



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 15-Feb-2023 | Report No: PIDA35328



BASIC INFORMATION

A. Basic Project Data

Country India	Project ID P179337	Project Name Assam State Secondary Healthcare Initiative for Service Delivery Transformation (ASSIST) Project	Parent Project ID (if any)
Region SOUTH ASIA	Estimated Appraisal Date 08-Feb-2023	Estimated Board Date 27-Apr-2023	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) India	Implementing Agency Assam Health Infrastructure Development and Management Society (AHIDMS), Health and Family Welfare	

Proposed Development Objective(s)

To strengthen management capacity, access, and quality of the secondary healthcare system in Assam

Components

- Component 1: Strengthened management capacity of health systems at state, district, and facility level
- Component 2: Improved access to and quality of essential services in existing secondary facilities
- Component 3: Enhanced access to and structural quality of secondary care

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	313.83
Total Financing	313.83
of which IBRD/IDA	251.03
Financing Gap	0.00



DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	251.03
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Non-World Bank Group Financing

Counterpart Funding	62.80
Borrower/Recipient	62.80

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **India’s economy will slow down, coming off a strong recovery in FY21/22 (April 2021-March 2022).** The spillovers from the Russia-Ukraine war and the global monetary policy tightening cycle are expected to weigh on India’s economic outlook: elevated inflation on the back of higher prices of key commodities, heightened global uncertainty, and rising borrowing costs will affect domestic demand, while slowing global growth will dampen India’s export growth. The growth in FY22/23 will slow to 6.9 percent from 8.7 percent in FY21/22.¹ Domestic demand is expected to remain on a moderate recovery path, despite external headwinds. The government’s strong capex program will support investment, while private consumption will benefit from consumer spending in high- and middle-income groups. Net exports will continue to drag on growth. The rising merchandise trade deficit will push the current account deficit to 3.2 percent of GDP in FY22/23. Due to recovering demand and elevated food and oil prices, headline inflation is expected to stay above the Reserve Bank of India’s (RBI) tolerance range but should gradually ease to 5 percent next year.² The government’s gradual fiscal consolidation efforts will be bolstered by strong revenue performance. Goods and Services Tax (GST) collections continue to be strong, having crossed the INR 1 trillion mark every month since July 2021, reaching as high as INR 1.67 trillion in April 2022.

2. **Although India has made remarkable progress in reducing extreme poverty over the past two decades, the COVID-19 pandemic has slowed progress, and poses risks to welfare.** Prior to the pandemic, the share of the population living below US\$2.15 per person per day (2017 PPP) is estimated to have fallen

¹ World Bank real GDP forecasts for FY22/23 published in Macro Poverty Outlook, October 2022.

² Ibid.

from 22.5 in 2011 to 10 percent 2019.³ This was accompanied by a sharp decline in the incidence of multidimensional poverty, from 27.7 percent in 2005/06 to 16.4 percent in 2019/21.⁴ However, the pace of poverty reduction has slowed in recent years, with key welfare indicators being slow to improve.⁵ More than 40 percent of India's population lived below the lower-middle income poverty line even before the pandemic.⁶ Inequality in consumption has remained stable, with a Gini index of around 35 over the past two decades. Child malnutrition has remained high, with 35.5 percent of children under the age of 5 being stunted and 67 percent of children aged 6-59 months being anemic in 2019-21.⁷ Despite a substantial social protection response from the Government of India (GoI), the COVID-19 pandemic has likely reversed recent welfare gains, exposed vulnerabilities in the labor market, and posed new risks to welfare. Urban unemployment has increased, with an increasing share of self-employed and casual wage workers, suggesting an incomplete and uneven recovery from the pandemic.⁸

3. Assam is the largest economy in northeast (NE) India, a commercial hub for the region, and India's gateway to Southeast Asia. However, the state lags most large Indian states in the size of its economy and poverty reduction. In FY19/20, Assam's real per-capita income was INR 60,660 (~ US\$800), 35 percent below the per-capita national income. The state's economy contracted by 0.4 percent in FY20/21, but it is estimated to have rebounded with over 9 percent growth in FY21/22.⁹ Although Assam had rapidly reduced poverty between 1994 and 2005, the rate of decline has since slowed down and stagnated at high levels. Thirty two percent of the population is poor in Assam compared to 22 percent nationally.¹⁰ Thirty three percent of its population is also multidimensionally poor,¹¹ and there are geographic inequities—51 percent of the population in Hailakandi district is multidimensionally poor as compared to 11 percent in Kamrup metro.¹² With a total population of 35 million of which 86 percent live in rural areas,¹³ the state is the 14th most populous state in India and is highly rural.

