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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 18-Feb-2021 | Report No: PIDA30132

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
India	P173589	Meghalaya Health Systems Strengthening Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	26-Mar-2021	15-Jul-2021	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of India	Department of Health and Family Welfare, Government of Meghalaya	

Proposed Development Objective(s)

The project development objective (PDO) is to improve management capacity, quality and utilization of health services in Meghalaya.

Components

Improving accountability, management and strengthening governance
Strengthening systems to improve the quality of health services
Increasing coverage and utilization of health services
Contingent Emergency Response Component

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	50.00
Total Financing	50.00
of which IBRD/IDA	40.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	40.00
Non-World Bank Group Financing	
Counterpart Funding	10.00
Borrower/Recipient	10.00

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **India's Gross Domestic Product (GDP) growth has slowed in the past three years, and the COVID-19 outbreak is expected to have a significant impact.** Growth has moderated from an average of 7.4 percent during FY15/16-FY18/19 to an estimated 4.2 percent in FY19/20. The growth deceleration was due mostly to unresolved domestic issues (impaired balance sheets in the banking and corporate sectors), which were compounded by stress in the non-banking segment of the financial sector, and a marked decline in consumption on the back of weak rural income growth. Against this backdrop, the outbreak of COVID-19 and the public health responses adopted to counter it have significantly altered the growth trajectory of the economy, which is now expected to contract sharply in FY20/21. On the fiscal side, the general government deficit is expected to widen significantly in FY20/21, owing to weak activity and revenues as well as higher spending needs.

2. **Although India has made remarkable progress in reducing absolute poverty, the COVID-19 outbreak has reversed the course of poverty reduction.** Between 2011-12 and 2017, India's poverty rate is estimated to have declined from 22.5 percent to values ranging from 8.1 to 11.3 percent. Recent projections of GDP per capita growth rate indicate that as result of the pandemic, poverty rates in 2020 have likely reverted to estimated levels in 2016. Data from the Centre for Monitoring Indian Economy (CMIE) shows urban households are facing greater vulnerabilities: between September-December 2019 and May-August 2020, the proportion of people working in urban and rural areas has fallen by 4.2 and 3.8 percentage points respectively. Approximately, 11 and 7 percent of urban and rural individuals, identifying themselves to be employed in the recent period, have performed zero hours of work in the past week. Overall, the pandemic is estimated to have raised urban poverty, creating a set of new poor that are likely to be engaged in non-farm sector and receive at least secondary or tertiary education, as compared to existing poorer households who are predominantly rural with lower levels of education.

3. **In the past decade, the health sector has witnessed major reforms especially in service delivery and financing.** The National Rural Health Mission (NHM) has increased the states' fiscal space for investments in health services and set up mechanisms for accountability between the center and states through annual project implementation plans and budgets. In 2008, Rashtriya Suraksha Bima Yojana (RSBY), a health insurance program for the poor, was launched, which in 2018 was expanded into *Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana* (AB-PMJAY), which aims at providing protection against hospitalization expenses for 40 percent of India's population. Additionally, the 14th Finance Commission recommendations increased the share of central tax devolution (from 32 percent to 42 percent) providing states with greater flexible funds to finance their priorities while 15th Finance Commission reduced the devolution from 42 percent to 41 percent. The recent Human Capital Index Report (2020) shows that in India, a child born today will be 49 percent as productive when she grows up as she could be if she enjoyed complete education and full health. Further it is imperative to note that India spends merely 1.28 percent of its GDP in public spending on health. This is lower than both the regional average (2.0%) and the average for its income group (2.8%).

