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Report Number: ICRR0024784

1. Project Data

Project ID	Project Name
P148531	Uttarakhand Health Systems Devp Proj
Country	**Practice Area(Lead)**
India	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-59480	30-Sep-2023	64,951,752.53
Bank Approval Date	**Closing Date (Actual)**	
26-Jan-2017	31-Dec-2024	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	100,000,000.00	0.00
Revised Commitment	64,951,752.53	0.00
Actual	64,951,752.53	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

The original Project Development Objective (PDO) was: 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. (Financing Agreement Schedule 1, page 4).

The revised PDO at project closing was: to improve access to quality health services, in the State of Uttarakhand.

The PDO revision was approved as part of Second Restructuring Package Seq No 2 on 26-May-2021, at which time the credit disbursement was 20 percent. The PDO was revised to focus on access to and quality of services. Also, to capture that the activities related to the COVID-19 Emergency Response, the PDO was revised to cover entire state instead of its initial particular focus on hilly districts of Uttarakhand. There was a revision in the PDO and the PDO/IR indicators to reflect the expansion of geographical scope to statewide. (ICR para 12, page 5).

Reference to the objective on financial risk protection was also dropped to avoid duplication of efforts due to two major health systems reforms at the national level that were being rolled out in the state. This included: (i) Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY), a flagship federal health insurance scheme covering hospitalization related care for poor and vulnerable population; and (ii) Ayushman Bharat Health and Wellness Centers scheme that included the primary care packages (child and adolescent health and NCD care) planned under the project.

The ICR Review therefore applies a split evaluation.

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

Yes

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

No

c. Will a split evaluation be undertaken?

Yes

d. Components

Component 1. Innovations in Engaging the Private Sector (Total estimated amount: US$80 million, including IDA US$64 million and GoUK US$16 million; Actual: US$39.5 million). This component aimed to 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. It also aimed to 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 included two subcomponents:

- Subcomponent 1.1. Innovations in integrated delivery of healthcare services (primary, referral, and emergency care) (Total estimated amount: US$47.5 million). This subcomponent aimed to improve access to an integrated network of primary care, referral services, and emergency care in the state by engaging the private sector.
- Subcomponent 1.2. Innovations in healthcare financing (Total estimated amount: US$32.5 million). This subcomponent aimed to 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, and management of NCDs in primary care settings; and ii) financing the purchase of health care services from public as well as private providers.

Component 2. Stewardship and System Improvement (Total: US$45 million; IDA: US$36 million, GoUK: US$9 million; Actual: US$40 million). This component aimed to bolster the Government's capacity to work

with the private sector and improve health system quality, particularly the innovations planned under the project. This component focused on strengthening institutional structures for stewardship and service delivery and building human resource capacity to ensure effective project and health program implementation.

Note: Components changed, as Subcomponent 1.2 was dropped, and Component 2 was partially dropped, with new activities added. Additionally, there were revisions in component costs with cancellation along with an increased focus on access and quality of integrated delivery of healthcare services.

- In May 2021 (during second restructuring), Sub-component 1.2 on Innovations in Healthcare Financing, was dropped, following the revisions in the PDO by dropping reference to financial protection. The MTR (Oct 2020) had noted that this is no longer relevant as the landscape in Uttarakhand has changed drastically in terms of rollout of government programs and schemes related to financial risk protection since project preparation. The state decided to The World Bank Uttarakhand Health Systems Development Project (P148531) universalize Atal Ayushman Uttarakhand Yojana (AAUY) (state health insurance scheme that expands the federal insurance scheme (PM-JAY) to cover much larger population). In addition, the primary care and preventive and promotive packages related to non-communicable diseases are being covered through on-going initiatives such as the Health and Wellness Centers supported under Ayushman Bharat comprehensive primary care initiative. (Restructuring paper, 2021, and ICR Table 1, Page 3).
- In May 2021 (during second restructuring), Component 2 on Stewardship and System improvement was revised to include the COVID-19 activities as part of the COVID emergency response, and received IDA reallocation bringing it up to an amount of $36 million. (ICR Annex 6, Table 3, Page 29-30).
- In December 2024 (during fourth restructuring), Component 2 on Stewardship and System Improvement, was revised to drop E-hospital activity as the state's overarching plan under the federal scheme, Ayushman Bharat Digital Mission, was not finalized. Without this, it was decided that a stand-alone activity would not be sustainable. Bringing IDA portion to be $34.08 million. (ICR table 1, Page 3).

Reference: ICR Table 1, Page 3; Annex 6, Table 3, Pages 29-30; Annex 3, Page 24.

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

At Appraisal, the project cost was estimated at US$125 million consisting of an International Development Association (IDA) Credit of US$100 million equivalent, and a Borrower contribution of US$25 million. (PAD, page i-ii).

