIT Members

Sr. No.	Office	Member
1	PD, UKHSDP	Chairman
2	DGHS, DoMHFW	Member
3	Additional PD (UKHSDP)	Member secretary
4	Joint Director (PPP cell)	Member
5	Joint Director (Research and health information system)	Member
6	Joint Director (Multisectoral coordination)	Member
7	Joint Director (Capacity building and training)	Member
8	Joint Director (Procurement)	Member
9	Joint Director (Social safeguard)	Member
10	Joint Director (Environment)	Member
11	FC-NHM, UKHFWS	Member

Fund Flow under the UKHSDP

Figure 3.2. Fund Flow under the UKHSDP



6. In the initial period, an ISA will support the project implementing agency in functions such as network expansion and claims processing for the primary care expansion of RSBY, until the Government moves to using the same insurance arrangements used under the program for secondary care, determined through a competitive bidding process. Such phasing will allow greater flexibility in the initial design of the primary care expansion, as also generation of state-specific data, which will then be useful in pricing of the insurance cover by potential bidders.

7. The project has a RF and an M&E system that will enable effective tracking of indicators, results, and implementation progress. The progress of the project toward achieving its targets will be monitored against the results and indicators described in the RF attached in annex 1. In addition to using existing state administrative systems for data compilation and reporting, the GoUK will prepare annual reports on the status of the performance indicators listed in the RF, to track the overall implementation progress toward achieving the PDO. Independent monitoring and verification agencies for the performance-based contracting under the project will ensure appropriate internal controls and validated information emanating from the project.

8. The project builds upon existing health information systems currently used for reporting, including the HMIS, the Integrated Disease Surveillance Program, and the MCTS, all of which are mainly focused on the NHM priorities—communicable diseases and maternal and child health. Information is collected at all levels, starting from the sub-centers, where health care workers collect data, which then flows to the PHC (manually) and finally to the CHC, where designated staff enter data into the GoI's information system. The data then flows to sub-districts and districts, where validation is done. Every quarter, reviews are also conducted at the state level, on the original forms and also on the facility registers at the block level. RSBY and MSBY have their own data flows, involving the hospital network and the insurance company, which are aggregated

at the state nodal agency level. New activities under the project, such as the Health Helpline, will also generate substantial amounts of data that could be very helpful too.

9. Many challenges do exist with the current health information system, such as delays in reporting, incomplete coverage (for example, data on private hospitals is not available, with a few exceptions), and duplication. The problems are encountered at different levels: data collection, filling up of forms, transportation by carriers, transcription at CHC level, and report generation at the headquarter level. The MCTS and clinical registers run in parallel and reviews are done, but there are problems with authentication. Finally, although data is discussed at monthly review meetings, in general it is not used for feedback and decision making. Therefore, in general, integration of data sources is inadequate and its analysis and use at the state level also leaves much to be desired.

10. The project will finance the strengthening of the state's M&E systems by supporting capacity building and streamlining of M&E systems in the health sector in Uttarakhand. The project will also promote stronger integration of existing data sources and the use of evidence for decision making.

11. During implementation, the impact of investments will be assessed through selected evaluations. The project envisions several innovative interventions, particularly in the area of private sector engagement. These include extending RSBY and MSBY to the primary care level, outsourcing of the CHCs, and the use of MHVs to reach remote areas. A central aspect of project design will be to subject the core activities to rigorous evaluations, to help create an evidence base to inform future implementation of the health system reform agenda both in Uttarakhand and beyond. Random assignment of interventions at the facility and district levels, and the phased rollout of activities, can be used to help establish causality of interventions on key outcomes of interest. For example, a household survey on health care seeking behaviors and OOP payments could help serve as a baseline for project interventions and a rich source of information to identify possible future research topics.

FM

12. The UKHFWS will be the implementing agency for this project and the UKHFWS has successfully implemented the earlier World Bank Health Project[4] with the state. The UKHFWS, an implementing body of the NHM in the state, has functioning FM systems, which meet the requirements of the project and the World Bank reporting. The project FM risk is 'Moderate'. The following are the FM arrangements for the project:

(a) **Budgeting.** A budget head '2210-01-110-97-01-42' has been created for the project and this head will be used for the project throughout the project life.

(b) **Fund flow.** The current system of transferring financial resources from the budget to the UKHFWS's bank account will be followed by the project. A separate project bank account will be opened by the UKHFWS. To open the bank account, permission needs to be obtained from the Finance and Health Departments and a government order needs to be issued. This bank account will be handled jointly by the PD and FC, who

[4] The overall FM performance and FM arrangements in the field for the earlier project was 'Satisfactory'.

will be the joint signatories. All payments and procurements will be carried out by the UKHFWS.

(c) **Accounting.** The_project accounts will be maintained in Tally software by the UKHFWS. The UKHFWS has implemented Tally for all other accounts and they will follow the same procedure for this project as well. Accounting is being done on double entry cash basis according to NHM rules. A list of chart of accounts and details will be worked out according to the requirement of the project cost table and the Interim Financial Report formats. A chartered accountancy firm/Tally consultants can be hired to support the project in setting up the Tally chart of accounts and provide initial training to the project staff.

(d) **Staffing.** The Accounts Department will be managed by an FC, deputed from the Finance Department of the state. The FC is supported by an accounts manager and a Tally accountant who are employed on contract basis for the NHM. It was agreed that the following staff will be hired for the project from the market: (i) one finance manager: chartered accountant with adequate experience in accounting, auditing, and FM; (b) one accounts manager: Masters in Commerce with adequate experience in maintaining accounts in Tally; (c) two audit officers: chartered accountant (Inter) with adequate experience in audit; and (d) two Tally accountants: Bachelors in Commerce with Tally accounting experience. All payments and accounting will be centralized in the headquarter location of the UKHFWS.

(e) **Reporting.** IUFRs-based disbursement will be used for the project. IUFRs are to be submitted to the World Bank on a half-yearly basis within 45 days from the end of the period. The IUFRs will disclose receipt and utilization of project funds (both World Bank share and counterpart contribution). The IUFRs will be based on project accounts and will reflect the actual expenditure for the project components based on figures reconciled with the World Bank. Any advances given by the project will be separately shown in the IUFRs. The IUFRs will provide contract wise payments and project progress in physical and financial terms. The IUFR format has been agreed and finalized during negotiations. With regard to disbursement, the project will first spend from the budget and then claim reimbursement from the World Bank. All expenditures reported in the IUFRs will be subject to an annual project audit.

(f) **Auditing.** The annual audit of the Project Financial Statements (PFSs) will be carried out by a chartered accountancy firm (empaneled with the Comptroller and Auditor General panel of firms for audits) appointed by the project according to the ToR agreed with the World Bank. All supporting records and documents under the project will be subject to this audit. The PFS will summarize all receipts and expenditures reported in the IUFRs. The annual audit report will consist of (i) annual audited PFSs; (ii) an audit opinion; and (iii) a management letter highlighting weaknesses, if any, and identifying areas for improvement. The annual project audit report and accounts will be submitted to the World Bank by the prescribed date in each year. Any difference between the expenditure reported in the IUFRs and those reported in the annual project audit reports will be analyzed and those expenditures which are

confirmed by the World Bank as being not eligible for funding will be adjusted in the subsequent disbursements. The audit report mentioned in table 3.4 will be monitored.

