Report Number: ICRR0024452

1. Project Data

Project ID P149340	**Project Name** Nagaland Health Project
Country India	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	**Closing Date (Original)**	**Total Project Cost (USD)**
IDA-59270	31-Mar-2023	42,992,939.35
Bank Approval Date	**Closing Date (Actual)**	
19-Dec-2016	30-Jun-2024	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	48,000,000.00	0.00
Revised Commitment	43,000,000.00	0.00
Actual	41,846,504.33	0.00

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

a. Objectives

The objectives of the project were “to improve health services and increase their utilization by communities in targeted locations in Nagaland” (Financing Agreement, January 16, 2017, Schedule 1, p. 4).

Targeted locations included all 11 District Hospitals and 21 Community Health Centers in the state, as well as 55 Primary Health Centers, 90 Sub-Centers, and 500 villages within the catchment areas of targeted health facilities.

b. Were the project objectives/key associated outcome targets revised during implementation?
No

c. Will a split evaluation be undertaken?
No

d. Components
The project had two components, as follows:

Component 1: Community Action for Health and Nutrition (Appraisal: USD 18 million, fully financed by IDA; Restructuring: USD 13 million; Actual: USD 7.14 million). This component aimed to empower communities to oversee, manage, and improve Health, Nutrition and Population (HNP) services, and their utilization. An incentive strategy was to be used, whereby results-based funding (RBF) would be provided to communities based on progress on indicators related to improved health and nutrition services and practices. Communities were to use the incentive payments on activities and investments that would yield potential impacts on health and nutrition. The component was expected to support knowledge development and skill building of Village Health Committees (VHCs), as well as other stakeholders in the communities. An Incentive Agreement would be signed between the VHCs and the Department of Health and Family Welfare (DHFW), which would include an action plan and targets to be met. An initial phase was included as a pilot in two districts. The results from this pilot would inform the scaling up of this component to all targeted areas.

Component 2: Health System Development (Appraisal: USD 42 million, of which IDA USD 30 million, Government of Nagaland (GON) USD 12 million; Actual: USD 49.38 million, of which IDA USD 35.83, GON USD 13.55 million). This component would support improvements in the management and delivery of health services, including both facility-specific and system-wide investments. It included two subcomponents:

Subcomponent 2.1: Investments to Improve Service Delivery Conditions at Targeted Health Facilities. The subcomponent aimed to improve conditions for staff and patients in targeted health facilities, by financing off-grid electrical power solutions, including solar energy technology in larger facilities, and battery and inverter systems to be charged by the grid in smaller facilities. In addition, the project would finance solar water pumps, water heaters, improved water supply systems for wash basins and toilets, and septic tanks.

Subcomponent 2.2: Development of Health System Components. With the purpose of improving the management and effectiveness of health services, the project would support: (a) the development of systems and processes to improve the supply chain management system; (b) the development of an interoperable information and communication technology (ICT) platform to support supply chain management, financial management, human resource management, the health management information system, and mobile applications for behavior change communication; (c) the development of a medium-

term health human resource strategy for the state; (d) other investments such as minor repairs, equipment, and supplies for health services; (e) monitoring and evaluation; and (f) project management.

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

At appraisal, the total project cost was USD 60 million, of which USD 48 million would be financed by IDA and USD 12 million would come from state government parallel financing. In November 2020, USD 5 million of the IDA credit was cancelled due to exchange rate fluctuations. The actual project cost was USD 56.5 million, comprised of USD 43 million from the IDA credit and USD 13.5 million from the state government. The reduction in counterpart funding maintained the original 80:20 ratio of IDA to government financing.

The project was approved on December 19, 2016, and became effective on March 20, 2017. The Mid-Term Review was carried out in June 2020. The original closing date was March 31, 2023. There were two closing date extensions, for nine and six months, for a total of 15 months, with a final closing date of June 30, 2024.

The project underwent four restructuring processes:

1. The first restructuring (November 26, 2020) responded to findings and recommendations from the Mid-Term Review. The end-of-project targets for PDO and intermediate results indicators (IRI) were revised upward, and three new IRIs were introduced. The results-based model in Component 1 was extended to District Hospitals and District Health Authorities. In addition, USD 5 million was cancelled from the credit due to savings coming mainly from an exchange rate depreciation of the Indian Rupee (INR) against the USD.

