



Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 14-Jul-2022 | Report No: PIDA263203

**BASIC INFORMATION****A. Basic Program Data**

Country India	Project ID P178252	Program Name Systems Reform Endeavours for Transformed Health Achievement in Gujarat (SRESTHA-G)	Parent Project ID (if any)
Region SOUTH ASIA	Estimated Appraisal Date 14-Jul-2022	Estimated Board Date 28-Sep-2022	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Program-for-Results Financing	Borrower(s) Government of India	Implementing Agency Health and Family Welfare Department (HFWD) through, Government of Gujarat	

Proposed Program Development Objective(s)

The Program Development Objective is to improve quality, equity, and governance of comprehensive primary health care, adolescent girl services, and disease surveillance.

COST & FINANCING**SUMMARY (USD Millions)**

Government program Cost	7,618.00
Total Operation Cost	4,256.00
Total Program Cost	4,255.13
Other Costs	0.88
Total Financing	4,256.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	350.00
World Bank Lending	350.00



Total Government Contribution	3,906.00
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Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

- 1. The growth rebound in FY21/22 was quick, pulled up by investment, recovering consumer demand and, a low base.** Real GDP growth moderated from an average of 7.4 percent during FY14/15-FY18/19 to an estimated 3.7 percent in FY19/20¹, mostly due to (i) shocks to the financial sector, and (ii) decline in private consumption growth². Against this backdrop, the outbreak of COVID-19 had a significant impact, with real GDP contracting by 6.6 percent in FY20/21³. On the fiscal side, the general government deficit widened significantly in FY20/21, owing to higher spending and lower revenues⁴. However, with the easing of Covid-19 restrictions, Goods and Services Tax (GST) collections have crossed the INR 1 trillion mark every month since July 2021, reaching as high as INR 1.67 trillion in April 2022. The robust GST revenue collections are expected to continue as the economic recovery gathers momentum. The real GDP in FY21/22 expanded by 8.7 percent and exceeded the FY19/20 level, on the back of increased capital expenditure by the government and recovering consumer demand. Given the global concerns on significant uncertainty around the pandemic, elevated inflation, geo-political tensions, and extended supply disruptions, growth in FY22/23 is expected to be 7.5 percent⁵. The expected recovery will put India among the world’s fastest-growing emerging economies over the next two years.
- 2. Although India has made remarkable progress in reducing absolute poverty in recent years, the COVID-19 outbreak has delayed the course of poverty reduction⁶.** Between 2011-12 and 2020-21, India’s poverty rate has declined from 22.5 percent⁷ to values estimated to range between 9 to 12.3 percent⁸. However, projections of GDP per capita growth suggest that this estimated decline also includes a reversal of poverty reduction due to the pandemic⁹. Labor market indicators from high frequency surveys -including from the Centre for Monitoring Indian Economy (CMIE)- suggest that vulnerability has increased after the pandemic, particularly for urban households, with a moderate recovery in 2021. Overall, the pandemic and its economic impacts are estimated to have raised urban poverty, creating a set of “new poor” that are relatively more likely to be engaged in the non-farm sector and to have received at least secondary education. In order to respond to the pandemic, GoI has deployed significant resources as part of the Prime Minister Garib Kalyan Yojana (PMGKY) for social assistance, including for urban poor households and migrants.
- 3. Gujarat is among one of the country’s more economically prosperous and urbanized states.** The state accounts for 7.7 percent of India's GDP, with annual GDP growth rate of 12.9 percent between 2015-21 which is higher than the

¹ National Accounts Data, National Statistical Office, Ministry of Statistics and Program Implementation (MOSPI).

² National Accounts Data, National Statistical Office, MOSPI.

³ National Accounts Data, National Statistical Office, MOSPI.

⁴ Union budget 2021, 2022, Ministry of Finance.

⁵ World Bank real GDP forecasts for FY22/23 published in June 2022.

⁶ World Bank projections. The Government of India has deployed significant resources for social assistance, including towards urban poor households and migrants.

⁷ Consumption Expenditure Survey 2011-12, National Sample Survey Office (NSSO), Government of India

⁸ World Bank estimates. Macro Poverty Outlook, October 2021.