Table 3.4. Audit Report

Implementing Agency	Audit	Auditors	Audit Due Date
UKHSDP	PFS	Chartered accountant	Nine months after the end of each fiscal year (March 31)

(g) **Contract management.** Due to the nature of PPP projects being planned in the project, contract management is very essential for this project. The project will hire suitable persons with financial legal and technical background to manage the contracts. The project will also need to build an MIS for tracking these contracts during the project period. Contract and variation management will be one of the key challenges for the project.

(h) **Internal audit.** The internal audit will be an integral part of the project design and will cover all activities under the project. The internal audit will be carried out by a chartered accountancy firm according to the ToR agreed with the World Bank. The ToR for the internal audit will cover review of aspects covering internal controls and contract management. The auditors will be appointed based on selection criteria agreed with the World Bank, within one year of project effectiveness. The audit reports along with the compliance will be shared with the World Bank.

(i) **Internal control.** All financial controls applicable to routine expenditures will also apply to the expenditures under the project. All payments will be approved/vetted in accordance with the schedule of powers in place for the UKHFWS. All project related receipts and payments/withdrawals will be reconciled with periodic World Bank statements.

(j) **Disbursement for components**

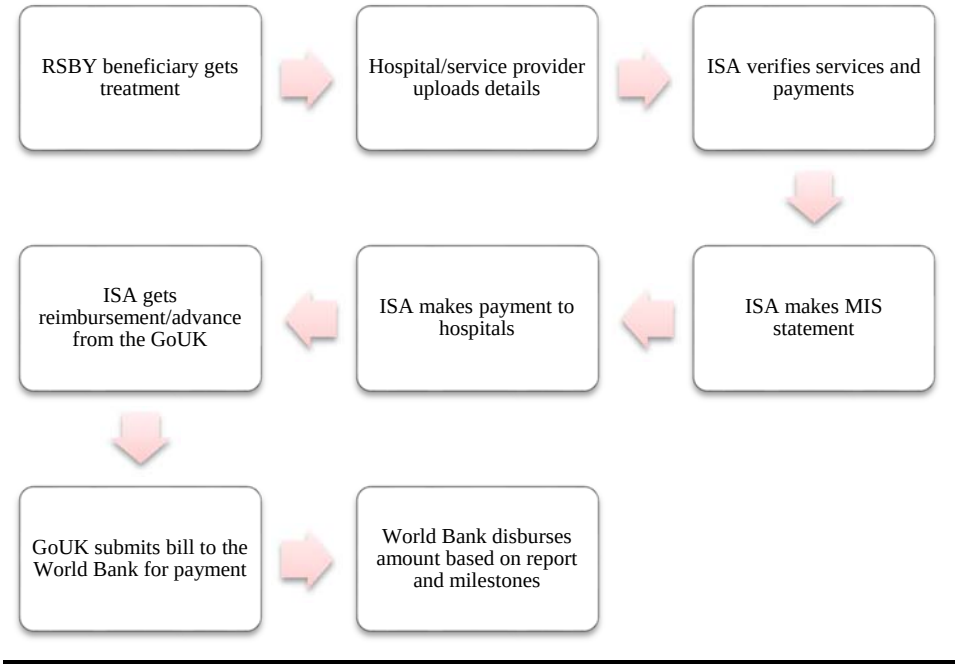
(i) **Disbursement for Subcomponent 1.1.** Financial payments will follow the achievement of service delivery indicators and will be made according to the contractual terms.

(ii) **Disbursement for Subcomponent 1.2.** It will be based on the claims in the initial years and insurance premiums thereafter. Two innovative packages are being added to the existing RSBY/MSBY, one for childcare and one for NCD (which will be rolled out later). Under the pilot scheme, the state government covers the costs of childcare provided by empaneled hospitals to members of RSBY and MSBY households, according to a standard schedule of procedures and rates. All RSBY and MSBY households in the pilot areas are eligible. The benefits package and reimbursement schedule will be determined by panels of experts based on available information on costs, private sector prices, and rates paid by government schemes in other states. Hospitals are empaneled following an assessment according to RSBY and MSBY guidelines. Beneficiaries are free to choose the empaneled hospital from which they receive treatment. The

empaneled hospitals identify the procedures to be carried out for addressing the illness of the patient. The hospitals will provide the details of the diagnosis and the procedures followed to the RSBY and MSBY insurance for verification. The empaneled hospitals will carry out the agreed procedures and once the procedures are complete, the RSBY and MSBY data will be uploaded online, for the cost of treatment of beneficiaries covered by the pilot scheme on the basis of a schedule rate for procedures. The project will hire an ISA to service public and private health insurance schemes. The ISA is tasked with checking hospital claims, as well as supporting beneficiaries. Once the ISA approves the hospital bills it will make payments to the hospitals and claim reimbursements from the GoUK. All payments will follow the defined payment procedure and electronic payments will be made to the hospitals. The project will hire the existing insurance company/ third-party administrator (TPA) (subject to approval of procurement) in the initial years to pay the actual claims paid by the TPA. The package rates and conditions for treatment will be fixed by the GoUK. The GoUK may provide an advance to the TPA and adjust the advance against the claims submitted by the TPA or pay the claims directly. The details of claims will be maintained by the TPA and an MIS report will be submitted to the GoUK for processing the claims. All claims will be according to the agreed package rates. The GoUK will send quarterly Interim Financial Reports to the World Bank for the actual claims paid by the TPA and approved by the GoUK. From Year 4 the project will hire the insurance company and reimburse the actual insurance premium for these packages. From Year 4, the project will reimburse the actual insurance premium paid to the competitively procured vendor.

(iii) **Disbursement for Component 2.** It will be reimbursed based on actual payments according to the contracts and expenditure incurred by the project, because it will provide for goods, services, and incremental operating costs.

Figure 3.3. Process for RSBY/ MSBY claims payment and Disbursement under the project



13. **Disbursements.** Disbursement will be on reimbursable basis, as the state will provide the budget for project expenditure. Table 3.4 shows the disbursement categories envisaged for the project

Figure 3.4. Disbursement Categories

Category	Amount of the Financing Allocated US$, millions	Percentage of Expenditures to be Financed (inclusive of taxes)
(1) Goods, non-consulting services, and consultants' services, incremental operating costs, and training for the project	74	80
(2) Medical insurance claims and medical insurance premiums for Part 1(b) of the project	26	80
Total Amount	100	

14. **Retroactive financing.** The project is planning to execute certain contracts under retroactive financing. The eligibility criteria for retroactive financing are

- the activities financed are included in the project description;
- the payments are for items procured in accordance with applicable World Bank procurement procedures;
- such payments, in aggregate, do not exceed 20 percent of the loan amount;
- payments were made by the borrower not more than 12 months before the expected date of Loan Agreement signing; and

- the date after which payments may be made is agreed at appraisal, confirmed during negotiations, and recorded in the Loan Agreement.

15. **Disclosure of information.** The UKHSDP will be required to disclose the following on the project website: (a) IUFR for every quarter; (b) annual PFSs; (c) annual project audit report; and (d) contract details of major contracts.

16. **Adequacy of FM Arrangements.** For this project, there is only one implementing entity with simplified implementation arrangements, and from the FM perspective, the project is simplified and for the most part based on the existing government systems. The FM risk rating for the project is currently rated 'Moderate'. Overall, the FM arrangements at the UKHFWS after taking the abovementioned steps may be considered adequate to support the use of World Bank funds.