2. On June 9, 2021, the project was restructured to include a sub-component to support activities in response to the COVID-19 pandemic. Financing was provided for essential equipment, medical supplies, and pharmaceuticals.

3. On January 19, 2023, the project closing date was extended from March 30, 2023, to December 31, 2023, to allow for completion of activities and closing of pending contracts.

4. On December 23, 2023, the project was extended for an additional six months, from December 31, 2023, to June 30, 2024, to allow for completion of construction of the Knowledge Center and Library of the Hojima Medical college, which had been delayed due to climate issues and unavailability of some materials in the area.

3. Relevance of Objectives

Rationale

At the time of appraisal, the state of Nagaland, located in the North-East region of India, had a population of 2 million. While per capita net state domestic product was USD 1,192, slightly below the national figure of USD 1,297, the socioeconomic distribution was somewhat more equitable than the national average, with 19 percent of the population living below the official poverty line, as compared to 22 percent at the national

level. Tribal communities made up almost 90 percent of Nagaland's population, and 70 percent of the state's population lived in rural areas (PAD, p. 1).

HNP outcomes in Nagaland were mixed. Child malnutrition was 29.1 percent, below the national average of 38.7 percent nationwide. On the other hand, communicable diseases remained important, and non-communicable disease indicators were increasing. Health service utilization was low, with full immunization at 33.2 percent (65.3 percent nationwide), and only 3.6 percent of pregnant women received full antenatal care and 18.6 percent delivered in a health facility (as compared to the nationwide averages of 26.5 percent and 72.9 percent, respectively). Low utilization was attributed to several factors, including limited capacity in health services, difficulty in accessing health facilities, and lack of skilled health care workers, with 2.32 doctors per 10,000 people, as compared to the country's average of 3.35. There was no medical college in the state, there were challenges in staffing rural health facilities, and absenteeism was common. In addition, the conditions in health facilities were poor, with unreliable electricity supply, and many facilities lacked water supply and sanitation to ensure good hygienic conditions for patients and staff.

The project aimed to improve health services and increase their utilization. The project was aligned with India's National Health Mission, whose policy was to "ensure universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs" (nhm.gov.in). The project was also aligned with the objectives and strategies of the DHFW of Nagaland. Specifically, in 2002 a state law transferred responsibility for local services to Village Councils, including assets and financial resources. In the health sector, VHCs were responsible for management of local health services, including salaries.

At appraisal, the project was well aligned with the Country Partnership Strategy for India for FY 2013-2017 (Report No. 76176), specifically under the Strategic Engagement Area 3: Inclusion. This strategic area included the outcome "Strengthened public and private health-delivery systems," under which the Bank aimed to support the development of accessible and affordable health care facilities. At closing, the project continued to be relevant under the Country Partnership Framework for the period FY 18-22 (Report No. 126667), as extended by the India: Performance and Learning Review (Report No. 185500) until December 31, 2024. The project was aligned with Objective 3.4: "Improve the quality of health service delivery and financing, as well as access to quality healthcare."

The project's objectives were well situated within the Bank's prior interventions in the country and sector. This was the first World Bank operation in Nagaland. Project design benefited from prior analytical work. Specifically, the study on Influencing Multisectoral Action for Health Outcomes (P145691) highlighted the importance of behavior change interventions at the community level to address health risk factors. The Bank also carried out a Health, Nutrition and Population Technical Assistance to North East States in India (P146929), which assessed critical issues of the project and provided recommendations on project design, including community-level strategies, human resources, energy and water and sanitation for health services, supply chain management, and ICT needs. This Technical Assistance also concluded that in some cases, communities had made substantial investments and carried out activities with potential impact on health and nutrition, while in others, committees were hardly active.

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

To improve health services in targeted locations in Nagaland.