The project had two fund cancellations that aggregated to US$41.33 million, consisting of IDA Credit of US$33.83 million, and government funds of US$7.5 million.

(i) September 2020 (first restructuring): US$30 million of the IDA credit was cancelled, and financing to each of the components was reduced proportionately. Counterpart financing was reduced by US$7.5 million. Cancellation was due to significant cost savings resulting from lower than estimated contract values of several large contracts, exchange rate fluctuations, and implementation and contracting delays of some activities. This freed up unspent funds for other operations as the IDA cycle had concluded for India, and

resources were needed to meet new COVID-19 response needs. Total project amount was US$87.5 million (IDA portion was US$70 million).

- Component 1 on Innovations in Engaging the Private Sector, received a partial cancellation of US$31.12 million (IDA, $24.9 million and government counterparts, US$6.22 million), reducing the total allocations from US$80 million to US$48.88 million (IDA portion was US$39.1 million).
- Component 2 on Stewardship and System Improvement, received a partial cancellation of US$6.38 million (IDA, US$5.1 million and government counterparts, US$1.28 million), reducing the total allocations from US$45 million to US$38.62 million (IDA portion was US$30.9 million).

(ii) December 2024 (fourth restructuring): US$3.83 million of IDA credit was cancelled and e-hospital activity under Component 2 was dropped. The amount was cancelled due to exchange rate fluctuation savings. E-hospital activity was dropped as the state's overarching plan under the federal scheme, Ayushman Bharat Digital Mission, was not finalized. Without this, it was decided that a stand-alone activity would not be sustainable.

The project received one no-cost extension and change in closing date:

(i) May 2023 (third restructuring): No-cost extension and change in the closing date from September 30, 2023, to December 31, 2024. The third restructuring called for a 15-month no-cost extension due to: Significant savings resulting from the exchange rate changes; delays during project initiation and the COVID-19 pandemic; and delays due to challenges faced in complex procurements and implementation of innovative public private partnership (PPP) clusters.

The project had revisions in components, activities, costs and reallocations.

(i) In September 2020, at first restructuring, following partial cancellation:

- Component 1.1 funds were revised, bringing the IDA portion from US$47.5 million to US$25.6 million.
- Component 1.2 funds were revised, bringing the IDA portion from US$32.5 million to US$13.5 million.
- Component 2 funds were revised, bringing the IDA portion from US$36 million to US$30.9 million.

(ii) In May 2021, at second restructuring, following the discontinuation of subcomponent 1.2:

- Component 1 (or Subcomponent 1.1) on Innovations in integrated delivery of health care services received reallocation in the IDA portions bringing it from US$25.6 million to US$34 million. (ICR Table 3, Page 29-30).
- Component 2 on Stewardship and System improvement was revised to include the COVID-19 activities as part of the COVID emergency response, and received reallocation in the IDA portion bringing it up from US$30.9 million to US$36 million. (ICR Table 3, Page 29-30).

(iii) In December 2024, at fourth restructuring. following partial cancellation:

- Component 1 (or Subcomponent 1.1) on Innovations in Integrated delivery of healthcare services due to exchange rate fluctuation savings, bringing IDA portion down from US$34 million to be US$32.09 million. (ICR Table 3, Page 29-30).

- Component 2 on Stewardship and System Improvement, was revised bringing IDA portion down from US$36 million to be US$34.08 million. (ICR table 1, Page 3).

At project closing, total actual disbursement was US$81.2 million, of which actual disbursement of IDA credit amounted to US$64.95 million. The originally planned Borrower contribution of US$25 million was revised to US$17.5 million in 2020, and actual disbursement reported at US$16.2 million.

Reference: ICR Table 1, Page 3, and Table 3, Page 29-30.

3. Relevance of Objectives

Rationale

Development objectives were responsive to challenges in the State of Uttarakhand, especially in the hilly districts, in terms of poor access to quality health services, and to financial protection against illness costs.

The project prioritized activities that would 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. The project aimed to have a 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 aimed to also support the very large floating population that visits the state for business, pilgrimage, and tourism. (PAD, Para 14, Page 4).

The project's key focus was (i) to improve access to health services for some of the most remote population groups in the country, and to further enhance inclusion of the underserved population; (ii) to support strengthened engagement with private health care providers, expanding their role in meeting the unmet health access needs of the state's population; (iii) to strengthen 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; and (iv) to strengthen the performance of the public health system.

At entry, the project was well aligned to the country national priorities (economic growth, poverty reduction, and shared prosperity) and aimed to support national and global efforts toward ensuring Universal Health Coverage, expanding financial protection, and strengthening the performance of the public health system. It was well aligned to the objectives stated in the World Bank Group 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 also supported another CPS objective, that of, the private sector: (i) "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; and (ii) "strengthened public and private health-delivery systems". The project's focus on access, quality, and financial protection in a low-income state was to directly contribute to the World Bank Health Nutrition and Population Global Practice goals of supporting progress towards UHC and ensuring financial protection and service delivery. (PAD para 11-12, page 4).