4. **Meghalaya is part of the North East region, predominantly rural and with a distinct tribal identity**. Carved out of Assam in 1972, the state has a Legislative Assembly and three autonomous Hill Councils, covering 11 districts, 6 municipal councils, 22 towns and 6,459 villages. With a population of 3 million (Census 2011), the state is on an average poorer than rest of India, but more equitable, as only 12 percent of the population live below the National Poverty Line in comparison to 22 percent at the national level (2011-12).[1] The state is predominantly rural (80 percent), with a hilly terrain, rapidly urbanizing and with poor connectivity. Despite its matrilineal and matrilocal tribal identity, local indigenous political systems and complex governance processes often exclude women.[2] Further, while women's participation in the workforce is relatively high at 34 percent[3] compared to other Indian states, they are overrepresented in agriculture and allied activities.

5. **The state budget is dependent on Central transfers, with significant deficits limiting fiscal space for investment.** The Gross State Domestic Product (GSDP) has grown 10-11 percentage points annually over last four years. At the same time, the state government's total debt is 30 percent of GSDP constraining fiscal space. Therefore, the state is dependent on fiscal transfers from the Central government, as its own resources constitute only 20 percent of total revenue.[4] This has led to erratic growth in government health expenditures in the state along with lower capital expenditure in the sector.

Sectoral and Institutional Context

6. **Meghalaya faces continuing challenges in basic health and nutrition outcomes along with a growing burden of Non-communicable diseases (NCDs).** In 2019-20, the Infant Mortality Rate (IMR) of Meghalaya increased from 30 (in 2014-15) to 32 per 1,000 live births, the prevalence of stunting among under-five children increased from 43.8 percentage point (in 2015-16) to 46.5 percentage point. There are

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[1] In 2017-18, Meghalaya's per capita net domestic product at current prices was INR 81,098, 30 percent lower than the national figure of INR115,293. (Reserve Bank of India. 2019. Database on Indian Economy. March 3. https://dbie.rbi.org.in/DBIE/dbie.rbi?site=statistics)

[2] Oosterhoff P, Saprii L, Kharlyngdoh D, Albert S. When the Hen Crows: Obstacles that Prevent Indigenous Women from Influencing Health-care Policies–A Case Study of Shillong, Meghalaya, India: IDS, 2015.

[3] Periodic Labor Force Survey; 2014-2015

[4] CAG Audit Report, State Finances for the period ending March 2018, Report no. 1 of 2019

differences among districts with few performing better than others and rural-urban differences with latter performing better in majority of the health indicators. At the same time, it is estimated that in 2017, NCDs (including hypertension, diabetes, cardiac conditions and cancers) accounted for 55 percent of all deaths in Meghalaya, with another 7 percent due to injuries.[5]

7. **Significant gaps and inequalities persist in health service coverage.** In 2019-20, only 63.8 percent of children aged 12-23 months were fully immunized in the state (national average: 62 percent in 2015-16). Only 58.1 percent of births in Meghalaya were in a health facility (national average: 79 percent in 2015-16). These indicators are significantly lower in rural areas: the infant mortality rate (33.6% rural and 23.4% urban), ANC visits (50% rural and 68% urban), and institutional births (54% rural and 83% urban). Further, stunting, underweight and anemia levels are higher in rural areas as compared to urban areas in Meghalaya.[6]. At the referral level, only 60 percent of the 41 District Hospitals and Community Health Centers (CHCs) designated as First Referral Units (FRUs) are functional.

8. **The population is more dependent on government health services than elsewhere in India, although household out-of-pocket spending on health care is still a significant burden on the poor.** The state budget for health in FY19/20 was US$155 million (INR 1,142 crores), or 7.4 percent of total public expenditure, which is significantly higher than the national average of 3.9 percent. Per capita government expenditure on health in FY15/16 was US$34 (INR 2,223) in Meghalaya, less than half of other small states in the North East region but double the national average of US$17 (INR 1,112). In Meghalaya in 2017, the average out-of-pocket expenditure (OOPE) incurred by patients for a hospitalization was US$35 (INR 2,385) for treatment at a public hospital and US$408 (INR 27,375) at a private hospital.[7] Also, there exists rural-urban differences, with OOPE in rural areas at INR 3,190 and INR 3,353 in urban public health facilities.