Sectoral and Institutional Context

Health Outcomes and Utilization

4. Despite substantive improvements in some reproductive, maternal, neonatal and child health (RMNCH) outcomes and utilization in the last decade, Assam still lags most Indian states in health outcomes and faces geographic inequities. Assam has reduced its infant mortality and under-five mortality by a third,¹⁴ and its maternal mortality ratio (MMR) by half from 390 to 195 deaths per 100,000

³ World Bank Poverty and Inequality Platform. <https://pip.worldbank.org/country-profiles/IND>. In 2004, India's extreme poverty rate was 39.9 percent using the same international poverty line.

⁴ UNDP (United Nations Development Programme), OPHI (Oxford Poverty and Human Development Initiative). 2022. 2022 Global Multidimensional Poverty Index (MPI): Unpacking deprivation bundles to reduce multidimensional poverty. New York.

⁵ World Bank Poverty and Inequality Platform. <https://pip.worldbank.org/country-profiles/IND>.

⁶ US\$3.65 per capita per day (2017 PPP). World Bank Poverty and Inequality Platform. <https://pip.worldbank.org/country-profiles/IND>.

⁷ Government of India, Ministry of Health and Family Welfare, 2022. National Family Health Survey (NFHS - 5), 2019–21 report.

⁸ World Bank Macro Poverty Outlook. October 2022. Estimates from PLFS data.

⁹ Directorate of Economics and Statistics, Government of Assam.

¹⁰ Reserve Bank of India (2020). Handbook of Statistics on Indian Economy, Table 154. <https://www.rbi.org.in/scripts/PublicationsView.aspx?id=19887>

¹¹ Multidimensional poverty complements income poverty measurements because it measures deprivations directly. India's multidimensional poverty metric includes indicators in health (child and adolescent mortality, antenatal care, nutrition), education (years of schooling, school attendance), and standard of living (cooking fuel, sanitation, drinking water, electricity, housing, assets, bank account).

¹² https://www.niti.gov.in/sites/default/files/2021-11/National_MPI_India-11242021.pdf

¹³ State estimates for 2021 from Population projection for Indian states (2011-2036). Registrar general and census commission of India.

¹⁴ National family health survey (NFHS) 2015-2016, and 2005-2006, <http://rchiips.org/nfhs/>



live births in the last decade.¹⁵ However, the state's health outcomes are still worse than national averages. MMR in particular stands out—the state's MMR is twice as high as the national estimate. Utilization has improved and is mostly at par with the national levels: 87 percent of women give birth in a facility now compared to 24 percent in 2005, and antenatal care has improved from 66 to 85 percent.¹⁶ However, there is variation across the state with 97 percent of women in Jorhat district giving birth in a facility compared to 64 percent in Dhubri district. Additionally, the immunization rate is lower than the national average, and varies geographically.

5. **In addition to the unfinished RMNCH agenda, the state also needs to address the emerging double burden of disease.** Like in most Indian states, the burden of non-communicable diseases (NCDs) is growing in Assam—56 percent of poor health is due to NCDs.¹⁷ The NCD burden in the state is slightly lower than the national average, with 12 percent women and 15 percent men in the state hypertensive, and 9 percent women and 15 percent men diabetic.¹⁸

6. **Climate change could further worsen health outcomes in Assam.** Ranked as one of India's most vulnerable states to climate and disaster impacts,¹⁹ Assam has high risks of extreme weather events such as flash floods, droughts, cyclones, and landslides, leading to loss of livelihoods, assets, and infrastructure. The state's weak health system leaves its population poorly prepared to respond to the impacts of climate change.²⁰ Additionally, poor health in turn further undermines the population's resilience to climatic shocks and their ability to adapt.