⁹ World Bank estimates. Source: Macro Poverty Outlook, 2020.



national growth rate. Gujarat's per capita income has grown at a rate of 8.3 percent during 2012-20 against India's growth rate of 6 percent. Moreover, as per the last available data (2018), Gujarat's ranking amongst Indian states has risen from 9th in 2011 to 3rd in 2018. Poverty levels in the state have declined from 33 percent in 2005 to 17 percent in 2012. However, despite being one of India's fastest growing states, poverty reduction in Gujarat has been slower than in other advanced states.¹⁰ With a total population of 60 million of which 43 percent live in urban areas¹¹, the state is India's ninth most populous state and is highly urbanized. Gujarat, like most other states, has a youthful population, with 66 percent of working-age (15-64 years) and 29 percent aged below 15 years.

Sectoral and Institutional Context

4. **Gujarat has seen a steady improvement in many key reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH+N) indicators over time. However, it lags with its comparators (other states with similar per-capita income) and has large within-state geographic inequities.** For example, the maternal mortality ratio for Gujarat has declined from 122 maternal deaths per 100,000 live births in 2010/12 to 70 in 2017/19; however, the rate is high compared to Kerala (30) and Tamil Nadu (58).¹² Utilization of some essential health services has also improved: institutional deliveries have increased from 53 to 94 percent, and children fully immunized from 45 to 76 percent between 2005/06 and 2019/21¹³. However, the state has some stark differences across districts in key health indicators which require immediate attention (e.g. for children aged under 2 years fully immunized, *Banaskantha* district reported 44 percent while *Tapi* district reported 98 percent).
5. **Gujarat, like several other states, is undergoing an epidemiological transition, and faces a double burden of communicable and non-communicable diseases (NCDs).** Access and utilization of NCD and mental health services remain poor in the state. Three of the top five causes of morbidity and mortality were maternal and neonatal disorders and communicable diseases in 2001 in the state, which was replaced by NCDs in 2019¹⁴. The state has higher prevalence of hypertension and diabetes compared to India and other larger states with similar per-capita income¹⁵. These are further compounded by large inter-district variations (e.g. the percentage of women with hypertension is 13 percent for *Botad* and 27 percent for *Anand*). On mental health, while Gujarat is among pioneer states to have a stand-alone state mental health policy and is implementing innovative, evidence-based intervention to reorient mental health services¹⁶; however, this remains an agenda to focus with 10 percent of rural and 5 percent of urban residents facing mental health problems¹⁷.
6. **Furthermore, climate change is expected to exacerbate human health risks.** Gujarat's geography makes it one of the most vulnerable states of India to the effects of climate change which manifests itself in the form of cyclones and storm surges on the western coast, rising temperatures and droughts in the arid and semi-arid regions, and extreme rainfall and flooding events throughout the state. Both extreme and slow onset climate events, along with resource stress, present a very significant challenge for human health in Gujarat as these will impact food security and increase the frequency of dehydration, malnutrition, mental health, vector, and water borne diseases among others, including potential zoonotic conditions.

¹⁰ <https://documents1.worldbank.org/curated/en/933681504004310148/pdf/119147-BRI-P157572-Gujarat-Poverty.pdf>

¹¹ <https://www.censusindia2011.com/gujarat-population.html>

¹² <https://censusindia.gov.in/census.website/node/294> (accessed on June 17, 2022)

¹³ Various National Health and Family Surveys (NHFSs).

¹⁴ Global Burden of Disease India Compare Data Visualization - <http://vizhub.healthdata.org/gbd-compare/india> (Accessed January 23, 2022)

¹⁵ 20 percent of men and 20 percent of women have hypertension; and 9 percent of men and 8 percent of women have high blood sugar levels (NFHS-5).