At closing, the project was well aligned with the World Bank Group Country Partnership Framework (CPF) for India for FY 18-22. This framework was discussed by the Board of Executive Directors on September 9, 2018, and was extended to FY25 by the Performance and Learning Review dated October 23, 2023. The project directly contributed to Focus Area 3- Investing in human capital, aiming to "Improve the quality of health service delivery and financing as well as access to quality healthcare" (objective 3.4). As one of the six states chosen for intensive health system strengthening support in the CPF, the project implemented three of the four proposed 'how to' approaches.

The project's PDO on improving access to quality healthcare services by promoting innovative practices, including mobilizing the contracting of (i) private sector resources to deliver care, and (ii) strengthening the capacity of the Department of Medical Health and Family Welfare (DoMH&FW) to contract and monitor service delivery across the state, contributed to meeting the goals of the CPF (FY18-22).
Additionally, lessons learned from innovative interventions financed by the project will serve as a (iii) lighthouse for other states across India considering stronger partnerships with the private sector to provide healthcare services. Although the project removed the financial protection component and objective from the PDO, it still improved access to free services, diagnostics, and medicines, and helped reduce reliance on out-of-pocket expenditures among Uttarakhand residents. UKHSDP PDO was well aligned with the Government of Uttarakhand (GoUK's) health strategies and directly supports national efforts to meet SDG3.8 (Universal Health Coverage). (ICR paras 8 to 10, pages 4 and 5).

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

to improve access to quality health services

Rationale

The theory of change:

To tackle the state's health challenges, the project aimed to increase access to quality health services and improve financial risk protection. It adopted a multipronged approach that included activities such as Public Private Partnerships (PPP) for health care provision, telemedicine, mobile health vans (MHVs), facility accreditation, training of health personnel, and support for an insurance system to cover healthcare costs borne by households when seeking care. At the time of the project design, developing a theory of change was not a requirement. Nonetheless, ICR authors reconstructed the theory of change based on the project activities, outputs, and outcomes envisaged at the time of project design. (ICR para 3, page 1).

Outputs and intermediate results

The Ministry of Health aimed to create an institutional environment to support ongoing and new public private partnerships (PPP) for facility clusters, with specialists filling vacancies, and established full range of clinical services in PPP facilities. It established a program to strengthen quality of healthcare at facilities (primary health care (PHC), community health centers (CHC), and mobile health vans (MHV)). It also aimed to ensure that the MHVs were staffed with at least one female doctor with sonologist certification and could reach to the underserved patients, and that the outsourced CHCs provided C-section and emergency services. It also improved capacity to offer telemedicine services. Additionally, the health helpline was strengthened to reach out to patients.

The second objective of the PDO was to improve the quality of health care services through training and facility accreditation activities. The number of Government healthcare facilities in the state issued with an entry (or higher) level certification by the National Accreditation Board for Hospitals (NABH) was selected as the PDO indicator to monitor efforts to improve the quality of care. The capacity was built at the NABH to expand the certification of health facilities, to train health personnel on quality standards, and develop and update disaster response. Accreditation required a combination of efforts to upgrade the infrastructure within health facilities, improve systems for waste management, availability of medicines, healthcare workers, and their training, among other quality actions. (ICR, Page 6).

Key outputs linked to the achievement of the PDO Outcome

- Three PPP contracts were awarded to provide services through three district/ sub-district hospitals, 6 CHCs, and 9 MHVs.
- All PPP facilities were compliant with the HR requirements prescribed under the Indian Public Health Standards.
- For the first time ever, a full range of clinical services was made available in three district-level hospitals and six community health centers (CHC) in Uttarakhand through PPP.
- Improved access to medicines and diagnostics through PPP clusters.
- Telemedicine services were expanded with four hubs and 400 spokes across the state.
- Upgradation of equipment and diagnostics (including CT scans) made available at project-supported facilities.
- Eight NABH accredited health facilities were established.
- Full complement of staff and services available at the accredited facilities.
- Eight facilities renovated and upgraded.
- SOPs established and staff trained in these SOPs.

Key outputs linked to the achievement of the two Components (Component 1.1 and Component 2).

Component 1.1: Nine MHVs were introduced in the State. It Improved access to services (including diagnostic services) closer to the community. It strengthened referral linkages with higher-level facilities. 100 percent of female patients availed MHV services for Hb testing. Nine PPP health facilities were operational on 24*7 basis for consultation, admission, and referral. C-sections and major and minor surgeries were made available at the CHCs for the first time in the State. Availability of HR increased substantially across all project facilities including full complement of specialists at PPP facilities.

Component 2: Health personnel were trained at all levels on clinical and non-clinical aspects, and bio medical waste management. Ten ICUs were supported with 1,349 functional ICU beds. 100 percent of facilities were supported by the project under PPP and NABH cluster adhering to Standard Treatment Protocols (STPs).