17. **Supervision.** Supervision will be limited to half-yearly supervision, as the risk level is Moderate. In the initial year, quarterly visits will be made to ensure that the accounting system is setup and the required output is being derived from the system. Once the system is established, then more desk reviews with half-yearly missions should be sufficient. In Year 1, two to three weeks of FM involvement is expected.

Procurement

18. The UKHFWS is the implementing agency of the UKHSDP. Under the current system, procurement was handled by respective units in silos and there was no coordination among these units. It is proposed to establish a dedicated procurement cell within the UKHFWS that will handle all types of procurement (goods, non-consulting services, and consulting services) in coordination with respective units. Procurement of goods and non-consulting services shall be conducted using an e-procurement platform available at https://uktender.gov.in while consultancy services shall be conducted following normal World Bank procedures. All types of procurement for the project shall be conducted following the World Bank's 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers', dated January 2011, revised July 2014 (Procurement Guidelines); 'Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers', dated January 2011, revised July 2014 (Consultant Guidelines); and the provisions stipulated in the Financing Agreement.

19. For each contract to be financed by the loan, the different procurement methods or consultant selection methods, prior review threshold, time frame, and so on are agreed in the procurement plan. The procurement plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. A General Procurement Notice (GPN) was published on May 30, 2014 in United Nations Development Business and a Specific Procurement Notice shall be published against corresponding contract packages when it becomes ready. All goods and services financed under the project shall be procured using the World Bank's Standard Bidding Documents (SBDs) and Standard Request for Proposals except in PPP contracts.

20. The procurement cell within the PIT shall facilitate procurement of goods and services in coordination with the respective units handling procurement.

21. **Staffing of the procurement cell.** The procurement cell shall have adequate staff supported by a consultant and support staff. The procurement cell shall operate under the overall directions and guidance of the additional PD. All procurement activities under this project shall be processed through this cell.

22. **Procurement committee.** The evaluation of contracts for procurement of goods and non-consulting services, and consultancies will be managed by the procurement committee. Membership of procurement committee is as follows (in line with the arrangements under the UKHFWS and directorate of health and family welfare):

- Additional PD - UKHSDP
- Nodal officer - Procurement UKHSDP
- Finance Controller - UKHSDP
- Technical officer (concerned technical area)
- Joint Director procurement of services/Joint Director procurement of goods (DoMHFW)

23. **Verification committee.** Verification of items according to the ToR and agreement with the contractor/supplier on specifications, functionality, quality, and quantity to be verified by the verification committee on a regular basis. The verification committee needs to take into account the field visit report of project staff and working group members on the items received by the state under this project. Membership of verification committee is as follows:

- Additional PD - UKHSDP
- Nodal officer - Procurement
- Consultant - procurement
- Consultant - M&E

Capacity Assessment of the Implementing Agencies

24. A procurement capacity assessment has been conducted during the preparation mission using PRAMS. The assessment found that the Uttarakhand state government has Procurement Rules 2008. The state also has PPP policies and procedures in place. The UKHFWS has experience in procurement of private health service providers through PPP mode following the state's PPP policies. The assessment team also noted that, the Uttarakhand government uses an e-procurement platform for procurement of goods and services.

25. During the assessment, the team found that there are some deviations of procurement norms from the state government's regulations such as purchase preferences, the two-envelope system, a weak grievance mechanism system, multiple entities handling procurement, and so on. It also noted that while a procurement unit exists under the DoMHFW, there was no dedicated staff for the cell. The assessment team also noted that there were issues in contract management, particularly in managing PPP contracts. The PPP contracts were not designed properly and the assessment team identified many gaps in the bidding documents of PPP form of contracts. The current staff handling procurement were found to be well versed with the state government's procurement procedures; however, they do not have experience in the World Bank's procurement procedures. Based on the fact-findings, the procurement risk would easily stand at Substantial, and with few mitigation measures, the residual risk would stand at Medium. However, in the project, most of the procurement activities will focus on outsourcing of health services to private service providers in the form of the PPP mode and contract management is an issue. In view of this, the overall residual risk for this project is rated Substantial.

26. As a result of capacity assessment, a number of mitigation measures have been proposed. Some of the mitigation measures are, but not limited to, strengthening of the procurement cell with adequate staff; attending training on World Bank procurement procedures; establishing a complaint handling mechanism; conducting supplier meet workshops particularly for the private health service providers; and so on. The mitigation measures are elaborated in table 3.5.

Table 3.5. Risk and Mitigation Measures

Risk Factor	Rating	Mitigation Measures	Residual Risk
Legal framework	Substantial	While the Government has Procurement Rules and PPP policies in place, the contract documents for PPP contracts were not designed properly. Therefore, the team needs to focus on improving the PPP contract document. An expert on that subject needs to be hired to prepare the PPP contract document.	Moderate
Institutional framework and staffing	Substantial	The UKHFWS to strengthen existing procurement cell with adequate staff. A senior officer has been identified for the procurement cell who will be supported by a procurement consultant. Two staff from the UKHFWS has attended attend two weeks training in Administrative Staff College of India in July 2014 on World Bank procurement procedures. The existing PPP cell shall be strengthened with adequate staff. The PPP cell shall also recruit a contract management specialist and explore the option of recruiting a legal officer.	Moderate
Inconsistencies in procurement system	High	Use of World Bank approved SBDs; developing a better version of bidding documents for procurement of private health service providers through PPP mode; attending training/workshops, and so on.	Substantial
Lack of transparency, fairness, and grievance redress	High	Use of the e-procurement system, establish a website that will disclose project-related information, and establish a grievance redress mechanism	Substantial

mechanism in the procurement process			
Lack of adequate participation by the private sector (PPP)	High	A town hall meeting with private health service providers was organized in September 2014 to create awareness on the upcoming project.	Substantial
Overall residual risk			**Substantial**

27. Procurement risk and the progress on various mitigation measures will be reassessed during the implementation phase and risk rating will be done accordingly. Further, the World Bank will conduct a post review of those contracts falling under the World Bank's post-review threshold level. Therefore, the concerned implementing agency is required to make all relevant documentation available to the World Bank or its nominated auditors, as and when required.

Procurement Arrangements under the Project

28. The project has two components: (a) Innovations in Engaging the Private Sector (for integrated service delivery and for health financing) and (b) Stewardship and System Improvement (to enable innovations in engaging the private sector).

29. The first component has two subcomponents.

(a) Subcomponent 1.1 will expand access to services by creating an integrated, technology-enabled health system architecture with enhanced focus and availability of primary care, emergency care, and necessary referral services. The state has already acquired some experience with PPPs for service delivery. However, existing contracts are posing challenges due to (a) poor contract design, lack of supervision and monitoring, lack of incentives, and penalties and (b) lack of institutional capacity to design, procure, manage, and monitor the PPPs.

(b) Subcomponent 1.2 shall aim to expand financial protection programs such as RSBY and MSBY. The focus of this subcomponent will be on designing and evaluating benefit packages around childhood and adolescent health, as well as NCDs in a primary health care setting. Currently the state government has a contract agreement with the Bajaj Allianz General Insurance Company Ltd. However, child health care is not included in the service agreement and, therefore, the project may have to sign a contract with the existing insurance company or an existing TPA on Single-Source Selection (SSS) method to provide child health care services until such time the project can put in place an insurance company selected on a competitive basis.