¹⁶ <https://cmhlp.org/projects/quality-rights-gujarat/>

¹⁷ National Mental Health Survey 2015/16



7. **Gujarat allocates a modest share of its budget to health relative to other comparator states; this share is also lower than the 8 percent target set in the 2017 National Health Policy (NHP).** Though Gujarat’s average state health expenditure has remained at 6 percent between 2015-20, other large states have shown a higher share of the state budget allocated for health in 2021-22 compared to the previous five years¹⁸. This share should have increased for Gujarat state, given COVID-19 which necessitated more resources for the health sector. ***Indicators of financial risk protection against catastrophic medical expenses have been improving over time.*** Gujarat’s mean out-of-pocket (OOP) spending per inpatient visit in 2017/18 was INR 15,448 which is below national average and comparable to Tamil Nadu, and much lower than other key states like Punjab, Maharashtra, and Kerala. Furthermore, 10 percent of the households in Gujarat incur catastrophic spending on healthcare which is lower than the national average of 15 percent but higher than in states like Assam and Tamil Nadu.
8. **The technical assessment, based on the information available for the state, observed that, while the utilization of services improved over time, some of the critical health indicators are still lagging and can be attributed to four key systemic issues.**
- First, the service delivery model has traditionally been facility-based, without a Comprehensive Primary Health Care (CPHC) approach¹⁹ – although there is renewed push for a CPHC approach through Health and Wellness Centers (HWCs)²⁰ program of the federal government. However, until now, implementation of HWCs in most states including Gujarat has focused largely on designating a facility HWC operational, and an appropriate CPHC service delivery model that is people-centered, with population-based services for NCDs is yet to be scaled up.
 - Second, there are key governance issues hampering performance, including gaps in mechanisms for measuring and monitoring relevant progress indicators. While the state’s health system has shown good progress in a few areas (e.g. RMNCAH), progress in institutional capacity and governance has been poor. Gujarat ranked 6th (among 19 larger states) in the latest NITI Aayog’s Health Index 2020;²¹ this ranking has improved marginally from the previous round’s rank of 7th. While the state is amongst the best performers on inputs and processes, its health system performance did not show improvement between 2018-19 and 2019-20, mostly due to poor performance in the monitoring of key health measures and data integrity; governance; and health systems and service delivery.
 - Third, despite remarkable progress in setting up health facility infrastructure, shortfall in human resources continues to be a challenge. This persisting gap in HR is a major challenge and service delivery redesign would have to factor in available capacity in the private sector as well.
 - Finally, even though Gujarat has been one of the first states in India to focus on quality of care (QoC) initiatives in health sector, the state’s focus has mostly been only on accreditation and certification, and not on other critical QoC aspects. There is scope to further strengthen technology and data-driven decision making to improve program management as well as quality of services. The state also does not have an overarching QoC strategy. The QoC strategy that needs to be developed would focus on patient outcomes and critical aspects of QoC.^{22,23}

¹⁸ <https://prsindia.org/budgets/states/gujarat-budget-analysis-2021-22> (accessed on February 6, 2022)

¹⁹ Comprehensive Primary Health Care refers to the provision of holistic and appropriate care across a wide range of preventive, promotive, chronic and rehabilitative services and include an assessment of a patient’s risks and needs at the primary care level. See “Contribution of primary care to health systems and health.” By Starfield B, Shi L, Macinko J. *Milbank Q.* 2005;83(3):457–502

²⁰ <https://ab-hwc.nhp.gov.in/>

²¹ http://social.niti.gov.in/uploads/sample/SHI_Round_fourth_Report.pdf (accessed on February 6, 2022). By the National Institution for Transforming India (NITI).

²² The Lancet Commission on high-quality health care observed that for improving health systems at scale, approaches like accreditation and focusing on patient satisfaction have not been consistently effective in improving quality. See *High-quality health systems in the Sustainable Development Goals era: time for a revolution*. The Lancet Global Health, 6(11), pp.e1196-e1252.