Seven COVID-19 testing laboratories were established in the state meeting standards established by the Indian Council of Medical Research. 100 percent of families were covered under the Family Health Survey, with their records digitized and maintained to support tracking and follow-up of population based interventions and disaster response services. The State of Uttarakhand has a disaster response plan prepared and shared with the State Disaster Management Authority (SDMA) and Director General, Health Services.

Intermediate indicators (1 out of 12 not achieved):

- 9 fully operational PPP facilities were established, meeting target.
- 245 specialists were in PPP clusters, surpassing targets 2 times over.
- 68,614 (F: 33,081, M:30,984) OPDs done by MHVs under PPP clusters, disaggregated by gender, surpassing targets.
- 100% female patients availed MHV services for Hb testing under the PPP clusters, fully meeting target.
- 1,332,382 PPP telemedicine consultations were conducted, surpassing targets 2.8 times.
- 3 outsourced CHCs where at least one emergency C-section was reported during each quarter, not meeting target of 6.
- 35,233 health personnel were trained, surpassing target 3 times.
- 1,349 ICU functional beds were established, surpassing targets by 50%.
- 100% of facilities were supported by the project under PPP and NABH cluster with at least 80% adherence to Standard Treatment Protocols (STPs), fully meeting targets.
- 7 COVID-19 testing labs in the status, fully meeting targets.
- Family heath survey (FHS) were covered and digitalized, surpassing targets.
- Disaster response plans were prepared by project, but with a delay of 5 years.

Outcomes

Three outcome indicators included (and one of three was not achieved): 1. Number of outpatient visits to Primary Health Centers (PHCs), CHCs, and mobile vans per year, disaggregated by districts; 2. People who have received essential health, nutrition, and population (HNP) services; and 3. Number of Government healthcare facilities in the state issued with an entry (or higher) level certification by the National Accreditation Board for Hospitals.

1. 4,015,828 outpatient visits were achieved under the project, surpassing the target of 1,232,128, three times over.

2. 276,019 deliveries attended by skilled health personnel (specialist or non-specialist doctor, midwife, nurse, or other health personnel with midwifery skills) in health facilities in the intervention districts, surpassing the target of 180,491, 1.5 times over.

3. Out of a target of 9, 8 NABH-accredited facilities were established, meeting only 89 percent of target.

Source of data: ICR Annex 1, Page 16; Table 2, Page 6.

Rating
Substantial

OBJECTIVE 2

Objective
to expand health financial risk protection (original outcome objective)

Rationale
The theory of change:

The theory of change and intermediate results were the same as under the original Objective 1, above.

Outputs and intermediate results:

The Ministry of Health aimed to improve insurance coverage into MSBY/RSBY and through insurance purchasing health services from public and private facilities to provide benefits package for child, adolescents and NCDs in PHC finalized and piloted, and that children receive annual health assessments and immunizations.

Intermediate indicators (4 out 6 not achieved to date)

- # of people with access to Health Insurance, achieved target to date at midterm review/restructuring.
- Households enrolled in RSBY/MSBY insurance, achieved target to date at midterm review/restructuring.
- # of children covered with expanded health insurance, not achieved target at midterm review/restructuring.
- # of children immunized, not achieved target at midterm review/restructuring.
- Benefits package for children complete and piloted, not achieved target at midterm review/restructuring.
- Benefits package on NCDs complete and piloted, not achieved target at midterm review/restructuring.

Outcomes:

The project aimed to increase hospital admissions and outpatient consultations covered by insurance. The one outcome indicator was fully achieved to date.

Number of hospital admissions and outpatient consultations covered by any form of health insurance supported by the project (RSBY and MSBY), disaggregated by gender, met target to date.

Note: This PDO objective was dropped as were associated components and indicators, during the second restructuring of the project (May 2021).

- The PDO to expand health financial risk protection was dropped at second restructuring in 2021.
- On sub-component 1.2 on Innovations in Healthcare Financing, the October 2002 midterm-review (MTR) noted that this is no longer relevant as the landscape in Uttarakhand has changed drastically in terms of rollout of government programs and schemes related to financial risk protection since project

preparation. The state has decided to universalize Atal Ayushman Uttarakhand Yojana (AAUY) (state health insurance scheme that expands the federal insurance scheme (PM-JAY) to cover much larger population). In addition, the primary care and preventive and promotive packages related to non-communicable diseases are being covered through on-going initiatives such as the Health and Wellness Centers supported under Ayushman Bharat comprehensive primary care initiative. (Second Restructuring Paper, May 2021).

Source: ICR Annex 6, table 3, Page 29.

Rating
Modest

OVERALL EFFICACY

Rationale
The objective to improve access to quality health services was substantially achieved; the objective to expand health financial risk protection was partly achieved. The aggregation of achievements is consistent with a modest overall efficacy rating.