30. The second component focuses on strengthening the Government's capacity to engage effectively with the private sector, and therefore, enabling the Government to provide effective stewardship to improve the quality of services in the entire health system, particularly in its capacity to effectively pursue the innovations being planned under this project. This component will finance research and evidence generation, use of evidence for strategic planning, and improved information systems for data generation and management, including timely feedback to providers. An independent monitoring and verification agency will also be hired to support the

state in field-level monitoring and performance validation of the contracted entities. It will also finance an assessment of existing facilities, as well as contracting of agencies on a turnkey basis to support the attainment of National Accreditation Board for Hospitals and Healthcare Providers (NABH) quality standards in identified public health facilities in the state. The scope of such turnkey contracts may include training of staff, creation of standard manuals and other quality documentation, and some minor refurbishments, among others. The project management costs including salaries of full time staff assigned to the project, hiring of consultants, training, office rent and utilities, office maintenance and repair, vehicle hiring, communication and other administrative costs will also be financed from this component.

Selection of Consultants

31. The UKHSDP shall use Standard Request for Proposal for selection of consultants. The following methods will be adopted depending upon the size and complexity of assignments and as agreed in the procurement plan.

- Quality- and Cost-Based Selection (QCBS)
- Quality-Based Selection (QBS)
- Selection under Fixed Budget (FBS)
- Least-Cost Selection (LCS)
- Selection based on Consultants' Qualification (CQS)
- SSS
- Individuals

32. For the PPP mode of contracting, the UKHSDP has already developed and used a bidding document to procure a private health service provider in the past. For this project, the team shall develop a better version of a bidding document under the preview of PPP policies of the state government.

33. A short list of consultants for services estimated to cost less than US$800,000 equivalent per contract may be composed entirely of national consultants in accordance with the provision of paragraph 2.7 of the Consultant Guidelines.

Procurement of Goods and Non-Consulting Services

34. **International Competitive Bidding (ICB).** It is likely that most of the procurement packages in Component 1 will fall under ICB. A model bid document was prepared and was cleared by the World Bank. The implementing agency will use the same bid document for procurement of an integrated health service provider.

35. **National Competitive Bidding (NCB).** Procurement of goods and non-consulting services shall be conducted in accordance with paragraphs 3.3 and 3.4 of the World Bank Procurement

Guidelines. For this project, no works contracts are foreseen. For the procurement of goods, the implementing agency will use the World Bank's SBDs and the following additional provisions shall apply:

- Only the model bidding documents for NCB agreed with the GoI's task force (and as amended from time to time), shall be used for bidding.

- Invitations for bid shall be advertised in at least one widely circulated national daily newspaper (or on a widely used website or electronic portal with free national and international access along with an abridged version of the said advertisement published in a widely circulated national daily, among others, giving the website/electronic portal details from which the details of the invitation to bid can be downloaded), at least 30 days before the deadline for the submission of bids.

- No special preference will be accorded to any bidder either for price or for other terms and conditions when competing with foreign bidders, state-owned enterprises, small-scale enterprises, or enterprises from any given state.

- Except with the prior concurrence of the World Bank, there shall be no negotiation of price with the bidders, even with the lowest evaluated bidder.

- Extension of bid validity shall not be allowed with reference to contracts subject to the World Bank's prior review without the prior concurrence of the World Bank (a) for the first request for extension if it is longer than four weeks and (b) for all subsequent requests for extension irrespective of the period (such concurrence will be considered by the World Bank only in cases of force majeure and circumstances beyond the control of the purchaser/employer).

- Re-bidding shall not be carried out with reference to contracts subject to the World Bank's prior review without the prior concurrence of the World Bank.

- The system of rejecting bids outside a pre-determined margin or 'bracket' of prices shall not be used in the project.

- Rate contracts entered into by the directorate general of supplies and disposals will not be acceptable as a substitute for NCB procedures unless agreed with the World Bank on a case-to-case basis. However, such contracts will be acceptable for any procurement under the Shopping procedures.

- Two or three envelope system will not be used (except when using an e-procurement system assessed and agreed by the World Bank).

36. **Shopping.** The Shopping method in accordance with paragraph 3.5 of the Procurement Guidelines shall be adopted for procuring readily available off-the-shelf goods of value less than US$100,000. For the Shopping procedure, a list of vendors/contractors already registered with government departments may be used for inviting quotations. The procurement plan should determine the cost estimate of each contract and the aggregate total amount. The borrower should

solicit at least three price quotations for the purchase of goods, materials, or services (non-consulting), to formulate a cost comparison report.

37. **Direct Contracting (DC).** Goods and non-consulting services which meet the requirement of paragraph 3.6 of the World Bank Procurement Guidelines may be procured following the DC method.

38. **Advance procurement.** Retroactive financing up to an amount of 20 percent of the credit amount will be available for financing expenditures incurred 12 months before the Financing Agreement signing date.

39. **Method of procurement.** The following methods of procurement shall be used for procurement under the project. It has been agreed that if a particular invitation for bid comprises several packages, lots, or slices, and is invited in the same invitation for bid, then the aggregate value of the whole package determines the applicable threshold amount for procurement and also for the review by the World Bank.

Table 3.6. Procurement Methods

Category	Method of Procurement	Threshold (US$ Equivalent)
Goods and non-consulting services (excluding IT contracts)	ICB	>3,000,000
	LIB	Wherever agreed by the World Bank
	NCB	Up to 3,000,000 (with NCB conditions)
	Shopping	Up to 100,000
	DC	According to para 3.7 of the Procurement Guidelines
	Force account	According to paragraph 3.9 of the Procurement Guidelines
	Framework Agreements	According to paragraph 3.6 of the Procurement Guidelines
Consultants' Services	CQS/LCS	Up to 300,000
	SSS	According to paragraphs 3.9–3.11 of the Consultant Guidelines
	Individuals	According to Section V of the Consultant Guidelines
	QCBS/QBS/FBS	For all other cases
	(i) International shortlist (ii) Short list may comprise national consultants only	> 800,000 Up to 800,000

Note: QCBS = Quality- and Cost-Based Selection; LIB = Limited International Bidding

Prior Review by the World Bank

40. The World Bank shall prior review the following contracts:

- Goods: All contracts more than US$2 million equivalent
- Services (other than consultancy): All contracts more than US$2 million equivalent
- Consultancy services: Above US$1 million equivalent for firms and US$300,000 equivalent for individuals

41. The first contract shall be prior reviewed by the World Bank irrespective of the value. In addition, the justifications for all contracts to be issued on Limited International Bidding, SSS (>US$30,000), or DC (>US$30,000) basis will be subject to prior review. These thresholds are for the initial 18-month period and may be modified based on the procurement performance of the project.

42. **Supervision mission.** In addition to the prior review to be carried out by the World Bank, procurement staff will participate in two formal review missions annually, along with the implementation support mission, which will include a Procurement Post Review (PPR). For the avoidance of doubt, the World Bank shall be entitled to conduct, at any time, independent procurement reviews of all the contracts financed under the credit. The implementing agency shall prepare a list of contracts and submit it to the World Bank for conducting PPR. The PPR will be conducted on an annual basis.