Health Systems Context: Financing and Financial Risk Protection

7. **Through concerted efforts to improve its budget allocation to health, Assam now (i) spends more public resources on health as a share of its budget, and (ii) has lower out-of-pocket expenditure (OOPE) compared to most states in India. However, per capita government health spending is still lower than the national levels.** Assam allocated nearly 7.1 percent of its total budget on health in 2021/22 (national average: 6.0 percent) compared to 4.9 percent in 2013/14 and is now close to the 8 percent target set in the 2017 National Health Policy (NHP).²¹ Additionally, OOPE is lower in the state than in India: about one third (36.7 percent) of total health expenditure in Assam is from OOPE compared to 48.2 percent at national level. However, in absolute terms, the state spends less than national average on health (INR 1,426 compared to INR 1,815 per capita).²²

8. **Financial risk protection in Assam is pro-poor and higher than the national average, with room for improvement.** Sixty seven percent of the households in the state have access to a health insurance/financing scheme that covers at least one member as compared to the national average of 41 percent. In addition to the national Pradhan Mantri Jan Aarogya Yojana (PM-JAY) scheme, the Government of Assam (GoA) is implementing Atal Amrit Abhiyaan (AAA), a cashless scheme available to

¹⁵ Special Bulletins on MMR by Registrar General of India 2007-2009, 2018-2020

¹⁶ NFHS 2019-2021, and 2005-2006, <http://rchiips.org/nfhs/>

¹⁷ Health Dossier 2021, Assam. https://nhsrindia.org/sites/default/files/practice_image/HealthDossier2021/Assam.pdf

¹⁸ National family health survey 2019-21, <http://rchiips.org/nfhs/>

¹⁹ <https://www.ceew.in/publications/mapping-climate-change-vulnerability-index-of-india-a-district-level-assessment>

²⁰ <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>

²¹ These are Budget Estimates (BE). Revised Estimate (RE) for Assam is 7.4% for 2021-22. Accessed from: <https://prsindia.org/budgets/states/assam-budget-analysis-2022-23>

²² National Health Accounts 2018-19

below poverty line (BPL) and low-income households to reduce OOPE and catastrophic health expenditures. As a result, the elderly, rural population, and those with lower levels of schooling are more likely to have insurance coverage in the state. Financial risk protection in Assam is also better than the national levels with 6 percent of the households bearing catastrophic healthcare spending against the national average of 15 percent.²³ There are still additional gains to be made however: reducing fragmentation between schemes and augmenting management capacity of the state insurance agency will further improve insurance coverage and utilization.

Health Systems Context: Service Delivery

9. **Although Assam has been steadily improving its health systems performance, the state of its secondary health care system²⁴ in particular leaves much to be desired.** Despite recent increase in its rank in NITI Aayog Health Index by three positions, the state still ranks 12th out of the 19 large states.²⁵ State performance deteriorated in areas of (i) shortage of specialists at district hospitals (DHs) and nurses in primary and community health centers, (ii) implementation of human resource management information system (HRMIS), (iii) lack of functional First Referral Units,²⁶ and (iv) lack of a functional cardiac care unit in any of the DHs in the state.

10. **Investment in secondary care and well-functioning referral system is critical to the state for reducing its MMR and addressing its unfinished RMNCH agenda.** Thirty percent of all deliveries in rural Assam, and 40 percent in urban areas were in public hospitals.²⁷ Despite high rates of institutional deliveries overall and in public hospitals, MMR is high, indicating that (i) access to high quality obstetric care specially at secondary facility level needs to improve—secondary level provides most of the life-saving comprehensive emergency obstetric and neonatal care (CEmONC) needed to reduce maternal and newborn mortality, and (ii) appropriate referral linkages are needed in addition to high quality primary care provision. Indeed, less than a third of the maternity wards and labor rooms in DHs in the state are LaQshya certified.²⁸

11. **Secondary care investments are also essential for the state to address the growing burden of NCDs.** While the state is making inroads in addressing the rising burden of NCDs at the primary level, it lacks the capacity for NCD management at the secondary level. At the primary level, comprehensive primary health care (CPHC) including NCD care is being provided in 34 percent of sub-centers (SCs) and 68 percent of primary health centers (PHCs)²⁹ and the government intends to cover all PHCs by 2022 and 92 percent of SCs by 2024. However, at the secondary level, adequate, accessible, and appropriate specialist care for NCDs is available only at a few tertiary care hospitals, which reduces access and utilization of this critical service, increases risk of catastrophic health spending particularly for the poor and leads to increased NCD morbidity and mortality.