Rationale

The theory of change stated that health services would be improved through support to Village Health Committees (VHCs), investments in facilities, and system-wide improvements. Support to VHCs would be done through RBF based on achieving indicators linked to improving the provision of health services. Investment in health facilities included infrastructure and equipment to ensure availability of water for patient and health worker hygiene and sanitation, as well as implementation of solar and/or batteries to ensure continuous electricity supply. Targeting health facilities for investments was carried out based on criteria linked to high demand for services and a minimum level of capacities in place, in order to maximize impact. A total of 177 facilities were initially targeted, later being scaled up to 188 facilities (11 district hospitals, 165 primary health centers, and 12 sub-centers). There were 500 villages in the catchment areas of these health facilities. System-wide improvements involved implementation of an ICT system that included patient registration, laboratory services, billing, pharmaceutical and medical records, a human resources database, a bio-medical waste management system, inventory of drugs and medicines, and equipment maintenance. In-service training would be provided for health workers, as well as support for pre-service training for para-medical staff, such as laboratory technicians and nurses. Finally, the project would support the development of a medical college in the state through technical assistance to plan its construction as well as financial support for the construction of the knowledge center. Taken together, these interventions would logically and plausibly lead to improved health services.

Outputs

At the community level:

All the 500 targeted VHCs received training, meeting the target, and all the targeted VHCs had a female co-chair, also meeting the target.

At project closing, all the VHCs had received health and nutrition incentives in the previous year as part of the RBF strategy, meeting the target.

Citizens and/or communities were involved in planning, implementation, and evaluation of development programs.

At the health facility level:

Targeted health facilities with at least one functional flush or pour flush toilet facility increased from a baseline of 46 percent to 100 percent, meeting the target.

Targeted health facilities with electricity supply improved by the project increased from a baseline of 0 to 188, meeting the target.

A total of 11,606 health personnel staff received training, exceeding the target of 5,000 staff. Training included bio-medical waste management, supply chain management, and pre-service training for nursing and paramedical school personnel.

All targeted health facilities were constructed, renovated, and/or equipped.

Health facilities receiving all essential medicines, according to the essential medicines list from the state, increased from a baseline of 20 percent to 87 percent, exceeding the target of 70 percent. The endline survey of the project indicated that 48 percent of households reported receiving free medicine from public facilities in project areas, as compared to 34 percent in non-intervention areas (ICR, p. 4).

Targeted health facilities that had the necessary equipment and supplies for disinfecting and disposal of biomedical waste increased from a baseline of 30 percent to 100 percent, meeting the target. By project end, 57 percent of the 188 targeted facilities had received *Kayakalp* certification in recognition of exemplary adherence to national cleanliness, hygiene, infection-control, and environment-friendly practices and protocols (ICR, p. 5).

At the systems level:

A procurement manual based on Government of Nagaland guidelines was adopted by the DHFW, and staff were trained on its use.

A common database was developed and integrated with the Health Management Information System, allowing the recording of all service delivery data reported by health facilities.

Targeted paramedical teaching schools that improved their physical infrastructure, as per the standards of the India Nursing Council (INC) and the All-India Council for Technical Education (AICTE), increased from a baseline of 30 percent to 100 percent, meeting the target.

Outcomes

At the community level, the percentage of female community health workers (Accredited Social Health Activists, ASHAs) supplied with complete kits increased from a baseline of 22 percent to 93.5 percent, below the target of 100 percent. As indicated in the ICR (p. 17), this indicator showed an upward trend at the time of closing. The kits enabled the ASHAs to provide the services under their responsibilities to the community and included 10 items, such as basic medicines, oral rehydration therapy, chloroquine, birth control items, etc.

At the health facility level, health facilities with at least one functional handwashing facility with running water increased from a baseline of 31 percent to 100 percent, meeting the target. In terms of numbers, all 188 targeted facilities were covered.

Rating

Substantial

OBJECTIVE 2

Objective

To increase health services utilization by communities in targeted locations in Nagaland.

Rationale

The theory of change stated that utilization of health services by communities would increase if health services improved (as per Objective 1), and if the demand side were covered through health promotion activities implemented at the community level. Health promotion activities would be under the responsibility of the VHCs and included community-wide promotion activities, home visits to promote healthy behaviors, encouragement of citizens to seek preventive health services, and detection of unattended patients.