43. **Procurement planning.** The UKHFWS shall prepare a procurement plan covering the first 18 months of the project implementation. The prior review thresholds will also be indicated in the procurement plan. The procurement plan shall be agreed upon between the borrower and the World Bank before negotiation and shall be subsequently updated annually (or earlier/later, if required) and will reflect the changes in prior review thresholds, if any. All procurement plans, their updates, or modifications shall be subject to the World Bank's prior review and 'no objection' before implementation. In addition, the World Bank will carry out an annual ex post procurement review of the procurement falling below the prior review threshold mentioned above.

44. **STEP.** This online procurement plan execution system shall be adopted to update the agreed procurement plan. It is a web-based tool owned by the World Bank, which helps track dates of the different stages of a procurement activity that is planned or under implementation. The system establishes a new, easy to use, and more efficient way for World Bank teams and World Bank clients to interact, while at the same time providing an audit trail of the process. The World Bank will make arrangements to train the staff of implementing agencies in operating STEP.

45. **Complaint handling mechanism**. The UKHFWS shall establish a complaint handling mechanism to address complaints/grievances from contractors/suppliers more effectively. On receipt of complaints, immediate action will be initiated to acknowledge the complaint and redress the same within a reasonable time frame. All complaints during bidding/award stage, as well as complaints during the contract execution along with the analysis and response of the PIT shall invariably be submitted to the World Bank for review.

Anticorruption Measures

46. **Disclosure requirements.** The project shall comply with the disclosure requirements stipulated in the World Bank's Procurement Guidelines and Consultant Guidelines, January 2011. Accordingly, the following documents shall be disclosed on the project's website: (a) procurement plan and all subsequent updates; (b) invitations for bids for goods; (c) requests for expression of interest for selection/hiring of consulting services; (d) short list of consultants; (e) contract awards; (f) lists of contracts following DC, CQS, or SSS on a quarterly basis; and (g) action-taken reports on the complaints received on a quarterly basis.

47. The following details shall be published by the Project Implementation Unit through Client Connection or sent to the World Bank for publishing on their behalf on the World Bank's external website and United Nations Development Business online: (a) GPN; (b) requests for expression of interest for consulting services estimated to cost more than US$300,000; and (c) contract award details of all consulting services, with an estimated cost of more than US$300,000. The project shall also publish on its website any information required under the provisions of disclosure, as specified by the Right to Information Act of India.

Environmental and Social (including safeguards)

48. **Environment.** The nature of this project provides tremendous opportunities to enhance the sanitation, hygiene and infection control, and waste management systems and processes in the state so as to further promote sound public health outcomes, while also ensuring that there are no adverse impacts to the environment. An integrated approach will support the project objective of providing cleaner health facilities and high quality of health services to the state of Uttarakhand.

49. Waste generated by health care activities carries the potential of infection, injury, or other health impacts, especially if it is unsegregated and poorly managed. Infectious waste, if badly managed, has the potential to endanger the health of patients, health care workers, waste handlers, rag pickers, and the general community. Sharps waste poses the highest risk among the whole range of infectious health care waste. The waste with highest infectious potential include used needles and syringes, soiled dressings, body parts, diagnostic samples, blood, chemicals, pharmaceuticals, medical devices, and radioactive materials. Improper occupational practices and unsafe handling of infectious waste potentially expose health care workers, waste handlers, patients, and the community to infection and injuries. Open and uncontrolled slow burning of mixed waste, which includes plastic waste, produces emissions, such as dioxins and furans, which can be potentially hazardous and carcinogenic. Inadequate and poor quality of basic utility services such as water supply, sanitation hygiene, and solid waste management also has the potential to spread diseases and infections.

50. Environmental aspects will be an integral part of Components 1 and 2. Under Component 1, the project will also enhance and strengthen the PPP arrangements between the health care facilities and the private sector, specifically those who are operating the centralized waste treatment facilities. Under Component 2, the state will support strengthening of skills and systems needed for sound practices in infection control and good methods for treatment and disposal of infectious and hazardous waste. There is a need to strengthen the capacity of various stakeholders on waste management and infection control, ensure the availability of human resources designated to waste management, and strengthen the monitoring system to ensure compliance with the GoI's national regulations.

51. Because waste management and provision of utility services require the involvement of multiple stakeholders, the project will focus on improving coordination and working mechanisms between the DoHFW and the Department of Environment, Uttarakhand Pollution Control Board, urban authorities, municipalities, and utility providers. An integrated approach toward better sanitation, hygiene, and improved municipal solid waste management will support the project's objective in providing cleaner health facilities and providing high-quality health services. Under Component 2, the state can strengthen the PPP system arrangements for waste collection and

treatment with the centralized facilities and develop a customized and online waste tracking and monitoring system.

52. Since the environmental impacts related to this project are well identified and manageable, the project has been categorized as 'B' in accordance with the World Bank Operational Policies. OP 4.01—Environmental Assessment—has been triggered requiring the project to develop an ESMP. The UKHFWS has completed a sample survey and a situational analysis, based on which the ESMP was developed. Given that Uttarakhand is a hilly state with unique geographical requirements, the ESMP defines innovative management systems to ensure good practices in water supply, nutrition, sanitation, infection control, and waste management. The ESMP also includes issues related to occupational and community health and safety, and mechanisms for grievance redressal and capacity building. The ESMP was consulted with key stakeholders and disclosed before project appraisal on September 2, 2014.

53. **Social.** No negative social safeguard issues and impacts on the project are expected because the proposed project activities do not involve any construction works, land acquisition, or involuntary resettlement. However, as the state has about 3 percent of tribal population, many of whom reside in the hilly and remote areas of the state, OP/BP 4.10 is triggered. The state has developed an integrated Environmental and Social Management Plan (ESMP), which includes a tribal action plan, and was disclosed on September 2, 2014. The ESMP, including the tribal action plan therein, has since been updated and re-disclosed on December 1st, 2016. A detailed social assessment was also conducted and is summarized in annex 6.

Annex 4: Implementation Support Plan

India: Uttarakhand Health System Development Project

1. The implementation support plan for the project has been developed based on the specific nature of the project activities, the existing capacity of the implementing agencies, lessons learned from past operations in the country and sector, and the project's risk profile in accordance with the Systematic Operations Risk-Rating Tool. It aims to make implementation support to the client flexible and efficient, and focuses on achieving results and institutional development while meeting the World Bank's fiduciary obligations. This implementation support plan will be reviewed once a year to ensure that it continues to meet the implementation support needs of the project.

2. **Strategy and approach for implementation support.** The implementation support strategy is based on the combination of several mechanisms that will enable enhanced implementation support to the GoUK and timely and effective monitoring. The mechanisms to be employed comprise: (a) intensive supervision and hand-holding in the first year, given the complexity and innovative nature of project activities and the limited capacities in the state; (b) regular technical meetings and field visits by the World Bank; and (c) internal audit and procurement and FM reporting. Information from various sources will be used to assess and monitor progress of the project throughout its implementation. In addition, the progress on the governance and accountability actions will be reviewed every six months as part of the implementation support missions.

3. The project will have semiannual implementation support missions, including field visits. The semiannual missions will focus on review of the project performance against the RF and agreement on planned actions. The scope of the implementation support mission will also include monitoring the GoUK's compliance with stipulated FM, procurement, and safeguards guidelines. All implementation support missions will produce aide memoires describing the main findings and agreed next steps.