Overall Efficacy Rating	Primary Reason
Modest	Low achievement

OVERALL EFFICACY REVISION 1

Overall Efficacy Revision 1 Rationale
The same achievement of Objective 1 was observed as under the original overall efficacy. Objective 2 to expand financial risk protection was dropped at the second restructuring in May 2021.

Overall Efficacy Revision 1 Rating

Substantial

5. Efficiency

At project appraisal: 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. (PAD, para 39, Page 12). The PAD stated that: (i) although, benefits will rise more than proportionately, implying an efficiency gain, 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; (ii)

the project has a strong focus on primary care in its various incarnations—community health centers (CHCs), expanding the health insurance (RSBY/MSBY) package to include primary care, and Mobile Health Vans (MHVs)—all of which offer very favorable cost-effectiveness ratios based on global evidence, and a global research project. 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; (iii) 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 – implies very high benefits vis-à-vis the investments made, consistent with recent economic research in this area; (iv) on equity grounds, financial protection would be improved by the innovation of expanding health insurance coverage (RSBY/MSBY) to include outpatient expenditures—a major source of out-of-pocket and catastrophic episodes in the state. (PAD paras 39-42, Pages 12-13).

At project closing: The ICR noted a substantial increase in proportional benefit from the innovative public private partnership (PPP) care model. Available data allowed the ICR team to estimate the costs of delivering health services to the catchment populations of the PPP clusters in Tehri, Ramnagar and Pauri before and after their implementation. Available data also allowed the ICR team to estimate the costs of delivering health services to the catchment populations of the three cluster PPPs, before and after their implementation, and compare these with health care utilization rates.

Some key takeaways from the efficiency analysis include:

a. Significant increase in access and utilization of quality health services (e.g., more outpatient visits, inpatient admissions, minor and major surgeries, X-rays and laboratory investigations).

b. Reduction in costs by about 27 percent per cluster under the PPP model.

c. Many services that were previously unavailable at certain health centers were provided (e.g. ultrasounds and c-sections).

d. Other activities such as staff training and telemedicine were done at very low cost per unit.

The project's PPP activities delivered more quality services at a lower estimated cost. Although data available is very limited for calculating the cost-benefit of other project activities, the ICR team were able to show the low cost of key interventions:

a. staff were trained at a cost of US$34.11 per person,

b. each telemedicine consultation cost US$2.15,

c. the installation and maintenance of one ICU bed cost US$6,302, and

d. upgrading each facility to achieve National Accreditation Board for Hospitals (NABH) accreditation cost $1,461,588.

The ICR notes that the project has significantly improved access to quality essential and specialized health services in Uttarakhand at reduced out-of-pocket costs.

However, implementation shortcomings reported by the ICR (Table 1, Pages 3-4) resulted in partial cancellations and by project closing date extensions: (i) severe implementation and contracting delays of some

activities (pre-September 2020, first restructuring); (ii) delays during project initiation and the COVID-19 pandemic, and delays due to challenges faced in complex procurements and implementation of innovative PPP clusters (pre-September 2023); (iii) delays in establishing the Project Governing Board and Project Steering Committee; and (iv) delays in the recruitment of specialists, which impacted the implementation (e.g., environment, financial management and MIS specialists). This reduced overall efficiency.

Efficiency Rating

Substantial

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

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐ Not Applicable
ICR Estimate		0	0 ☐ Not Applicable

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

6. Outcome

Relevance of objectives across the entire project is rated high, as there was full alignment between the objectives, country programs, and the Country Partnership Framework at closing.

Efficiency, also assessed across the entire project, is rated substantial, reflecting what would be expected in the operation's sector.

Under the original objectives, overall efficacy was rated Modest.

Under the revised objectives, overall efficacy was rated Substantial.

According to IEG/OPCS guidelines, when a project’s objectives/associated outcome targets are revised, the final outcome is determined by the weight of Bank disbursements under each set of objectives.

Under the original objectives, the outcome is rated Moderately Unsatisfactory (3) with a weight value of 0.6 (3 x 20% in credit disbursements).

Under the revised objectives, the outcome is rated Satisfactory (5) with a weight value of 4 (5 x 80% in credit disbursements).

These weight values add up to 0.6 + 4 = 4.6, rounded to 5, which corresponds to an overall outcome rating of Satisfactory.