²³ At 10 percent level threshold

²⁴ Secondary Healthcare is the next level of care after primary healthcare. This level refers to health services given by specialized medical personnel. In the Indian public sector, district hospitals and sub district hospitals are the facilities providing secondary healthcare.

²⁵ https://www.niti.gov.in/sites/default/files/2021-12/NITI-WB_Health_Index_Report_24-12-21.pdf

²⁶ Facilities that provide 24-hours specialist care in medicine, obstetrics and gynecology, surgery, and pediatrics

²⁷ Government of India. NSS 75th Round-Key Indicators of Social Consumption in India: Health. New Delhi; 2019 (75th round of NSS)

²⁸ National certification program on obstetric and maternity care quality

²⁹ <https://pib.gov.in/Pressreleaseshare.aspx?PRID=1783807>



12. Ensuring access to high-quality and affordable hospital services is a prerequisite for patient survival, long-term health, and protection against catastrophic health spending.³⁰ A well-functioning two-way referral system also needs to be prioritized to ensure care continuum for long-term care, retain trust in public health facilities, and sustain utilization.^{31,32} With decades of investments in primary care, the low hanging challenges in infectious diseases and RMNCH are being incrementally addressed. While additional primary care improvements are needed, secondary care also needs to be urgently prioritized to make substantial gains in addressing the second order challenges in infectious diseases and persistent RMNCH challenges such as high maternal mortality and tackle the emerging NCD burden holistically. Harmonized linkage with secondary level care with focus on care continuum is also needed to ensure the effectiveness and success of the ongoing primary care investments.³³

13. Public hospitals are a large source of healthcare and in particular the inpatient care for the rural population in the state. However, the quality of care in these hospitals is poor, which impacts patient safety, demand, and utilization. Twenty eight percent of households in the state rely on public hospitals for overall care, compared to 20 percent in the private sector. Public sector inpatient care-seeking is also high: 46 percent of the rural and 35 percent of the urban population use public hospitals for inpatient services in the state.³⁴ Therefore, poor quality public hospitals not only compromise patient safety but also dampen demand. Only 10 of the 14 essential health services and 9 of 14 prescribed diagnostic services are available on average in DHs in Assam.³⁵ Only 2 of the 25 existing DHs are National Quality Assurance Standards (NQAS) certified and none offer all 14 essential services.³⁶ Similarly, essential drug availability is inadequate: half of the essential drugs are not available in DHs and 44 percent of the patients are not able to procure their full prescription when seeking care in DHs.³⁷ As a result, hospitalization rates in Assam are half the national average.³⁸ The state has the lowest inpatient care uptake if childbirth is excluded, indicating both foregone care and supply-side issues. The reasons mentioned by beneficiaries for not accessing public hospital care in the state include (i) lack of trust, (ii) low quality, and (iii) service unavailability including drugs.³⁹

14. Lack of DHs, non-availability of beds and shortage of human resources for health (HRH) are other major proximal causes of poor performance of the state's secondary health system. Six districts in the state have no DHs and 4 districts need additional DH due to the population, geographical location, and patient load. DH level bed availability is also lower in the state compared to the national average: DHs

³⁰ Lewis. 2015. "Better Hospitals, Better Health Systems: The Urgency of a Hospital Agenda." CGD Policy Paper 053. Washington DC: Center for Global Development

³¹ Ayushman Bharat Health and Wellness Center, 2021; Available at - <https://static.pib.gov.in/WriteReadData/specificdocs/documents/2021/sep/doc202192010.pdf>

³² Brar et al 2022 doi: 10.4103/jfmpc.jfmpc_2560_20

³³ Lahariya et al. 2020. doi: 10.4103/jfmpc.jfmpc_1240_19.

³⁴ 75th round of NSS. If we exclude childbirth, 77 percent of rural population and 48 percent of urban population in the state use public hospitals for inpatient care.

³⁵ Niti Aayog (2021). Best practices in the performance of District Hospitals in India.

³⁶ The 14 essential services that a district hospital is supposed to provide are: (1) General Medicine, (2) General Surgery, (3) Obstetrics & Gynecology, (4) Pediatrics Including Neonatology (as required for level II SNCU), (5) Emergency (Accident & Other Emergency) (Casualty 24X7 Basis), (6) Critical Care (ICU), (7) Anesthesia, (8) Ophthalmology, (9) Ear, Nose, Throat (ENT), (10) Orthopedics, (11) Public Health Management, (12) Dental, (13) Radiology, and (14) Dermatology.