4. To ensure high quality and comprehensiveness of support in light of the project design, the World Bank team will comprise not only health specialists and economists, but also specialists in FM, procurement, safeguards, and governance and accountability, with the specific team composition for each mission determined based on the requirements at that time. Team members from the Social Protection and Global Practice and International Finance Corporation (IFC) may also need to regularly join the World Bank missions.

5. The staff skills mix required for implementation support is summarized in table 4.1. Apart from the specified skills, other technical areas of expertise will be procured on a short-term basis.

Figure 4.1. Staff Skills Mix

Focus	Skills Needed	Resource Estimate	
		First 12 months (Number of staff weeks)	12–72 months (per year) (Number of staff weeks)
Team leadership and coordination	Task team leader	9	6

Technical reviews and support, including data analysis and health system strengthening	Health specialists, social protection specialist, IFC private sector specialist, economist	18	12
Institutional arrangements and RF	Operations specialists	6	4
FM training and review	FM specialist	8	4
Procurement training and review	Procurement specialist	8	4
Environmental Management Cell and Common Treatment Facilities evaluation	Environmental specialist	6	4
Social accountability	Social specialist	6	4

Annex 5: Economic and Financial Analysis

India: Uttarakhand Health Systems Development Project

1. The economic aspects of the project embrace many issues. After outlining the macroeconomic context, this annex addresses the following topics: (a) recurrent costs and budgetary implications; (b) cost-effectiveness considerations; (c) cost-benefit considerations; (d) efficiency considerations; and (e) equity considerations.

2. In principle, the project's activities could contribute to a healthier workforce that raises economic growth and productivity in Uttarakhand. Current literature suggests links between health status, employment, and other economic indicators. It shows that better health can have positive effects on employment, thus improving the economic wellbeing of individuals and families. Improved population health can also promote growth and productivity, which in turn can lead to improved population health measures in a virtuous circle. Recent literature also suggests that the intrinsic (direct) value of a healthier population is significantly more important than the instrumental (indirect) value that is achieved by way of higher economic output. The former is therefore emphasized here.

3. The economic rationale for public spending in the health sector is multi-faceted. Insurance market failures, market power among the providers of medical care services, externalities associated with some health goods, newer behavioral economic theories that emphasize underutilization of care, and equity considerations are all cited as reasons for government intervention. These factors help explain why over 80 percent of health spending in high-income countries is typically public (that is, financed through general taxes or social health insurance). In India, the majority of health spending continues to be from private out-of-pocket sources, though this has started to change over the last decade, and the public share can be expected to continue its upward trend over time.

Overall Macroeconomic Context

4. As noted, Uttarakhand has had one of the fastest growing economies in the country in recent years. The state has achieved robust Gross Domestic Product (GDP) growth in recent years, generally exceeding 8 percent per year in real terms, much of it coming from services and manufacturing and a much smaller contribution from agriculture. Health sector investments must be mindful of this broader fiscal and economic environment.

Budgetary Implications of Recurrent Costs

5. The project's components include programmatic initiatives that imply ongoing recurrent costs that will continue after project completion. An important question is whether these costs can be absorbed into Uttarakhand's regular health budget. Estimates indicate that annual project costs amount to slightly over 5 percent of the state's annual health budget of INR 1872 crore (2016/17). Or put differently, project costs are less than $2 per capita per year as against an existing health spend of about $28 per capita per year in 2016-17.

Cost-effectiveness Considerations

6. Cost-effectiveness evidence can help identify 'best buys' for achieving health improvements within a fixed budget. There is a large volume of international literature on the cost-effectiveness of health interventions that is broadly applicable to Uttarakhand, even if local studies are not generally available. The project has a strong focus on primary care in its various incarnations—CHCs, introducing PHC to the RSBY package, and MHVs—all of which in principle offer very favorable cost-effectiveness ratios. This is also true of certain Component 2 activities related to stewardship. Although these are less amenable to cost-effectiveness analysis, these investments can leverage improved results from the much larger investment in the health sector by the government.

7. More specifically, the Disease Control Priorities Project (DCP2) identified a list of so-called 'neglected low-cost priorities in South Asia' (measured by cost per disability-adjusted life year averted) which included several services that can be expected to benefit from the project activities. These include, for example, child immunization, treating acute respiratory infection among children under five years of age, secondary prevention of cardiovascular disease, and maternal and neonatal care (Laxminarayanan et al. 2006). Moreover, evidence from the most recent research in this area (DCP3) identifies interventions that are considered "very cost-effective", defined as those for which the cost per DALY averted is less than a country's GNI per capita. Again the list of such interventions includes many that will be supported under the project due to the focus on primary care. A partial list is shown in Table 5.1.

Table 5.1: Sample of "very cost-effective" interventions

Childhood immunizations
Oral rehydration therapy
Access to modern contraceptives
Intrapartum care in LICs
Quality improvement protocols for newborns in hospital
Comprehensive nutrition package
Cardiovascular disease management (screening and treatment)

Source: Horton, S. and C. Levin (2016).

Cost-benefit Considerations

8. A cost-benefit analysis converts the health gains achieved by a project or intervention into monetary terms. Although this exercise may sit uncomfortably with some, it can be useful for policy purposes and typically serves to underline the very high value attached to better health. The standard economic approach for quantifying the benefit of better health in monetary terms is based on the concept of the 'value of statistical life' (or life year). Essentially this captures the willingness to pay for better chances (probability) of living a long and healthy life. Studies from around the world suggest that the value of a statistical life year is at least five times higher than GDP per capita, which translates to about US$8,500 in Uttarakhand. With this value and if project spending (including recurrent costs, and so on) is about US$25 million per year at peak implementation, the project will only have to achieve an average of less than 3,000 additional life years annually to 'break even'. In other words, this would be equivalent to 3000 individuals gaining one additional year of life due to project investments each year. In contrast, the draft results framework expects

at least 150,000 patients receiving services financed by the project, and also a large number of pediatric patients receiving services, suggesting that the expected gain in life-years can be far higher than this threshold number. This is not a difficult target, considering that, for example, CHCs near Dehradun currently see about 250–300 outpatient contacts per day, or that improved child health coverage through the outsourced CHCs and expansion of RSBY could potentially reach millions of children receiving health services, with very high gains in life years for each death averted. The relative ease of surpassing this threshold implies multifold benefits in relation to the investments made. This will be consistent with an existing literature, most advanced in the United States, which has found benefit-cost ratios greater than 6 to 1 for many key interventions. In brief, the potential cost-benefit ratios that can be achieved by the project are very favorable.

Efficiency Considerations

9. The project can contribute to efficiency gains if it helps to achieve the same health gains at lower cost (or, equivalently, greater health benefits for the same cost). This will certainly be true from the household perspective by bringing services closer to the population, thus reducing travel costs to higher-level facilities. The Health Helpline, MHVs, the improved functionality of outsourced CHCs, and an expanded private provider network through RSBY and MSBY, aim at this very improvement in access to health services closer to the population. Although project activities may imply that overall operating costs might still rise, this is a result of investing in new modes of financing and delivering care—benefits will rise more than proportionately, implying an efficiency gain. Better management of cardiovascular disease through primary care can also reduce the need for hospitalization due to, for example, hypertension, contributing to improved efficiency. However, overall, the project is fundamentally about incurring additional cost in exchange for benefits that are well worth those costs and more—and not a pursuit of efficiency gains per se.