Rating Dimension	Original Objectives	Objectives after the 2021 Revision
Relevance of Objectives	High	
Efficacy:		
Objective 1: Improve access to quality health services	Substantial	
Objective 2: Expand health financial risk protection	Modest	--
Overall efficacy	Modest	Substantial
Efficiency	Substantial	
Outcome rating	Moderately Unsatisfactory	Satisfactory
Outcome rating value	3	5
Amount disbursed (US$ millions)	12.86	52.09
Disbursement (%)	20	80
Weight value	0.6	4
Total weights	4.6 (rounded to 5)	
Overall Outcome rating	Satisfactory	

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

Moderate financial and political risks exist regarding the continuity of activities and the development outcome already achieved. This is particularly true in the years following the project completion. The government has developed a comprehensive sustainability plan for public private partnership (PPP) clusters, covering service delivery, National Accreditation Board for Hospitals (NABH) accreditation, telemedicine, and Intensive Care Unit (ICU) maintenance. It details the continuation of the PPP model in Ramnagar (state-funded) and the transition of two other clusters back to public management. For the PPP clusters, the plan addresses post-project management of knowledge, human resources, finances, equipment, and quality control under both the public and the private sector contracting models. NABH standards will be upheld through ongoing staff training and safety protocols. Telemedicine sustainability focuses on capacity building and tech maintenance, while ICU efforts emphasize energy efficiency, patient safety, and staffing via medical college partnerships. Continued state funding for the Project Implementation Team (PIT) until April 2025 signals commitment, though long-term political and financial support remains uncertain.

Limited availability of information suggests that it could be difficult to sustain PPP staffing levels for clusters whose management has returned to the public sector. Specifically for the PPP clusters, as of January 2025, the PPP contract for the Ramnagar cluster had been extended by 15 months, and the Pauri and Tehri cluster management had been transitioned back to the public sector. Preliminary information on staffing across the clusters shows that Pauri has maintained all human resources to the level achieved during project implementation, including specialists, General Duty Medical Officers, nurses, lab, and x-ray technicians. For the Tehri cluster, whose management was returned to the public sector in late 2023, the number of General Duty Medical Officers and nurses has increased across the cluster, but there has been a loss of six of the eight specialists posted to CHCs, two staff nurses in one CHC, 13 lab technicians across the three facilities and all x-ray technicians in CHCs plus four in the district hospital since the cluster was handed over, as some of the underlying constrains to attract specialized staff in public facilities remain valid. This also constitutes a live and ongoing illustration of how the state can continue to use the PPP modality introduced and tested under the project for effective service delivery at an affordable cost. (ICR paras 49-50, page 14).

8. Assessment of Bank Performance

a. Quality-at-Entry

The PAD highlighted that the planned institutional arrangements were 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. (PAD, para 27, Page 9). The project also identified detailed implementation arrangements for administration and monitoring 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. (PAD para 27) and Annex 3).

The ICR also noted that the project preparation included analytical work, consultations, and technical assistance that allowed incorporation of best practices in PPP contracting and targeted support to populations with the greatest need. Analytical work funded externally was conducted over a year with IFC to develop contractual agreements and enhance the success of PPP clusters before finalizing the PAD. The analytical work included legal guidance, assessments of costing and facility outputs, and deep analysis of population needs for cluster selection and targeting. Qualitative and quantitative studies, including a geospatial analysis, were undertaken to understand health service availability and utilization patterns and to design the project interventions. All preparations were undertaken, emphasizing strengthening government capacity to prepare for the roll-out of activities.

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

The ICR noted that the task team conducted 18 supervision and implementation support missions in addition to technical support visits to resolve implementation challenges and bottlenecks as they arose. All issues on implementation progress were discussed in detail with the PIT to find feasible solutions and identify areas where the Bank needed to provide additional support. Given the complexity of the PPP contracts and procurement necessary to meet NABH accreditation, ICU upgradation, and establishment of a telemedicine network, the task team provided much support to ensure procurement processes were undertaken as quickly as possible while maintaining Bank requirements. This support greatly enhanced the capacity of the PIT to undertake complex procurement processes and helped ensure a high degree of procurement integrity, avoided any mis-procurement, supported the establishment of robust monitoring mechanisms, and resulted in the successful completion of the activities.

The ICR noted that the ISRs and Aide Memoires displayed sufficient candor in issue identification and the need for solutions. The ISRs over the first three years of implementation clearly outlined the Bank team's efforts to support the state in establishing the PIT and initiating project activities. The ISRs completed during the COVID-19 pandemic display results of detailed virtual implementation support/technical missions and rapid response to the new needs that arose during the pandemic.

The ICR noted that the Bank team demonstrated a high degree of proactivity. Given the slow implementation in the initial years and low disbursement coupled with changing policy environment in the context of one of the sub-components of health financing, the Bank team demonstrated a high degree of proactivity by partial cancellation of US$30 million, i.e., 30 percent of the IDA credit prior to mid-term review, issuance of a threat of suspension of disbursements and close monitoring of remedial timebound actions, and revision of the RF at mid-term to more closely align with project activities.

The ICR noted that the quality at entry and quality of supervision had only minor shortcomings arising from a complex implementation context. (ICR paras 45-47, pages 13-14).