²³ The national quality policy and strategy handbook of WHO also emphasizes institutionalization of culture of quality and lists several interventions apart from accreditation critical for delivering high quality healthcare. Source: <https://www.who.int/publications/i/item/9789241565561>



- One area where a different approach towards service delivery could have a large impact – more oriented towards the QoC, effectively requiring a redesign – is with safe deliveries. Although 94 percent of pregnant women in the state have deliveries at health facilities, the MMR in the state at 70 per 100,000 live births remains high. There is growing evidence that simply increasing deliveries at Health facilities in general – without taking into account the type of HF or its capability – is inadequate to improve maternal mortality and morbidity beyond a certain level. There is a need to focus on ensuring that women can easily deliver at – or within 30 minutes of – a HF with the capability to handle high-risk pregnancies, in case of complications.²⁴
9. **Despite the state’s renewed multisectoral focus on adolescent health, fragmented service delivery models and an uneven implementation of the adolescent health strategy has meant persistently poor outcomes for Adolescent girls’ health and nutrition²⁵ which the state government is now focused on improving.** Major educational investments, legislative actions, and programming efforts over the last few decades to increase girls’ schooling and curb child marriage have yielded some positive results. Furthermore, the Government of Gujarat (GOG), through implementation of the national program *Rastriya Kishor Swasthya Karyakram* (RKSK) continues to emphasize adolescent health and welfare, with a strong focus on adolescent girls. However, persistent gaps, particularly in health and nutrition outcomes of Adolescent girls remain because of a fragmented approach to service delivery, lack of effective multisectoral coordination, and poor monitoring of program performance.²⁶ The present institutional structure and outreach of the HFWD in Gujarat provides a unique entry point to resolve first-generation gaps in health and nutrition for Adolescent girls while simultaneously investing in inter-departmental platforms that drive improved outcomes across different pillars of human capital.
10. **Gujarat had done relatively well in disease surveillance. However, the COVID-19 pandemic has shown that the surveillance system needs improvements.** Key issues are: (i) many vertical programs with siloed surveillance systems²⁷; (ii) low private sector reporting; (iii) mortality and morbidity data not linked to the Integrated Health Information Portal (IHIP); and (iv) NCD surveillance yet to take off. Further, on the laboratory side, the state capacity is predominantly based on rapid diagnostic kits (RDK)²⁸ and advanced capacity beyond RDKs (diagnostics, RT-PCR, and genome sequencing) for outbreak response remains a challenge. Furthermore, with laboratory network divided in different groups, test data reporting is also fragmented²⁹. COVID-19 pandemic has re-emphasized the critical importance of “One Health” surveillance (OHS) on the principles of multisectoral and multi-institutional coordination for responding to outbreaks involving humans, animals, and their environment³⁰ and this needs to be adopted by Gujarat as well.

PforR Program Scope

11. **The SRESTHA-G will support the Government of Gujarat’s aim to improve its human development performance and advancing human capital gains.** The proposed PforR operation will help address gaps in primary health care, disease

²⁴ Health system redesign for maternal and newborn survival: rethinking care models to close the global equity gap.” By Sanam, R. and others. *BMJ Global Health*, October 2020.

²⁵ As per NFHS, anemia among women age 15-19 years is at 69%, around 22% women continue to marry before age of 18 years and around 34% women age 15-24 years continue to use unhygienic methods of protection during their menstrual period.

²⁶ Barua, A., Watson, K., Plesons, M., Chandra-Mouli, V. & Sharma, K., 2020. Adolescent health programming in India: a rapid review. *Reproductive Health*, 17, pp.1-10.

²⁷ For e.g. TB, HIV, Dengue, Malaria, Hepatitis, Measles, Diphtheria, Neonatal Tetanus etc.

²⁸ Iyer, V., Choudhury, N., Rajiva, A., Cottagiri, S.A., Sharma, A. and Mavalankar, D., 2019. Laboratory Capacity for Surveillance of Infectious Diseases in Gujarat: Quantity, Quality, Effects and Way Forward. *Health*, 11(07), p.998.

²⁹ Labs at primary health centers are under Adl. Dir Public Health, while labs at community health centers are under Adl. Dir. Medical Services. Similarly, labs at medical colleges are managed by Adl. Dir. Medical Education. There is no linkages or integration among these different groups of laboratory networks.