Equity Considerations

10. As noted, recent household survey data analysis indicates that equity of access and financial protection are both key challenges for Uttarakhand's health system. The risk of catastrophic health expenditure in the state is high, although slightly less than the national average. An estimated 5.3 percent of households spent more than 25 percent of their non-food expenses on health in 2011–2012. The risk of impoverishment is also high. A significant share of this OOP is for outpatient expenses. Among poor households, the monthly per capita expenditure is three times higher for outpatient care than for inpatient care. Utilization rates are also quite low in Uttarakhand— only 0.95 percent of the state's households sought inpatient care, falling to just 0.67 percent in rural areas—both significantly less than the national average of 2.5 percent. These results suggest that access denied and/or sick patients not seeking appropriate care when needed are common occurrences in the state.

11. To help address these challenges, project activities are well targeted to reach the poor. The focus on geographic access and primary care interventions are naturally well-suited to ensure that activities will benefit poor households. In addition, financial protection should be improved by the innovation of expanding RSBY to include outpatient expenditures—a major source of OOP and catastrophic episodes as indicated.

Annex 6: Summary of Social Assessment

India: Uttarakhand Health Systems Development Project

1. The team conducted an independent social assessment in 2014; its main findings are summarized in this annex.

Background

2. Uttarakhand is a young state, located in a highly mountainous region of the country. It is the 27th state of the Republic of India and was carved out of Uttar Pradesh on November 9, 2000. The state has two divisions (Garhwal and Kumaun), with 13 districts, which can be grouped into three distinct geographical regions, the high mountain region, the mid-mountain region, and the terai region. The average population density is 159 persons per km^2which varies from as high as 612 in Haridwar and 414 in Dehradun districts to as low as 37 in Uttarkashi and 48 in Chamoli. Nearly 89 percent of the villages have population less than 500. Around 93 percent of the area of the state is hilly and 63 percent of the land is covered with forests.[5] The state is a major tourist destination, being home to many sites sacred to Hindus. It is an ecologically rich area, with a large number of national parks and sanctuaries. It is rich in natural resources, with some of the great Himalayan peaks and major rivers of India being located there.

Demographic and Health Status

3. With regard to demographic and health status, Uttarakhand performs better than the national average on many key indicators. Although classified as an Empowered Action Group (EAG) state, those states with weak sociodemographic indicators and poor administrative capacity, Uttarakhand actually performs better than some non-EAG states in IMR or MMR.

4. While the MMR is lower than the national average, the state's goal of reaching 100 per 100,000 live births by 2012 was not achieved and the state is not on track to reach the Millennium Development Goal of 100 by 2015. The IMR is also a cause for concern, because the discrepancy between the Sample Registration System Bulletin 2011 estimate and the AHS 2011–2012 estimate seems (36 and 41 per 1,000 live births respectively) to indicate that the IMR is either stagnant or worsening; progress on that front has clearly suffered. At 41 per 1,000 live births (AHS 2011–2012), it falls significantly short of the State Health Policy goal of 28 per 1,000 live births by 2010; similarly, the under-5 mortality rate of 47 per 1,000 live births also falls substantially short of the targeted child mortality rate of 15 per 1,000 live births by 2010.

5. Both male and female literacy rates are higher than the national average. However, an area of concern is the sex ratio: both the Census 2011 and the AHS 2011–2012 place it significantly lower than the national average, at about 880 females per 1,000 males. Nine out of twelve of the districts registered a sex ratio < 900 (0–4 years), with Pithoragarh and Haridwar being the lowest at 819 and 851, respectively (AHS 2011–2012). Given the age group, this trend cannot be ascribed to migration and hence requires closer analysis.

[5] http://nrhm.gov.in/nrhm-in-state/state-wise-information/uttarakhand.html#state_profile

Utilization of Health Services

6. Utilization of services, particularly for maternal and childcare, has been steadily improving in Uttarakhand, and is better than in other EAG states. However, there remains room for substantial improvement in several areas.

7. With regard to reducing the MMR, some critical aspects of service utilization need to be addressed. The data indicate that 46 percent of women continue to deliver at home (AHS II 2011-–2012). Of those who delivered in an institution, about 40 percent of women stayed one day or less at the institution post-delivery.[6] Only 17 percent of women received full antenatal care ([ANC]; five checkups) (Coverage Evaluation Survey [CES] 2009), with significant disparity between urban and rural women. Nearly 32 percent of rural women received no ANC at all. More than 60 percent of rural women had consumed no iron and folic acid tablets/syrup, although most had received 2+ tetanus toxoid injections. Awareness of Janani Suraksha Yojana (JSY) continued to be low. This is particularly of concern, because women who were aware of JSY were more likely to deliver in an institution (more than 80 percent of women who delivered in institutions were JSY beneficiaries) (CES 2009).

8. Children who had been fully immunized (12–23 months) stood at 70.1 percent, which means one-third of children are not fully immunized; only 60.8 percent of children between 12 and 23 months had received at least one dose of Vitamin A and only 12.7 percent had received the second dose. Overall, health and nutrition indicators of children, particularly newborns and children under 3 need particular attention. One-third of children under 5 are underweight, and two-thirds are anemic. More than one-third of children are breastfed only 24 hours after birth, indicating a failure in awareness and/or proper counseling. More than half of married women are anemic as well. The impact of nutritional status and feeding practices in health outcomes is well recognized and needs to be supported (CES 2009).

Issues

(a) The overarching issue that determines utilization of services and health outcomes appears to be the difficult geographical terrain. In discussions with the Village Health Sanitation and Nutrition Committees (VHSNC) in two districts of Uttarakhand, members of the VHSNC shared that several villages were inaccessible from the road and were located between 5 km and 32 km deep into the hills and forests. While the '108' ambulances deployed across the state have significantly enhanced the availability of emergency transport, for communities that live deep in hills and forests, this facility is not available. The AHS 2011–2012 data indicate that the mean distance traveled in rural areas for an institutional delivery was 11 km, while in urban areas it was 5 km; and the mean time taken to reach the facility was 47 minutes in rural areas and 24 minutes in urban areas. More than 15 percent of women had to travel more than an hour to reach a health facility. The case was similar for ANC, with women having to travel almost 4 km to access the closest source for ANC in rural areas.

[6] UNICEF (United Nations Children's Fund). Coverage Evaluation Survey. 2009.

Nearly 30 percent of those who opted for a home delivery reported no access to transport as the reason.

(b) Apart from the rural-urban differential already seen—significant differences in key maternal health indicators by location—another important issue is the district-wise variation in disease incidence and/or prevalence. For example, diarrhea affects 1,402 in 100,000 in Uttarkashi and 208 in Almora; acute respiratory infection affects 4,687 in 100,000 in Teri Garhwal and 135 in Champawat; fever affects 22,523 in 100,000 in Haridwar and 881 in Bageshwar; and diabetes and hypertension affect 2,200 and 3,134 in 100,000, respectively, in Dehra Dun and 196 and 470 in Bageshwar (AHS 2011–2012). While some districts, such as Bageshwar and Udham Singh Nagar, report uniformly below-average service utilization, others have a mixed pattern, while yet others such as Haridwar and Dehradun are consistently high. It would be important to keep such variations in mind and track them over a period of time while deciding upon and prioritizing interventions.