9. **There are weaknesses in accountability, management and service delivery systems.** Meghalaya ranks third among eight smaller North-Eastern states as per the State Health index, which includes indicators of the quality of overall governance and management of the state's health system. Weak management capacity leading to a range of systemic gaps in service delivery, quality of services, and rational deployment and management of human resources. Key components of management and service delivery systems require significant investments and improvements.

    a. **Service quality.** Despite quality assurance teams being in place since 2010 under the National Quality Assurance Standards (NQAS) program, in 2019-20, only 2 of the 108 Primary Health Centers (PHCs), none of the 28 Community Health Centers (CHCs), and only 1 of the 13 Sub-District and District Hospitals (DH) were awarded this certificate.[8]

    b. **Human resources for health (HRH)**. The state is facing an acute shortage of medical specialists (including 42 percent vacancies in DHs) and graduate medical doctors. In addition, lack of

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[5] Indian Council of Medical Research, Public Health Foundation of India and Institute for Health Metrics and Evaluation. 2017. India: Health of the Nation's States – The India State-Level Disease Burden Initiative. http://www.healthdata.org/disease-burden-India

[6] National Family Health Survey (NFHS-5), 2019-20.

[7] International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. http://rchiips.org/NFHS/factsheet_NFHS-4.shtml; Government of India. 2019. Key Indicators of Social Consumption in India: Health – NSS 75th Round (July 2017-June 2018). Ministry of Statistics & Programme Implementation. National Statistical Office.

[8] Government of India. 2019a.

specialist hospital managers leads to current medical practitioners being pulled into administrative work. A 2014 World Bank study pointed out challenges related to staff motivation, absenteeism, poor working conditions, delays in salary payment, lack of appropriate incentives, monitoring, supervision and performance management, in post creation and staff allocation planning, and pay and promotion policies.[9] Absence of a robust health human resource policy and a management framework is affecting quality of care, especially during emergencies like the COVID-19 crisis that require optimum utilization of the available health workforce.

c. **Procurement and supply chain management.** The state is implementing several national schemes to improve access to medicines but is hampered by weak procurement and supply chain management. A 2014 World Bank assessment identified gaps and recommended policy changes and investments on the same. Procurement and distribution of medicines are done in a fragmented manner, responding to immediate needs but often not based on medium-term planning of district and facility-level requirements. Quality assurance and inventory management require improvements, while drug warehouses face problems of seepage and storage space.[10]

d. **Infection prevention and control, and biomedical waste management (BMWM).** The state is implementing BMWM, including waste segregation and management, vaccination of bio-medical waste handlers, and distribution of information, education and communication material. However, improvements are needed in several areas, including local waste disposal practices, treatment of effluent bio-medical waste from hospitals, the need for a common treatment facility, deep-burial pit design (non-compliant with standards), and overall management capacity for infection prevention and control.

10. **The Megha Health Insurance Scheme (MHIS) is designed to cover the full state population for inpatient services provided by government and private hospitals, in order to reduce the financial burden on households.** The scheme, however, has so far reached only 56 percent households in the state. The MHIS has merged with the national PM-JAY program, leading to a benefit package that is more comprehensive than the national scheme. In 2017-18, the MHIS reimbursed claims totaling US$4.2 million (INR 26.9 crore) for services delivered by the government system, and US$9.1 million (INR 58.7 crore) for private sector services. The payments made by the scheme for services provided by government hospitals are managed at the facility level. Primary challenges are related to poor coverage of households and under utilization of funds mobilized by government hospitals through medical claims reimbursement, resulting in missed opportunities for facility upgrades and improvement of services in hospitals. This is also indicative of weak management capacity at the facility level and poor oversight and monitoring capacity at the state level.