Outputs

The percentage of targeted villages where health and nutrition days were organized in the previous month increased from 14 percent to 92.9 percent, exceeding the target of 90 percent. The endline survey showed that the percentage of surveyed households who said that a family member had attended one of these events rose from 12 percent to 35 percent (ICR, p. 6).

The percentage of births in targeted communities for which birth certificates were issued in the previous year increased from 0 percent to 77.9 percent, exceeding the target of 75 percent. Of these, the rate of registration of female births increased from 0 percent to 81.8 percent, exceeding the target of 75 percent.

Outcomes

The percentage of children under one year of age registered for immunization in targeted communities whose growth was recorded at least twice in the previous month increased from a baseline of 6 percent to 81.8 percent, exceeding the target of 70 percent. In the case of female children, the increase was from 6 percent to 78.9 percent, also exceeding the target of 70 percent.

The percentage of children ages 9-11 months who were registered for immunization in targeted communities and who received all recommended immunizations increased from 40 percent to 76.2 percent, exceeding the target of 70 percent. These numbers were the same for female children.

The percentage of mothers who delivered in the previous 6 months in targeted communities and who had at least 4 antenatal care check-ups increased from 21 percent to 50.2 percent, meeting the target of 50 percent. As per the endline survey, the percentage of women who were able to produce a “Mother and Child Protection” card increased from 66 percent to 92 percent, this result being attributed to enhanced record-keeping and advancement of maternal health care practices (ICR, p. 5).

The number of people who received essential HNP services under the project was 836,419, exceeding the target of 320,000. The endline survey also showed that those household members who had an episode of illness in the previous 14 days and had sought care from a government-operated health facility rose from 38 percent to 62 percent. The incidence of household visits by ASHAs, nurses, or Anganwadi workers (health promotion staff from health facilities) increased from 10, 8, and 0 percent to 52, 20 and 47 percent. The purpose of these visits was mainly to monitor the growth of a child, vaccinate a child, or give supplementary nutrition.

Rating
High

OVERALL EFFICACY
Rationale
Objective 1 (To improve health services in targeted locations in Nagaland) is rated Substantial, as it almost fully achieved its targeted outcomes. Objective 2 (To increase health services utilization by communities in targeted locations in Nagaland) is rated High, as targeted outcomes were fully achieved. Thus, overall Efficacy is rated Substantial.

Overall Efficacy Rating

Substantial

5. Efficiency

At the time of appraisal (PAD, p. 51), a simple model was used to estimate the impact of total government health spending (including the expected project financing) over the six-year project implementation period. The estimates projected an increase of 10 percent annually in general outpatient and maternal and child services, resulting in a cumulative 1.2 million beneficiaries using public health services at a per capita cost of USD 42. This estimate was on the conservative side, as the project expected to serve a larger number of beneficiaries. With respect to benefits of the health and nutrition interventions, the PAD cited a study from the Lancet (The Lancet Commission for Investing in Health, 2013: “Returns on investing in health in India”) which concluded that a quarter of India’s growth (as defined by economic growth plus the value of life years gained over the period of 2007-2012) was the result of the decline in mortality in the country during that period. This translated into 3 percent of India’s 2007 gross domestic product. On this basis, the study estimated that for every USD invested in India, the return would be USD 10. The study also recommended that about half of health sector investment should go to health systems strengthening and capacity development. In the case of this specific project, GON health annual expenditures (including USD 10 million from the project) would be USD 60 million. As per the Lancet study, this would lead to a return on investment of about USD 600 million.

At closing, a cost-effectiveness model compared trends in Nagaland over the project period with national trends. The model estimated that a total of 15,209 disability adjusted life years (DALYs) were averted in Nagaland between 2017 and 2023. This total was the sum of an estimated 411 deaths of children under 5 years of age (equivalent to 12,112 DALYs), 16 pregnant women’s lives saved (equivalent to 418 DALYs), and 2,679 DALYs averted through outpatient visits. At a total program cost of USD 42.97 million, the incremental cost-effectiveness ratio was USD 2,825 per DALY averted, or 1.14 times GDP per capita in 2023. The project was deemed cost-effective if compared to the standard threshold of 1.5 GDP per capita.