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The project's results framework (RF) included relevant indicators across the components to measure the intended outcomes and monitor implementation progress. The original RF encompassed five PDO and 13 intermediate indicators that were revised to three PDO and 12 intermediate indicators after the second restructuring. Due to the nature of the activities financed by the project, most indicators measured absolute numbers (e.g., persons or facilities) rather than percentages, and reported cumulatively, which obscured annual progress. The PDO indicator on Health Helpline users and the intermediate indicator on health

insurance access were intended to be gender-disaggregated, but lacked specific targets, and only one included a gender-disaggregated baseline. Although the PDO explicitly targeted the vulnerable populations living in the state's hilly areas, only one PDO indicator was to be disaggregated by district to monitor project impact specifically on the target population. (ICR para 33, page 11).

b. M&E Implementation

The project's RF was systematically updated, including through implementation support missions. There were issues in getting data on the RF indicators during the project's first three years due to delays in recruiting an MIS specialist in the PIT. The team faced challenges in accessing the data since there was no structured system in the state to follow up and report on the RF indicators. These issues were overcome with the recruitment of an M&E expert in FY 2020 and proactive measures taken at the Health Secretary's level to monitor and update the RF indicators regularly. Following the restructuring in 2020, new indicators were introduced and monitored regularly, with outpatient visit definitions refined for statewide relevance and an independent agency overseeing PPP performance and payments. (ICR para 34, page 11).

c. M&E Utilization

The project used additional monitoring and evaluation strategies to identify implementation bottlenecks and track the implementation progress of specific activities. PPP contracts included key performance indicators (KPIs) to monitor performance, identify bottlenecks, and guide solutions at various levels. The independent verification agency tracked these KPIs, informed stakeholders, and supported data-driven problem-solving. Incentive-based payments were tied to KPI achievements, encouraging data use. The agency also monitored grievance redressal. The telemedicine command center's role expanded with project implementation to track indicators such as medicine availability across facilities and supported internal reviews to address challenges across monitored indicators. An additional important use of data for project implementation was the NABH accreditation gap analysis which played a key role in guiding facility-level investments and monitoring progress, though limited data availability constrained deeper efficiency assessments. (ICR para 35, page 11).

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

Overview: The project complied with safeguard policies. It also complied with Safeguard Policy OP 4.10 on Indigenous Peoples. The overall Safeguard Rating recorded in the Operational Portal was moderately satisfactory.

Environmental Compliance: The project developed an Environmental and Social Management Plan in year 2, and the World Bank Operational Policy 4.01 was integrated. Nevertheless, there were significant delays

in the recruitment of specialists, which impacted the implementation of environmental and social safeguards activities and led to a downgrade in ratings. There was no environment expert in the PIT from the start of the project until the second year of the project. Subsequently, the existing issues were rectified by implementing actions under the Environmental and Social Management Plan, and environmental safeguards improved from moderately unsatisfactory to moderately satisfactory by FY 2021 and remained as such till project closing. A biomedical waste management specialist was recruited in FY 2020, and training was provided at 13 district hospitals, with monthly environmental screening reports prepared by health facilities in three clusters. The project established two biomedical facilities. One was set up in the Kumaon region, and the other in the Garhwal region.

Citizen Engagement: A citizen engagement and communication plan was developed. This plan was based on perspectives from citizens and health functionaries regarding private sector engagement in public healthcare facilities through PPP. The project leveraged effective communication strategies, such as workshops conducted through third-party agencies, to increase awareness of the improved services. These workshops provided useful insights into community perceptions and the gaps, and enhanced trust in public healthcare facilities.

Indigenous Communities: Tribal communities constitute about three percent of the state's population and inhabit remote areas with poor connectivity. The project's cluster-based approach and MHVs helped significantly improve access to comprehensive primary care services and the availability of specialists in remote and Indigenous communities in all three clusters of the project.

Grievance Redressal Mechanism (GRM): The project established mechanisms for registering, resolving, and tracking grievances at health facilities within PPP clusters. These mechanisms were monitored monthly. Additionally, grievances could be addressed through the 104 integrated health helpline service, the online Samadhan portal, and a separate Grievance Redressal Committee with different levels of appellate authorities. From 2021, 177 grievances were received from the PPP clusters, and all of them were addressed regularly and resolved by the end of the project period.

Environment and Social Incident Response: The project reported a vehicular road accident on November 3, 2022. The accident involved one fatality and three passengers who suffered serious injuries. The project responded by undertaking a root-cause analysis and putting in place an appropriate action plan to mitigate future risks of vehicular accidents. The WB task team along with the Project team helped ensure that the family of the deceased received full insurance compensation and the other three survivors received all necessary medical treatment and monthly salaries despite being on extended medical leave. The case was recommended for closure. The final accident closure report and after-action memo was submitted in early 2024. (ICR, page 12).

b. Fiduciary Compliance

Financial Management: The project faced financial management (FM) performance difficulties in the first two years of project implementation due to delays in recruiting a financial manager and an initial lag in disbursements leading to ratings being Moderately Satisfactory. These issues were resolved, and accounting processes were improved with the use of computerized accounting through Tally.