11. **The state is implementing COVID-19 preparedness and response measures.** Adequate health system capacity and functional health facilities are required for resilience to disease outbreaks.[11] The Government of India (GoI) has mounted a response to COVID-19 starting mid- January 2020 which continues to be adapted to the evolving situation. As of January 29, 2021, Meghalaya has 13,749 COVID-19 positive cases, with 146 COVID-related deaths reported (highest in East Khasi Hills followed by West

[9] World Bank. 2014. Rural Recruitment, Retention and Job Performance in Meghalaya: A Qualitative Study.
[10] World Bank. 2014. Supply Chain Management System Development Strategies and Plans: Meghalaya.
[11] Nuzzo. 2019. *What Makes Health Systems Resilient against Infectious Disease Outbreaks and Natural Hazards.*

Garo Hills).[12] The national COVID-19 program has provided funding of US$0.84 million (INR 59.4 million) to Meghalaya to support its preparedness and response in the areas of diagnostics, infection control, patient and health worker safety, contact tracing, quarantine, case management, and communication. The state formed a task force, developed a contact tracing system, established quarantine facilities, and supplemented health services with medical equipment and human resources. Like in other states in India, the pandemic and lockdown measures, in response, have had adverse effects on the delivery and utilization of essential health services. In comparison to the same period in 2019, in April–June 2020, coverage of antenatal care was 18 percentage point lower, and there were 10.63 percent fewer deliveries in government and private health facilities, and 41 percent fewer major surgeries. Child immunization coverage declined by 18 percentage point, and in-patient services reduced by 45 percentage point.

12. The proposed project aims to support the state address some of the key challenges outlined above and strengthen the management capacity of the public health system to deliver effective results. Such systemic gaps, despite being among the highest per capita government expenditure on health in the country, clearly point to inefficiencies in the health system that are constricting health outcomes. It will do so through a combination of Results-Based Financing (RBF) approach combined with input-based financing to meet infrastructure requirements, combined with strengthened performance management to address management constraints and capacities in delivering quality services. The proposed project will bring systemic improvements in the state health sector which by the mid-term will lead to positive outcomes including improved health service outcomes for beneficiaries.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

The project development objective (PDO) is to improve management capacity, quality and utilization of health services in Meghalaya.

Key Results

Following indicators will be used to measure the achievement of the PDO:

PDO level result indicators	Management capacity	Quality	Utilization
Percentage point increase in average performance score in targeted administrative units as per internal performance agreement from baseline.	✓		
Cumulative number of districts hospitals which are NQAS certified.		✓	
The percentage point increase in average quality index score for CHCs and PHC from baseline.		✓	
Increase in number of patients utilizing government health services OPD in targeted facilities.			✓
Percentage of claims settled within agreed turnaround time.			✓

[12] http://meghalayaonline.gov.in/covid/login.htm

D. Project Description

13. **The Meghalaya Health Systems Strengthening Project combines results-based financing (RBF) and input-based financing approaches to achieve enhanced performance management in the public sector.** The project is supported by an IBRD loan in the amount of US$40 million using an Investment Project Financing (IPF) instrument structured in four components. It uses a system's approach and is broken down into three individual parts which need to be appreciated as forming part of a whole system's approach complimenting each other – the first component is a performance-based financing approach, while the second and third components are designed for input-based financing and these three parts together work complementary and are critical for achieving the project objectives. In addition, strengthening the management and organization of the health insurance program is expected to boost health insurance utilization and a swifter reimbursement to providers. Component 1 will focus on reforms to increase accountability through Internal Performance Agreements, Component 2 will focus on system development and quality improvements, Component 3 will invest in the state insurance program and Health and Wellness Centers (HWC) to increase service utilization, and Component 4 will be utilized for an eligible crisis or emergency for provision of immediate and effective response.