³⁰ Yasobant, S., Patel, K., Saxena, D. and Falkenberg, T., 2020. COVID-19 in India: Making a case for the one health surveillance system. *Indian journal of public health*, 64(6), p.135.



surveillance, quality of care, digital health, and lagging health and welfare outcomes for Adolescent girls. The operation’s design will explicitly build on the ongoing efforts around primary health care to boost their impact. The proposed operation will focus on strengthening institutional capacity for improving quality, access and affordability of health services including for vulnerable populations. TA necessary to develop and implement innovative service delivery models would be mobilized to catalyze results under this operation.

- The proposed PforR Program includes parts of the NHM and other sub-directorates of HFWD.** The estimated value of PforR Program is at US\$4.5 billion for the Program period and includes - CPHC reforms, strengthened disease surveillance, focus on adolescent girls, quality of care, digital health and citizen engagement. The Bank’s contribution to the Program will be US\$350 million.

C. Proposed Program Development Objective(s)

- The Program Development Objective is to improve quality, equity, and governance of comprehensive primary health care, adolescent girl services, and disease surveillance.

The program has following PDO level result indicators spread across three key result areas:

Table 1: PDO-Level Indicators

PDO-Level Indicator	Aspects of PDO Covered					Disease surveillance
	Quality	Equity	Governance	CPHC	AG services	
1. Increased population-based screening for key NCDs (tracked for the state, and for urban areas)	X	X	X	X		
2. Strengthened systems for data quality, and performance tracking and recognition for CPHC	X	X	X	X		
3. Improved anemia management for adolescent girls and boys	X	X	X	X	X	
4. Increased utilization of CPHC and adolescent healthcare services, and efficient disease surveillance reporting (tracked for the state and for 5 lagging districts)—See RA4		X		X	X	X
5. Improved hospitalization and mortality surveillance	X	X	X			X

Note: PDI number four is a Composite Utilization Indicator that consists of a weighted average of 10 individual sub-indicators (with each of these first scaled so that it is comparable with the others). This Composite Indicator will be tracked for the state as a whole as well as for 5 lagging districts, defined using the 2021 Niti Ayoog multidimensional poverty index – Dang, Dahod, Panchmahal, Narmada, and Banas Kantha districts.

- RA1: Improved service delivery for CPHC including RMNCAH, NCDs and mental health:** This Results Area will support the state’s renewed focus on CPHC. It will strengthen the service delivery model oriented around the HWCs, which has the potential to be transformational if implemented properly. Once implemented well, this HWC-based model will ensure that all individuals will have a PHC provider assigned to them, which will offer an expanded package of high-quality services³¹. All will undergo population-based screening at the household level and will be encouraged to go to

³¹ Expanded package of services under HWCs – **existing:** (i) Care in pregnancy and child-birth.; (ii) neonatal and infant health care services; (iii) childhood and adolescent health care services; (iv) family planning and other reproductive health services; (v) management of communicable diseases; (vi) management of common communicable diseases and outpatient care for acute simple illnesses and minor ailments; **new:** (vii) screening, prevention, control and management of NCDs; (viii) care for common ophthalmic and ENT problems; (ix) basic oral health care; (x) elderly and palliative health care services; (xi); emergency medical services; and (xii) screening and basic management of mental health ailments



their assigned PHC provider if they are at high risk for NCDs or other diseases (including climate induced diseases). If needed, they will then be referred by their PHC provider to higher-level health facilities with regular follow-up then occurring at the level of the PHC provider. This model would also have mechanisms for counter-referrals for continued follow-up and support post treatment. This is a wholistic and people-centered model that emphasizes prevention and lifestyle changes, and continuity of care from the household level and upwards. Operationalization of the HWCs, and expansion of service delivery packages, backed by detailed implementation strategies, and strengthened systems for data quality, performance tracking recognition of the CPHC are other areas of intervention under this RA.