Implementation efficiency faced some shortcomings. This was the first World Bank project in Nagaland, and the initial implementation process faced some challenges. Project design took this into account by including a pilot for the RBF that provided lessons learned to make the overall RBF program more efficient. Although the RBF model was piloted successfully, its rollout was slower than expected, resulting in fewer funding rounds than planned. Civil works faced difficulties because of scarcity of local contractors and difficulty of attracting contractors from other states given the remote location of Nagaland. Eventually, contracts were bundled together, and procurement processes were successful. The only civil work that had cost overruns and significant delays (causing two closing date extensions) was the Medical College library. The ICT contract was completed on time and had comparable costs as similar contracts in other states in India. In addition, comparative analysis of trends in targeted and non-intervention facilities gave mixed results. Overall, the project mostly achieved its objectives, having cancelled USD 5 million (because of reduced costs due to exchange rate fluctuations) and reallocation of USD 5 million for COVID-19 pandemic response.

On the whole, the project efficiency is deemed to be Substantial. As noted in the ICR (p. 8) and described above, there were several implementation factors that posed significant challenges to implementation efficiency, particularly the delayed rollout of the RBF, making the rating a low Substantial.

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 is rated High, as the objectives were fully aligned with national and state health policies. Project objectives were also relevant to the Country Partnership Framework at closing. Efficacy is rated Substantial, as the objectives were achieved but with shortcomings in the case of the availability of full kits for the ASHAs. Efficiency is rated as Substantial given that the project achieved the expected results, but with some shortcomings with respect to implementation efficiency. These ratings yield an outcome rating of Satisfactory, indicative of minor shortcomings in the project's preparation, implementation, and achievement.

a. Outcome Rating
Satisfactory

7. Risk to Development Outcome

The project was designed to work both on health systems and at the community level. With respect to health systems, the project supported the implementation of a 14-part ICT system, including a Drugs and Vaccines Distribution Management System, an Equipment Maintenance Management System, and a Human Resources System. These contributed to strengthening the overall state health system, making it more efficient and transparent. The project also contributed to the implementation of the first medical college in the state as well as the strengthening of the paramedical and nursing/midwifery schools. At the facility level, there was significant infrastructure improvement and personnel training on planning. At the community level, VHC capacities were sustainably strengthened.

The ICR (p. 32) identified three risks to development outcomes. First, the upgraded infrastructure, particularly the solar, water collection and storage, and sanitation infrastructure, will need continuous maintenance and operation, requiring adequate budget allocation. Second, training will need to continue, given staff turnover. Third, funding of VHCs has not been secured. Even though the ICR notes that some activities will not require additional funding, the capacity of VHCs to implement their full responsibilities is at risk. To address these risks, a sustainability plan was developed by the DHFW with details on funding needs.

8. Assessment of Bank Performance

a. Quality-at-Entry

Project design aimed to support the state of Nagaland in improving both the supply and demand for health services. The design of the project's Theory of Change was adequate. The use of a results-based model to finance local communities, within the framework of the Nagaland common law, was appropriate. The results framework measured the intended achievements except for the lack of some specific indicators to better inform the utilization of health services including institutional deliveries, and demand for treatment of communicable or non-communicable diseases.

This was the first World Bank project in Nagaland, a state with a large rural population and with difficult accessibility. The project's design took this context into account by carrying out prior technical assistance, initiating the project at a lower scale, and testing the RBF model. The design incorporated plans to scale up once there were initial lessons and the project management team gained experience on World Bank processes and procedures. Prioritization of the provision of electricity and water and sanitation services in health facilities was appropriate, given the state of the infrastructure at the time of appraisal.

The operational design was sound. Monitoring and evaluation arrangements were appropriate and included a baseline, a midline, and an endline survey. Fiduciary arrangements were assessed and planned. As almost 90 percent of the population belonged to tribal groups, the social management framework was incorporated into the project design. The risk assessment was appropriate, with institutional and fiduciary risks rated as substantial given the lack of experience and low capacity.