14. **Component 1. Improving accountability, management and strengthening governance (US$ 18 million):** This component will focus on reforms in governance and management structures to increase accountability through IPA tool, i.e., provision of grants as performance incentives. The contracts will be signed between the DoHFW and its subsidiaries at the state and sub-state levels. Performance-based contracts and RBF are proven to have a positive impact on service delivery, and it has the potential to catalyze comprehensive reforms in addressing structural problems of health service delivery. Therefore, institutions and health facilities will be financed for results measured against agreed indicators. These will constitute IPAs between the DoHFW and implementing institutions that will foster a spirit of more accountable government, and results-based monitoring, leading to improvements in service delivery, quality and utilization. The arrangement shall be modelled around the principal-agent (which is the DoHFW) as there exists a complete convergence of objectives between participating entities. Good Governance will be built in the performance management system at all levels and will be accompanied by a publicly accessible dashboard with performance metrics and results. Internal verification mechanisms for results at health facility and district health team level will be strengthened by independent third-party counter-verification of said results.

15. **Component 2: Strengthening systems to improve the quality of health services (US$ 17 million):** The investment under this component will: (a) Development and implementation of a quality assurance program including training, certification and quality tracking tools, and investments in the functionality of health services infrastructure, for district hospitals, CHCs and PHCs; (b) Provision of support for infection prevention and control, environmental and energy efficiency measures, and management of resources and biomedical waste at the health facility level; (c) Development of tools and provision of technical assistance including training and outsourcing to improve: (i) human resources supply, planning and management, (ii) in-service capacity-building, and (iii) pre-service education; (d) Strengthening of DoHFW's procurement of medicines and consumables and supply chain management at state and sub-state levels; (e) Development of systems for, and provision of training and technical assistance to, the administrative structures responsible for health system management in planning, management and monitoring; and (f) Provision of support for the management of the Project, including on its technical, fiduciary, safeguards management, monitoring and evaluation aspects. Under this component, the

project will also support review of the HR policy to promote women professionals' entry, transition and career advancement across various job roles in the health sector. The component will also incentivize hiring of women professionals through preferential clauses in the PPP contracts. This component involves various information and communication technology (ICT) activities to improve the overall efficiency and will also pilot ICT solutions under innovations. These investments will improve the capacity of the state government health systems to better respond to the ongoing COVID-19 pandemic as well as increase preparedness for future outbreaks. The project will implement 'Low Dose High Frequency (LDHF) Training' approaches. These approaches will implement specific 'vignettes' or knowledge tests to promote evidence based medical practice targeting key conditions related to the burden of disease in Meghalaya.

16. **Component 3: Increasing coverage and utilization of quality health services (US$5million):** This component will mainly focus to trigger increased utilization. The component will invest in increasing the coverage of the state health insurance program, pilot for strengthening primary care response through the Health and Wellness Centers, strengthening community interventions and engagement. More specifically, the project will finance strengthening the health insurance scheme design through activities like comprehensive evaluation of process and service utilization, and review of benefit packages and pricing. The project will support the state in implementing the Ayushman Bharat strategy for strengthening Health and Wellness Centres, with capacity to provide an expanded package of services, including for primary screening, counselling and referral for NCDs. Community-driven interventions to demonstrate the integrated and multisectoral approach for women and child development is also planned for selected districts.

17. **Component 4: Contingent Emergency Response Component (cost US$0 million)**: Provision of immediate response to an Eligible Crisis or Emergency, as needed.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

The proposed project aims to improve the quality and utilization of health services across the State, including remote and hard to reach areas, in an inclusive manner. No potential large-scale, significant or irreversible environmental impacts are envisaged The funding under the project is geared towards strengthening health service delivery with quality and performance improvement with most activities being soft in nature such as provision of technical assistance towards human resource management, supply chain management, training, outreach activities, referral services, health related behavior change communication and program management support, regulation of biomedical waste, monitoring of health services, population coverage of the MHIS, utilization by health services, and limited support to minor civil work towards infrastructure improvement. The relevant Environmental and Social Standards (ESS) for this project are ESS1, ESS2, ESS3, ESS4, ESS7, ESS8 and ESS10.

Meghalaya is a Schedule-VI state under the constitution of India and more than 86 percent of the population is scheduled tribe with three main ethnic communities. Given the difficult geographic terrain and some areas being hard to reach, there is a potential risk of unequal access to health services in those areas. Thus, the major social risks of the project are the risk of exclusion and access to services.