³⁷ Comptroller and Auditor General of India. 2021 Report No. 3 of 2021 – Performance audit of select district hospitals, Government of Assam.

³⁸ Also because patients cannot easily reroute to private hospitals: Private sector presence is much lower in Assam compared to other states.

³⁹ Government of India. NSS 75th Round-Key Indicators of Social Consumption in India: Health. New Delhi; 2019

in Assam have 18 beds/100,000 population compared to the national average of 24 beds.⁴⁰ Additionally, human resources for health (HRH) at the existing DHs is severely constrained, with only 12 percent of the DHs meeting the requirement for doctors, 4 percent for nurses and 52 percent for paramedical staff as per the Indian Public Health Standards (IPHS) norms.

15. Managerial capacity gaps at state and district administration and hospitals, and lack of autonomy and accountability of DH administration impede secondary care effectiveness and efficiency.

State and district level issues such as maldistribution and poor management of HRH, fragmentation in procurement, and institutional fragmentation further worsen service provision. The state HRH norms have not been revised since 1985—severe HRH gaps and skewed urban-rural HRH distributions in public secondary care are due to poor task rationalization and deployment, non-existent career progression structures, lack of in-service learning opportunities, and regressive HRH policies. Drug stockouts in hospitals are largely due to fragmented procurement systems at the state level and sub-par performance of State Medical Services Corporation. The efficiency of health insurance programs in the public sector (within the DHs and other public facilities) specifically on increasing the benefits packages in the routine services and claims, is limited. None of the DHs in the state have qualified hospital managers, which results in clinical staff spending time on administrative and managerial duties for which they are not trained. This suboptimal allocation of the limited HRH thus impacts efficiency and quality of secondary healthcare services. Lastly, the health wing of public works department (PWD) lacks standard practice for preventive maintenance and dedicated budget allocation from treasury for health infrastructure, resulting in poor health infrastructure and diminishing life of construction, poor quality and inefficient use of limited public sector financing.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To strengthen management capacity, access, and quality of the secondary healthcare system in Assam

Key Results

- Average performance score of district hospitals⁴¹ (percentage) (*management capacity and quality*)
- Deliveries in district hospitals⁴² (number) (*effective access*)

⁴⁰ Niti Aayog (2021). Best practices in the performance of District Hospitals in India. Note that bed occupancy rate could also improve, indicating poor quality and demand side issues: Average bed occupancy rate in Assam is 61, which is slightly higher than India average of 67 and lower than the ideal bed occupancy rate of 90.

⁴¹ Please note that the performance score of the district hospitals is a composite score that measures structural and process quality; patient satisfaction; hospital financing efficiency; and management capacity. For example, one of the structural quality measures included the score is whether the DH has standard operating procedure for surgical care, a process quality measure included is whether the major surgeries in the DH use WHO surgical care checklist.

⁴² DH deliveries are a tracer indicator for effective access of secondary care. Increases in district hospital deliveries (which provide high-quality services) are critical for the state to address its MMR and IMR.



- Availability of essential services⁴³ in targeted district hospitals, disaggregated by lagging districts⁴⁴ (number) (*access*)
- District hospitals with quality certification (number) (*quality*)
- Stockout of essential medicines in targeted district hospitals, disaggregated by lagging districts (percentage) (*quality*)

D. Project Description

16. **Component 1: Strengthened management capacity of health systems at state, district, and facility level.** Sub-component 1A will finance provision of performance-based grants (Internal Performance Agreement (IPA) grants) to select entities at state, district and facility level to strengthen management capacity for improved secondary care access and quality and subcomponent 1B will provide complementary technical support in areas of HRH, pre-service education, health infrastructure and IPA operationalization.

17. **Component 2: Improved access to and quality of essential services in existing secondary facilities.** The second component will improve access to and quality of essential services in existing secondary facilities through (i) provision of technical assistance, training, and design and implementation of quality tracking tools, (ii) contracting-in of services to fill clinical positions (specialist, doctors, and nurses) and other clinical services (for example, diagnostics), (iii) contracting out of non-clinical services (cleaning and gardening, laundry, pathology etc.), (iv) strengthened nursing colleges attached to DHs, and (v) repairs and renovations of existing secondary facilities and nursing colleges attached to DHs. Additionally, this component will support innovations to improve health systems efficiency focusing on equitable access and quality.