Mitigation measures were included to address these risks, mainly through the provision of a Project Preparation Advance to support preparatory activities, including the design of the Project Operational Manual, and hiring of consultants to ensure implementation capacity in the Project Management Unit (PMU).

Quality-at-Entry Rating
Highly Satisfactory

b. Quality of supervision
The World Bank team carried out regular supervision support with comprehensive reporting through Implementation Status and Results Reports and Aide Memoires. The team put particular focus on monitoring results. During the period when slow progress was identified (2019), the team made monthly visits to help accelerate implementation, resulting in improved project ratings. During the COVID-19 pandemic, supervision moved to virtual form, with bi-monthly meetings.

The supervision process focused on the achievement of results and responded to the implementation challenges faced by the project. The RBF was expanded to include district hospitals and district health authorities to enhance quality of care. The PMU was strengthened with technical staff, such as engineers, to help with the implementation of works contracts. The project was restructured to respond to the COVID-19 pandemic by reallocating funds to finance relevant medical inputs and equipment. The team also restructured the project to ensure that the project reflected implementation progress, requiring two extensions because of delays in the construction of the Medical College Library.

The team provided close supervision and assistance to the PMU in managing difficulties with the bidding process and contract management. Nagaland had a very limited number of local suppliers and contractors, project sites were highly scattered throughout the state, and there were heavy monsoons in 2018 that damaged roads and infrastructure.

Quality of Supervision Rating
Highly Satisfactory

Overall Bank Performance Rating
Highly Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The causal chain for the project (PAD, p. 12) was well designed, and an adequate results framework was developed to measure achievement of the two objectives. Overall, indicators were appropriate, but a measure of quality could have been included, given that activities were designed to improve quality of care. Also, given the focus on maternal and child health, the results framework could have included an indicator

on institutional deliveries. Regular monitoring was designed to use the DHFW's reporting and information systems. Project design included activities supporting the improvement of these systems. Baseline, midline, and endline surveys were also included in the M&E design, and all indicators had baseline numbers at the time of project launch.

b. M&E Implementation

M&E activities were carried out as planned. Baseline, mid-term, and end surveys were carried out. Overall, these surveys provided the necessary information, even though COVID-19 restrictions caused delays and limited the mid-term survey sample size. There were also some quality concerns with respect to the endline survey. Some difficulties were also observed in the reporting of administrative data coming from facilities with poor internet connectivity.

Project restructuring revised the results framework to better capture project activities. This included the promotion of an IRI to a PDO indicator on health services, adding IRIs as needed, aligning prenatal visit indicators with national standards (which indicated four antenatal care visits, as opposed to the three visits in the original project design), clarifying definitions, and increasing target values as the project was scaled up.

c. M&E Utilization

M&E results were regularly communicated with stakeholders, and action plans were designed to adjust activities and targets as needed. The mid-term survey identified areas in need of attention, leading to increased focus from the implementation and World Bank teams.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project was rated as Environmental Assessment Category B, partial assessment, at the time of appraisal. The main factor triggering Environmental Assessment OP/BP 4.01 was the potential adverse environmental impacts associated with biomedical wastes, generated by the provision of health services. An Environment Management Plan was developed for the project to address biomedical wastes, in line with the Government of India’s biomedical rules. The project provided necessary inputs, such as sterilizers and color-coded bags/bins, constructed deep burial pits, trained staff, and installed effluent treatment plants in eight district hospitals. In addition, the environmental assessment at the time of appraisal concluded that the quality of water and sanitation services in health facilities was poor. This issue was addressed as part of investment activities under Component 2 of the project.

The Operational Policies on Indigenous Peoples (OP/BP 4.11) and Involuntary Resettlement (OP/BP 4.37) were also triggered. A Social Assessment concluded that the project did not carry risks of adverse social

impacts. The Social Assessment, Social Management Framework, Resettlement Policy Framework, Tribal Development Plan, and Gender and Social Inclusion Guidelines were adopted and publicly disclosed by the state government prior to appraisal. Given that most project beneficiaries were members of Tribal communities, the Operational Policy on Indigenous Peoples was mainstreamed into project design. The Resettlement Policy Framework was designed taking into consideration that 93 percent of land is privately owned and governed by local customary laws. During the implementation period, a social safeguards screening checklist was developed for all sites before civil works began, and facilitators were trained in its use. The project promoted community engagement through the VHCs and facility-level health committees. Social audits were implemented by community groups in some villages. .