The project does entail a range of minor civil works for infrastructure repair and rehabilitation within the existing footprint of the facilities. The risks and impacts associated with these activities (such as noise and dust pollution, waste management, community safety, risk of sexual exploitation and abuse (SEA) and sexual harassment (SH) will be low, localized and short-term which may be mitigated with the strengthened capacity of the implementing agencies. No land acquisition or involuntary resettlement is expected under the project. Labor influx is not expected and required labor will be available locally. Therefore, project's SEA/SH risk has been rated as low.

However, given that the State has prioritized women in their programs and schemes, and gender based violence is one of the important areas that the state plans to address, the health professionals and health systems play an important role in caring for survivors of sexual violence, to the project will build capacity of health care professionals by sensitizing them toSEA and SH issues and measures as part of their training, and address mandatory provisions of The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 in DOHFW and in project facilities.

The project will support improvements in infection prevention. With the improved utilization of health services through the project, the quantity of bio-medical waste is expected to increase. However, the level of increase is not expected to be significant as it will be gradual over project period and can easily be managed by the health facilities with improvements being instituted through the project and reflected in the ESMF. Development and implementation of a plan for improving management and disposal of biomedical waste (BMW) generated by both government and private health facilities, in collaboration with the State Pollution Control Board and municipalities will be supported. This will help improve the overall ecosystem for BMW management that includes segregation, disinfection, collection and disposable that largely safeguards the environment and contributes in improving the quality of health service and patient safety. The ESMF provides the key mitigation measures with respect to BMWM, and other waste management including plastic, electronic waste, and chemical waste from laboratory. Waste Characterization study within first six months of project effectiveness will be undertaken to further inform the subject.

Further, to ensure gradual phasing of mercury-based medical equipment, the procurement and supply chain management of State will be strengthened. The project will also support interventions to make select health facilities environmental-friendly and energy efficient, like installation of solar power, water conservation measures through rainwater harvesting, etc.

DoHFW has prepared an ESMF and Stakeholder Engagement Plan (SEP? that will guide the project to address the adverse environmental and social risks and impacts. The ESMF includes screening checklist and guidelines for screening individual healthcare facilities (HCF) for environmental and social risks, as well as negative list of investments. E&S screening results will help in developing HCF specific ESIAs and ESMPs, as required, during the implementation of the project. ESMF further includes due diligence procedures and processes, mitigation actions with responsible agencies against each action and provides procedures relevant to the development of the subprojects, a generic Environmental and Social Management Plan (ESMP), and further guidance for developing the Bio-Medical Waste Management Plan (BMWMP) in accordance with the World Bank's Environmental and Social Framework (ESF).

The ESMF mandates that screening will be conducted for each of the subprojects to avoid any adverse environmental and social impacts including potential impacts on informal/ illegal settlers residing within the health facility premises/ land (if any). Concerns and needs of the vulnerable groups (including issue of access and risk of exclusion, occupational health and safety, and stakeholder engagement and grievance redressal etc.) will be addressed through following interventions: (a) HCFs in backward and remote districts and blocks to be undertaken for internal performance management (IPM) activities to improve access to performance link quality health care in those areas; (b) strengthening and devising exclusive awareness campaigns to educate and sensitize the poor and vulnerable on health seeking behavior through social and behavior change communication (SBCC); (c) instituting measures for occupational health and safety in line with World Bank EHS guideline and Government of India norms; (d) strengthening the grievance redress mechanism; (e) All healthcare facilities to be compliant with universal access provisions through retrofitting; and (f) health care providers to be sensitized for services to poor and vulnerable and mechanism for provision of health services in an inclusive manner that addresses the differential needs of the vulnerable population.