18. **Component 3: Enhanced access to and structural quality of secondary care.** This component will invest in (i) upgradation of up to 10 CHCs and SDHs to DH⁴⁵ following national guidelines⁴⁶ and provision of medical equipment and goods⁴⁷ to enhance equitable access to secondary care, and (ii) incremental operating costs of these newly upgraded facilities to improve structural quality of secondary care.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No

⁴³ The 14 essential services that a district hospital is supposed to provide are: (1) General Medicine, (2) General Surgery, (3) Obstetrics & Gynecology, (4) Pediatrics Including Neonatology (as required for level II SNCU), (5) Emergency (Accident & Other Emergency) (Casualty 24X7 Basis), (6) Critical Care (ICU), (7) Anesthesia, (8) Ophthalmology, (9) Ear, Nose, Throat (ENT), (10) Orthopedics, (11) Public Health Management, (12) Dental, (13) Radiology, and (14) Dermatology.

⁴⁴ Defined as seven districts that have the highest multidimensional poverty in the state using the Niti Aayog multidimensional poverty index of 2021 – Darrang, Tinsukia, Goalpara, Cachar, Karimganj, Hailakandi and Dhubri

⁴⁵ These investments will be made in identified existing SDH and CHCs to upgrade them to DHs.

⁴⁶ IPHS 2022 guidelines on the standards for new infrastructure for DH construction that includes layout and capacity with specification of services, and PWD norms on the civil works specifications that are accepted nationally.

⁴⁷ The project will only finance any additional medical equipment and goods for DH according to IPHS standards, needed after the medical equipment and goods financed by the PM ABHIM and XV FC.



Projects in Disputed Areas OP 7.60

No

Summary of Assessment of Environmental and Social Risks and Impacts

19. **The environmental risk for the project is rated as Substantial.** Key risks and impacts are anticipated related to construction, biomedical waste management, occupational health and safety, and community health and safety, and Borrower capacity to comply with the new ESF requirements. The project involves several implementing entities and requires coordination amongst several departments, all of which need clearly defined institutional setup to supervise and manage the environmental and social activities under the project. Construction activity gives rise to temporary and localized impacts such as generation of debris, dust, noise, water pollution, and potential accidents which all need to effectively be prevented, mitigated, or minimized onsite through good mitigation measures and design. There will be an increase in the generation of waste (medical waste and effluents) which will also need to be managed appropriately. The Borrower does not have experience in implementing Bank financed projects under the ESF. Client capacities will be bolstered during implementation through recruitment of qualified staff and capacity building to fulfill ESF requirements and manage mitigate environmental risks of the project. The Borrower has prepared an Environmental and Social Management Framework (ESMF) for the assessment and management of E&S risks and impacts for activities to be implemented. The ESMF establishes the principles and procedures to screen, assess, manage, and monitor the mitigation measures of environmental and social impacts of subprojects during implementation. In addition, Stakeholder Engagement Plan (SEP), Labour Management Procedure (LMP) and Environmental and Social Commitment Plan (ESCP) has been prepared to a standard acceptable to the Bank. These have been disclosed in country on Feb 1, 2023, with consultations held on Feb 3, 2023. The final documents will be disclosed both in country and in the WB external website before appraisal is completed.

20. **The social risks are rated as ‘Moderate’** based on the assessment of risks, impacts and weak borrower capacities. The risks pertain to (i) upgradation of 10 existing Community Health Centres (CHCs)/Sub-Divisional Hospitals (SDHs) to District Hospitals (DHs), (ii) repair and renovation of the 25 DHs, and (iii) infrastructure improvement of nursing colleges. Other activities with social implications are related to systems improvement- (i) setting performance management standards, (ii) demand-side interventions with community for improving health seeking behavior, and (iii) increasing of human resources in the health sector. Based on the proposed interventions, the following social risks are anticipated (a) temporary disruption/delay of health services due to change in location of existing medical facilities (to nearby areas) during upgradation of CHC/SDH and renovation of DH, (b) temporary relocation of staff accommodation, (c) impact on workers’ and communities’ health and safety during construction related activities, (d) insufficient systems to address employment related issues such as SEA/SH, and discrimination at the workplace in the health sector, (e) inadequate systems to include vulnerable populations (women/SC/ST/BPL) from receiving project benefits, and (f) weak grievance redressal mechanisms. No new land acquisition is expected as upgradation and renovation activities are planned on government/municipal land and within the boundaries of existing facilities. The project’s negative list eliminates activities resulting in (a) acquisition of private lands or physical relocation of PAPs, and (b) posing significant risks to indigenous communities that may require obtaining FPIC. Client capacities will be bolstered during implementation through recruitment of qualified staff and capacity building to fulfill ESF requirements and manage mitigate social risks of the project. Capacity building and training will be