15. **RA2: Improved integrated health service delivery models for adolescent girls:** This results area will support the State's efforts to improve health, nutrition and welfare service provision and utilization for adolescent girls and boys. The activities proposed under the RA contextualize the 3E framework of enhance, empower and employ³² for Gujarat to comprehensively address both supply side and demand side challenges in improving health, nutrition and welfare outcomes for adolescent girls (and boys) with the intent to maximize outcomes from the HFWD. The RA will intensify integrated implementation of key packages of health services geared towards adolescent girls and boys (enhance); improve both supply and demand side information barriers and practices for a comprehensive approach to service delivery, supervision and monitoring of services for adolescent girls and boys (empower and enhance); use the HFWD delivery platform to deliver technical trainings on health sector jobs that are currently in demand in the State (employ); and improve state-level prioritization of and cross-sectoral decision making on the adolescent girls agenda to maximize impact.
16. **RA3: Strengthened disease surveillance and early detection of outbreak and response:** This Results Area (RA) will strengthen the state's efforts to improve the existing surveillance system and moving towards Vision 2035 of Public Health Surveillance system for the state. This will be done by targeting a selected number of key areas where substantial gains can be made. In particular, the RA will help address: (i) the sparse degree of hospitalization and mortality surveillance in the current public health care system; (ii) fragmented data reporting in the laboratory network system; and (iii) the growing need for an effective, coordinated One health approach to manage risks from animal-human-ecosystems interactions, especially given the COVID-19 pandemic.
17. **RA4: Strengthened quality of care (QoC), governance, accountability and citizen engagement (Cross-Cutting RA)** Recognizing that poor quality of care is now a bigger barrier to reducing mortality than insufficient access³³, the RA will support a multi-faceted approach to QoC improvement to build people-centered health systems. It will support QoC interventions aligned with global best practices such as WHO's National Quality Policy and Strategy (NQPS) and Lancet's "High Quality Health Systems" framework focusing on: (i) improved governance, (ii) improved health system capacity and skills, and (ii) improved demand for quality in population and improve accountability. The Program would support implementation of interventions based on these framework and focus on processes and culture of quality rather than structural interventions, as supported by global evidence.^{34,35} The interventions under this RA will support in: (i) strengthening governance of the health systems by developing and implementing state QoC strategy, state health policy and other SBCC and operations research strategies; (ii) evolving definite and tangible tools for measuring quality of care, including patient experience and drawing critical learnings from Tamil Nadu's Bank-supported program; (iii)

³² Enhance delivery of health, nutrition (and education) services, empower adolescent girls, boys and their families, and employ adolescent girls. Source: World Bank 2020. Adolescent Girls: Challenges and Opportunities for Building India's Human Capital

³³ Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., ... & English, M. (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution. *The Lancet Global Health*.

³⁴ Quality of care encompasses three dimensions: structure (that is, inputs), clinical processes (that is, interaction between health workers and patients), and patient outcomes (that is, clinical outcomes, morbidity, and mortality).

³⁵ Smith, O., & Nguyen, S. N. (2013). Getting better: improving health system outcomes in Europe and Central Asia. The World Bank.



conducting *Swasthya Parishad* meetings (health assemblies) in the state; (iv) improving quality of CPHC service delivery by supporting NQAS certification of HWCs as well as other public health facilities including CHCs, SDHs and DHs; (v) improving quality of CEmONC centers; and (vi) boosting HWC utilization by people centered SBCC strategy. Finally, this RA is a cross-cutting, and its indicators and results indicators are designed to improve outcomes in the first three RAs.

18. **The activities supported by these RAs are well aligned with other WBG projects, and with the overall context of WBG support for India's Federal system** – building on the principle that the impact of WBG financing is enhanced through appropriate and complementary engagements at both the national and state levels. In particular, this State operation is designed to be complementary to the recently approved national-level Enhanced Health Service Delivery (EHSD, P178146) and Transforming India's Public Health Systems for Pandemic Preparedness (PHSPP, 175676) programs. These national-level operations focus on actions to be undertaken by GoI implementing entities – as well as 7 priority states (excluding Gujarat) in the case of EHSD – and these would be complemented, and reinforced, by the proposed state actions under SRESTHA-G for the state of Gujarat. In addition, the design of SRESTHA-G draws from the learnings of: (i) the pioneering *PforR* Tamil Nadu Health System Reform Program (P166373); and (ii) the Integrated Child Development Services Systems Strengthening and Nutrition Improvement Program for RA2 (P121731).