The medical waste generated due to COVID-19 testing, treatment, and any fatalities will be managed as per the WHO and Government of India protocols. The project also plans to support improvements in infection prevention at the health facility level, along with necessary supplies, PPEs, equipment and training. Given the planned provision of healthcare services, the communities may be exposed to health and safety hazards if these wastes are not properly managed and treated. The ESMF identifies the potential OHS risks associated with healthcare facilities and provides mitigation measures to address them. It also provides for measures related to COVID-19 situation for all staff directly and indirectly involved with health care facilities as well as workers involved in civil works. During the COVID-19 pandemic the Department has also been providing training programs for management of COVID-19 associated BMW and additional provision of PPEs to HCFs to safeguard from infections in COVID-19 designated HCFs. The ESMF includes the required mitigation measures to ensure health and safety of the workers, including OHS measures.

As recommended in the ESMF, the project will provide a range of training and capacity building support on managing environmental and social risks associated with the project. Training and capacity building will target the DoHFW/PMU, HCF staff, waste management workers and cleaners, as well as third-party waste management service providers (if any), including those involved in transporting the biomedical wastes.

Consultations with key stakeholders, including vulnerable and disadvantaged communities, were carried out to identify their concerns and requirements to inform project design and ESMF. The SEP further provides mechanisms to engage them during the project implementation in a continued manner. However, given the COVID19 situation, these were done largely in a virtual manner following the relevant interim technical note on public consultation prepared by the World Bank. During the project implementation, further consultation with community will be carried out and detailed out in the SEP.

Component 4 of the project is a Contingent Emergency Response Component (CERC). The project ESMF will be updated as soon as the scope in the event the contingency component becomes better defined and if CERC is activated during project implementation.

An Environment and Social Commitment Plan (ESCP) has been prepared by the client to ensure the successful implementation of mitigation measures and capacity enhancement of the implementing agency. The ESCP includes timeline for preparing required documents such as site-specific ESIAs and ESMPs, Medical Waste Management Plan (MWMP), Labor Management Procedures (LMP), Project Grievance Redress Mechanism (GRM) etc. The ESCP specifies various actions to be carried out during implementation. Due diligence will be completed during preparation to assess all potential impacts and risks through consultations with stakeholders and appropriate assessments. Relevant training

and capacity strengthening initiatives that have been identified have been included in the Environmental and Social Commitment Plan (ESCP).

E. Implementation

Institutional and Implementation Arrangements

18. **The DoHFW will be responsible for the implementation of the project.** The DoHFW governance and management structures and its directorates will be used for project implementation. A Project Steering Committee (PSC) under the Chairmanship of the Chief Secretary will provide an oversight to the project. The Committee will also include Principal Secretary, Health and Family Welfare, and Secretaries of other relevant departments. The Committee will oversee project implementation and results, be responsible for approving and monitoring the annual project plans and budgets and for approving amendments to the Project Operations Manual. The Commissioner and Secretary, Health and Family Welfare, will lead the Project Executive Committee (PEC) to provide regular monitoring and necessary approvals for the day-to-day implementation of project activities. Given the results-based focus of the project, which requires coordinated action by directorates within the DoHFW, the designation of the Commissioner and Secretary, DoHFW, the senior-most official within the department is critical for effective implementation.

19. **The Mission Director, National Health Mission (NHM) will be the Project Director and will lead the Project Management Unit (PMU).** The PMU will be responsible for the project implementation, including its regular monitoring and supervision with staff deputed from all three directorates. Approximately 10 staff and consultants will be included in the PMU and will be responsible for procurement and financial management, social and environmental safeguards, as well as technical areas including community mobilization, quality assurance, monitoring, information, education and communication, human resource development, capacity building and civil engineering. A Technical Assistance Provider will be contracted to augment the PMU's capacity in administrative and technical areas including procurement, financial management, hospital quality improvement, management of information systems and other technical areas. Technical and knowledge partnerships as well as multi-stakeholder engagements will be established to augment technical capacity of the department and support Village Health Sanitation and Nutrition Committees (VHSNC), including women's groups.

20. Additionally, the state and PMU will be supported with adequate capacity building efforts especially in the areas of fiduciary, procurement, environment and safeguards.

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APPROVAL

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Approved By

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