carried out extensively to all implementing agencies and supporting consultancies. A Social Specialist will be recruited in the SPMU and will be supported by additional consultants and advisors to strengthen implementation capacity.

21. **The project's SEA/SH risk has been rated as Low** through the application of the Screening Tools for Civil Works and Health. Construction of district hospitals might draw labourers from outside the state or from neighbouring districts, posing a risk to the host communities. The project will also finance recruitment and deployment of health workforce which may exacerbate the risks of sexual harassment and sexual abuse at the workplace. Risks of SEA/SH may arise under three circumstances: (a) risks of SEA/SH to community members, particularly women and children by contractors' workers during construction period; (b) risks of workplace sexual harassment at all establishments (SPMU, implementing agencies, consultants and contractors) under the project; and (c) risks of SEA/SH to patients by healthcare workers at the district hospitals and health facilities. There may also be instances where healthcare workers may need to play the dual role of responding to the survivors of sexual assault, by providing required medical treatment and psychological support, and at the same time assist survivors in their medico-legal proceedings by collecting evidence and ensuring a good quality documentation. Though the rating is Low, the project gives an opportunity to build capacity of all project personnel and health care professionals by sensitizing them to sexual exploitation and abuse (SEA) and sexual harassment (SH) issues and measures as part of their training, and address mandatory provisions of 'The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013' in the DoHFW and its directorates, line departments and in project facilities (district hospitals, nursing institutions and dental colleges). Additionally, HR policies of the Implementing partners will be strengthened through a Code of Conduct (CoC) applicable to (a) staff at health facilities, (b) construction workers, and (c) other project employees. The CoC will commit all personnel to acceptable standards of behavior. The CoC will include sanctions for non-compliance, including termination or even revoking of the employment contract. Project personnel will also receive awareness training on SEA/SH-related issues. Staff of implementing agencies, line departments including contract workers will also be subject to and trained on codes of conduct, for interacting with co-workers, beneficiaries, and local communities. Further, the project's GRM will include a channel to allow SEA/SH-related grievances to be received and addressed. This includes setting up of Internal Complaints Committee (ICC) and SH policy in establishments (DHs, nursing, implementing agencies) as per the requirements of the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013. The SPMU will put in place necessary mechanisms and procedures for confidential reporting with safe and ethical documentation of SEA/SH issues at the project level. The SEA/SH referral pathways will be established and communicated to all. SEA/SH related processes will be overseen and monitored on the ground by the SPMU as per the requirements of the ESMF.

E. Implementation

Institutional and Implementation Arrangements

22. **The Assam Health Infrastructure Development and Management Society (AHIDMS) will be responsible for project implementation.** AHIDMS is designated as the SPMU because GoA established AHIDMS for coordination and implementation of externally aided projects in the health sector. The project governance structure will include: (i) Project Steering Committee chaired by the Chief Secretary to oversee overall project implementation, and (ii) Executive Committee, headed by Principal Secretary (Health and



Family Welfare) for effective management of project activities and provide strategic direction and administrative approvals as and when needed. The SPMU will be headed by the Commissioner & Health Secretary, designated as the Project Director. The SPMU will be augmented with deputed staff and consultants to support planning, implementation, coordination, and management of various project activities at the state level. Specifically, the SPMU will engage technical consultants to strengthen its fiduciary, and environmental and social capacity. A cohort of hospital managers will be recruited and deployed to each DH, in line with Assam's commitment to create this exclusive cadre of managers, for overall coordination, management and implementation of project activities at the facility level.

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Approved By

Practice Manager/Manager:		
Country Director:	Santhakumar Sundaram	16-Feb-2023