The financial and audit reports were submitted regularly to the World Bank. This resulted in improved ratings back to Satisfactory in FY 21-22.

Procurement: There was delay in establishing the Project Governing Board and Project Steering Committee, which led to delays and difficulties in procurement. Furthermore, some of the procurement packages were complex (e.g. PPP, NABH, telemedicine), delayed and of sub-optimal quality that required intense implementation support. The procurement risk was mitigated by adhering to World Bank procurement guidelines, anti-corruption guidelines, and legal agreements. The World Bank team also facilitated workshops to strengthen contracting capacity and adherence to standards. The procurement improved with setting up of the governing mechanisms. (ICR, page 13).

c. Unintended impacts (Positive or Negative)

The ICR (paras 24-25, Page 9) reported two unintended positive impacts:

(i) The strengthening of service provision and increased access to quality care had important impact on the system's resilience and ability to manage surges in demand for care, arising from tourism, accidents, and natural disasters. Across the state, OPD services were made available for nearly one million additional consultations annually, allowing for the care of tourists visiting the state. Facilities near tourist sites saw demand double in the tourist season.

(ii) The disaster management cell and integrated plan have played an important role in preparing the state for disasters. For example, in 2023, the state suffered a major mining accident; the rescued workers from the site received emergency medical and ICU services, with project support. The project increased access to services in remote areas through improvements in the quality of CHCs, MHVs, and telemedicine, which have supported emergency response to these natural disasters while maintaining the availability of essential services during these times.

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Satisfactory	
Quality of M&E	Substantial	Substantial	

Quality of ICR	---	Substantial

12. Lessons

The ICR (Pages 14-15) identified some lessons and recommendations, including the following lessons moderately re-stated by IEG Review.

Enhancing Service Access and Utilization in Remote and Disaster-Prone Areas

The project highlighted effective strategies to increase healthcare service access and utilization, particularly in remote and disaster-prone regions. Notably, the deployment of public-private partnerships (PPP), mobile health vans (MHVs), and telemedicine were instrumental in reaching underserved populations. These approaches facilitated the delivery of essential health services and improved patient outreach in challenging environments.

Public-Private Partnerships: Design, Management, and Oversight

Well-designed and efficiently managed PPPs were shown to greatly improve access to quality healthcare and increase service utilization. Success depended on specific attention to staffing and performance measures, including cluster-based contracting, the establishment of clear staffing standards, deployment of mixed public-private staff, and implementation of performance benchmarks. Financial incentives tied to payments or key performance indicators (KPIs) further supported high-quality service delivery. Additionally, a strong oversight agency played a critical role, as robust monitoring and performance management were essential to the ongoing success of PPP initiatives.

Mobile Health Vans and Telemedicine: Reaching Remote and Vulnerable Populations

MHVs and telemedicine emerged as efficient solutions for extending healthcare services to remote and vulnerable groups. Their effectiveness was maximized through strengthened collaborations between MHVs and health facility clusters, which enabled timely outreach for consultations, medical tests, and specialist follow-up at primary health centers (PHCs) or district hospitals. Integrating MHVs with facility clusters ensured coordinated service delivery and improved patient outcomes.

The hub-and-spoke telemedicine system—linking medical college hubs to rural PHCs—enhanced efficiency by facilitating specialist consultations via digital devices, supporting standardized testing, and providing staff training. This model also contributed to greater cost-efficiency within the healthcare system.

Improving Quality of Care Through Systematic Accreditation

A holistic and systematic approach to health facility accreditation proved to be the most effective pathway to improving care quality. Strengthening accreditation systems and standards, alongside targeted investments to help health facilities meet these standards, raised the overall quality of care. Identifying and supporting facilities in their efforts to achieve accreditation were key components of this strategy.

Program Sustainability: Capacity Building and Flexibility

The sustainability of healthcare improvements depended on the Bank team's close engagement with the client and the project's adaptability to changing needs. Flexibility in building capacity and fostering good governance contributed to lasting positive impacts. Ongoing commitment to these principles ensured that the program remained responsive and effective over time.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a thorough and clear overview of the project performance. It was candid and aligned to development objectives. The analysis referred to the project's theory of change and helped the reader understand how project activities were linked to observed results. The ICR was remarkable in its data presentation and in providing a clear storyline distilled from a complex situation. Lessons were derived from project experience. The ICR was concise, internally consistent, and largely followed established guidelines.

The split rating calculation of the ICR was expected to derive efficacy ratings by illustrating the achievement of each objective before and after the revision, rather than by using a list of indicators. World Bank project assessments are objectives-based.

a. Quality of ICR Rating
Substantial