Environmental and Social risks were rated Moderate throughout the life of the project. Overall safeguard performance ratings were Satisfactory over the life of the project, with a Highly Satisfactory rating for Indigenous Peoples towards the end of the project.

A Grievance Redressal Mechanism was implemented to address procurement-related issues. Complaints were received and recorded mostly in district hospitals, where at least 30 feedback forms were reviewed monthly. No records of complaints and resolutions were kept.

b. Fiduciary Compliance

At the time of appraisal, fiduciary risk was rated as Substantial due to insufficient systems, experience, and capacities for implementation, as well as governance-related risks. To address these risks, a Project Preparation Advance supported the implementation of the PMU, including consultants responsible for fiduciary activities. Financial Management (FM) performance ratings were Moderately Satisfactory throughout project implementation and were upgraded to Satisfactory in 2023. The project followed World Bank FM guidelines, with the lower ratings mainly due to fiscal constraints that led to delays in fund transfers, contractor bill approvals, and payments for civil and solar works. A computerized accounting system was used, and Interim Financial Reports were submitted regularly to the World Bank. Internal audits were carried out in a timely manner (except during the COVID-19 pandemic), with no significant observations.

Procurement was carried out under World Bank guidelines. Procurement ratings were Moderately Satisfactory throughout the life of the project. The main reason for these ratings was the delays in finalizing awards, resulting in multiple extensions, especially for works and solar contracts. There was one complaint on a procurement process, which was resolved. A post-procurement review was carried out. Findings reiterated the delays in procurement processes and recommended compliance with World Bank procurement policies.

c. Unintended impacts (Positive or Negative)

The experience gained under this project has served other states in India. In particular, the tool to assess infrastructure gaps has been used in at least six other states. The RBF model was used in three other northeastern states in India.

d. Other

N/A

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Highly Satisfactory	Highly Satisfactory	
Quality of M&E	High	Substantial	The results framework could have included key indicators to measure quality of service.
Quality of ICR	---	High	

12. Lessons

The ICR (p. 15) provides some important lessons that are restated below:

Pilots can be useful in testing innovations and improving project design prior to scaling up activities. In this case, the RBF pilot provided important lessons that allowed for successful scaling up of activities. The pilot included preconditions on a minimum level of capacity and interest, inclusion of a woman co-chair of the committee, and development of health and nutrition plans. Several instruments were developed to allow the project unit to obtain feedback from implementers, beneficiaries, and other stakeholders.

Discretionary funding allows health facilities to determine how best to spend funds to achieve objectives. The RBF program allowed targeted spending on items deemed important by facility staff. Several conditions were set to ensure adequate spending of the incentive funds, including training in setting priorities, adequate budgeting and management of resources, and an accountability mechanism. The RBF program also benefited from the introduction of state-wide targets set by the National Health Mission, whereby the state could earn an additional five percent of funding if targets were met. Monitoring results from the RBF were aligned with Health Management Information System data, thus ensuring an independent accountability mechanism. The main challenge noted in the ICR was that RBF management involved significant administrative and overhead costs in time and effort by authorities.

Risks to sustainability of project investments increase if the project is a one-off operation. This project was the first World Bank-financed operation in Nagaland. Building relationships and gaining experience took time. While the project achieved its intended results, continuity would have allowed for the consolidation and further scaling up of system improvements and health promotion activities.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR was well written and provided a good analysis of the project. The theory of change was adequate. The ICR was results-oriented and candid. The quality of evidence was high, and the ICR also provided additional information on results, beyond the results matrix, where necessary and appropriate. The quality of analysis was good, pointing out both the positive results from the project, but also implementation challenges and potential improvements to the results matrix. The lessons were specific and were derived from the project's experience. The narrative was clear, well focused, and very concise, with a main text of 15 pages. On a minor note, the ICR could have explained in more detail the role of the VHCs and ASHAs in promoting community health and service utilization.

a. Quality of ICR Rating

High