D. Environmental and Social Effects

19. An Environmental and Social Systems Assessment (ESSA) was carried out for the identified Program. **The ESSA concluded that the environmental and social risk rating for the Program is Moderate.** The ESSA confirmed that the current system for managing the environmental and social aspects of the Program is well covered by the country regulatory framework and institutional arrangements, but enforcement, multi sector coordination and planning capacity could be strengthened further. The results area identified under the Program and the corresponding DLIs do not cover any capital expenditure or major construction and/or actions that will have significant adverse impacts on the environment and/or on the community. All interventions will be carried out within the footprint of existing facilities.
20. **The key environmental risks of the Program center on the biomedical waste (BMW) generated, and wastewater at the health care facilities.** Improper treatment, handling and disposal which could result in risks to communities and healthcare workers. Increase in generation of e-waste, hazardous waste, plastic waste also induced impacts and require attention for proper recycling and disposal, so they are not burned or mixed with municipal solid waste streams. Other risks and impacts include (a) worker occupational health and safety and public safety while HWCs are being refurbished; (b) the building, fire and electric safety and (c) infection control and worker safety and health. There will be no additional health facilities that will be created, all interventions will be carried out within the existing facilities such as repair, refurbishment and minor modifications to improve the environment and service delivery capacity of the health centers. The impacts arising through the upgradation of HWCs (like dust and noise) would be temporary and easily mitigated using country systems for pollution management and community and worker safety, though the ESSA recommends more structured approach to trainings on occupational health and safety of labor. The preparation of various action plans, guidelines and implementation strategies is also an opportunity to include indicators/ elements of assessing and addressing environment health and safety risks and design monitoring indicators to strengthen mainstreaming in future programs.
21. **The key social risk of the program is associated with risk of exclusion in tribal and backward areas and for migrant and informal workers in urban areas.** These risks mainly emerge due to (a) poor uptake and utilization of health facilities by traditionally vulnerable groups in underserved areas and tribal blocks in the state; (b) poor utilization of health facilities by women-led households and adolescent girls for reproductive health care, NCD screening, and preventive care; and (c) lack of access to quality health care for the urban poor and marginalized, including migrants



and informal workers; and finally (d) the low capacity of community level platforms such as *Jan Arogya Samiti* (JAS) and *Mahila Arogya Samiti* (MAS) at HWC for optimal delivery of services especially in tribal and backward areas. While the program aims to fill these gaps, ESSA furthers recommends strengthening these measures by (i) developing and adopting strategy for equitable health services in tribal and backwards areas, and for urban poor and marginalized including migrants and informal workers; and (ii) measures towards strengthening accountability and transparency.

22. **Stakeholder Consultations and Disclosure.** Multiple rounds of consultations and meetings were held with program officials from HFWD and its various Directorates including NHM, and State Health Systems Resource Centre (SHSRC), and other stakeholder departments/ Institutions such as Women and Child Development Department (WCD), Tribal Development Department, and Gujarat Pollution Control Board (GPCB). A state level multi-stakeholder consultation was carried out based on the draft ESSA on June 23, 2022, in Gandhinagar Gujarat inviting key officials from HFWD and its Directorates, key officials from other departments such as PWD, WCD, Tribal Development, and GPCB; and Civil Society Organizations/ NGOs working in health sector, among others. Comments and suggestions received during multi-stakeholder consultation have been incorporated in the revised ESSA. The final ESSA will be publicly disclosed prior to completion of appraisal. The draft ESSA report will be disclosed by the World Bank and HFWD, Government of Gujarat for receiving feedback from public and a wide range of stakeholders. The Final ESSA report will be redisclosed on the World Bank’s external website and HFWD website prior to negotiation.

E. Financing

23. The Program financing is described in the table 2.

Table 2: Program Financing

Source	Amount (US\$, million)	Percent of Total
Counterpart funding	4,176.00	92
International Bank for Reconstruction and Development (IBRD)	350.00	8
Total Program Financing	4,526.00	100

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Implementing Agencies

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