(c) Low awareness of health issues among communities is a third issue that needs to be addressed. Nearly 35 percent of those who had a home delivery reported that they did not think it was necessary to go to a health facility and 35 percent reported that they felt they got better care at home. About 21 percent of children with diarrhea were given no treatment, almost 50 percent were given less fluids to drink, and 43 percent received less than usual breastfeeding, indicating poor awareness of simple lifesaving interventions (AHS 2011–2012). Similarly, when asked why their children were not immunized, 11 percent of respondents said they did not think it was necessary, almost 50 percent said they did not know about vaccines, and 14 percent did not know where to go to be vaccinated.

(d) The declining sex ratio, particularly in certain districts of the state, is a cause for concern. Although literacy rates are higher than the national average, there is a growing preference for male children. The easy availability of testing facilities, particularly in urban areas, could be a contributing factor. There is active monitoring of violations of the Pre-Conception and Pre-Natal Diagnostic Techniques Act; however, the effectiveness of this in curtailing violations is questionable. This is only one aspect of the gender issue; access to health care is another important dimension that needs to be addressed, because there is some evidence that men are more likely to receive treatment for various conditions as compared to women (AHS 2011–2012).

(e) The difficult terrain, among other things, has had a negative impact on the availability of human resources in the health sector. This is particularly felt at the community level, because often the only health service accessible to many remotely located communities is the community health worker. Up to 20 percent of Auxiliary Nurse-Midwives (ANMs) are not available at the subcenters; and the shortfall is even higher at the PHCs (Rural Health Statistics Bulletin March 2012, Ministry of Health and Family Welfare, GoI). When considering the availability of doctors and specialists, the situation is grim, with massive vacancies of all types of specialists, particularly obstetricians and pediatricians. Field visits to the CHCs being run under PPP arrangements by the same provider showed a similar pattern: in a CHC located in the

peri-urban area (close to Dehradun), availability of necessary staff was not a problem; however, in another CHC, located in a remote area, most posts were vacant. In other words, even the private sector was not able to procure the services of health personnel in areas where the terrain was difficult.

Possible Interventions

9. The project aims to enhance access and equity of health services to all underserved populations of the state. The project supports interventions to strengthen state health systems to expand universal health coverage, ensuring affordable and high-quality health care for all. The following proposal is based on discussions with Health Department personnel, the NRHM team, representatives from the Department of Health and the Department of Women and Child, nongovernmental organization (NGO) representatives, members of the VHSNC, and visits to the field. The activities are meant to address the specific challenges and constraints faced in Uttarakhand, keeping in mind the capacity of the Uttarakhand health system and the overall objectives of the project. They can be categorized broadly as (a) enhancing availability of primary care services and (b) supporting PPP in health care delivery.

Enhancing Availability of Primary Care Services

(a) **Increasing the availability and outreach activities of MHVs.** The state had already deployed a number of MHVs that provide health care on a fixed schedule. Feedback from communities indicates that these mobile units provide valuable services, and communities do depend on them for their health care needs. The number of such mobile vans could be expanded to increase both coverage and frequency such that communities could rely on these mobile units for their regular health needs. At the moment the frequency is insufficient to support this; between visits from the mobile van, individuals need to make other arrangements for health care. This could be avoided if the mobile units could visit the communities on a more frequent basis.

(b) **Focusing on enhancing health awareness and health-seeking behavior.** Low levels of awareness of health programs and healthy behavior affect the health-seeking behavior of communities. There needs to be a strategic plan for reaching rural communities with key health messages, increasing their awareness of various health issues, and serving as catalysts for action. However, this is not enough: the quality and availability of services must increase in tandem to enhance the credibility of the system and make a sustainable change in the health-seeking behavior of communities. The introduction of a Health Helpline that not only provides health information and advice, but also guides patients through the health systems to offer a more coordinated, systemic response, can help raise awareness of simple lifesaving interventions, as well as direct the health demand to the appropriate level of care.

(c) **M&E mechanisms** will ensure the regular tracking of progress and impact of project interventions on women and vulnerable populations. At all levels, data will be maintained on utilization of services by women, and this data will be regularly reviewed and evaluated by a team consisting of representatives from both government and NGOs, and regularly reviewed by the PD for further action. Similarly,

disaggregated data on each district will be maintained and reviewed by an appropriately constituted team, to be reviewed regularly by the PD. This will ensure that regional and inter-district imbalances are appropriately addressed on time. In addition, the report of the committee monitoring the implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques Act will be regularly reviewed by the PD and the health secretary to ensure that all violations are being strictly followed up.

(d) **Strengthening links between Health, Education, and Women and Child Departments.** With the expansion of the School Health Program, there is a need to pursue a multisectoral approach to health, especially at the community level. The community-level workers are meant to work in a coordinated manner with the ASHA, ANM, and Anganwadi worker all working together with the common goal of serving the needs of children and their mothers. Similarly, the annual health checkup is done in coordination between the Health and Education Departments. Mechanisms for coordination, such as joint state- and district-level committees that oversee the coordinated action of these departments, will greatly facilitate the quality and effectiveness of these programs. For example, the Education Department representative reported that the school health checkups in one particular block had not been conducted satisfactorily and that they should be re-done. However, this was reported to the Health Department several months later, and only because a joint meeting was organized by the World Bank team. If such issues could be raised on time in a proper forum, they could be ironed out immediately.

Supporting PPPs

(a) **Partnering with NGOs.** NGOs have proved to be effective partners in several programs, notably the Adolescent Reproductive and Sexual Health Program, the Urban Health Centers and the Accredited Social Health Activist Plus Program. While the capacity of NGOs in Uttarakhand is limited, and their location in the really remote areas is sparse, they could yet be effective resources to reach out to areas, which are currently underserved.

(b) **Scaling up existing PPPs.** The current PPP arrangement for the management of the CHCs should be evaluated and scaled up if possible. The CHCs being run in a PPP mode in the outskirts of Dehradun seemed to be functioning satisfactorily. However, a number of issues have been raised during the field visits, and a detailed evaluation will need to be done to understand the feasibility of replicating the CHC/PPP model elsewhere. These include the following:

- **The value added of bringing a private partner in.** The CHCs close to the capital cities seemed to be working relatively well even when they were being operated by the Government, whereas those in more remote locations were not. It is not clear whether this partnership actually solved the original problem and increased net service availability.

- **The need to address infrastructural shortfalls.** With the increase in service delivery at the CHC close to the capital, there is a need to expand the physical infrastructure at the facility to sustain further increase in the service supply; however, this does not seem likely at this stage.

- **A deeper understanding of the costs of care.** The reimbursement of services is done on the basis of the number of diagnostic tests carried out, but it is not clear what the impact of this on over-prescription of diagnostic tests is, how much of that cost is borne by the patient, and whether this model is viable for the private partner.

- **The need to review the terms of the contracts and align incentives.** The private partner is not held accountable under the contract for delivery of national programs. Therefore, there is a focus on diagnostic and curative care, but programs such as those for tuberculosis and vector-borne diseases, are completely neglected. The terms of the contract need to be examined critically to ensure that the private partner also complies with the requirements of the public health programs.