



Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 17-Jun-2020 | Report No: PIDC29378



BASIC INFORMATION

A. Basic Project Data

| | | | |
|--|--|--|--|
| Country India | Project ID P173958 | Parent Project ID (if any) | Project Name Mizoram Health Systems Strengthening Project (P173958) |
| Region SOUTH ASIA | Estimated Appraisal Date Sep 07, 2020 | Estimated Board Date Jan 29, 2021 | Practice Area (Lead) Health, Nutrition & Population |
| Financing Instrument Investment Project Financing | Borrower(s) Sameer Kumar Khare | Implementing Agency Shri H. Lalengmawia | |

Proposed Development Objective(s)

Project Development Objective (PDO) is to improve utilization and quality of health services in Mizoram.

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

| | |
|---------------------------|-------|
| Total Project Cost | 32.00 |
| Total Financing | 32.00 |
| of which IBRD/IDA | 32.00 |
| Financing Gap | 0.00 |

DETAILS

World Bank Group Financing

| | |
|--|-------|
| International Bank for Reconstruction and Development (IBRD) | 32.00 |
|--|-------|

Environmental and Social Risk Classification
Moderate

Concept Review Decision
Track II-The review did authorize the preparation to continue



Other Decision (as needed)

B. Introduction and 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 in FY20/21. On the fiscal side, the general government deficit is expected to widen significantly to over 10 percent of GDP in FY20/21, owing to weak activity and revenues as well as higher spending needs. However, the current account balance is expected to improve in FY20/21, reflecting mostly a sizeable contraction in imports and a large decline in oil prices. Given this, India's foreign exchange reserves are expected to remain comfortable (equivalent to over 10 months of imports).

2. Since the 2000s, India has made remarkable progress in reducing absolute poverty. Between FY11/12 and 2015, poverty declined from 21.6 percent to an estimated 13.4 percent at the international poverty line (US\$1.90 per person per day in 2011 Purchasing Power Parity (PPP), continuing the earlier trend of rapid poverty reduction. Owing to robust economic growth, more than 90 million people escaped extreme poverty and improved their living standards during this period. Despite this success, poverty remains widespread. In 2015, 176 million Indians were living in extreme poverty, while 659 million—half the population—were below the higher poverty line commonly used for lower middle-income countries (US\$3.20 per person per day in 2011PPP). The covid-19 outbreak is likely to further moderate the rate of poverty reduction and risks people falling back into poverty. The slowdown in domestic consumption due to the necessary public health measures will adversely impact labor-intensive sectors, such as construction, retail trade, transportation, which provide livelihood opportunities for people with lower daily earnings and fewer years of schooling. The lowered demand is likely to reduce farmgate prices of agricultural commodities, increasing vulnerability for small farmers in the rural sector. Poorest households are also more vulnerable to the threat of contagion, as they are more likely to live and work in conditions where social distancing is difficult and are likely to spend a greater share of their budget on out-of-pocket healthcare expenditures if they fall sick. Government schemes to increase food allocations under the public distribution system and income support through direct transfers, social pensions and rural workfare programs are likely to contain these impacts to an extent.

3. India has also seen significant improvements in the health sector over the past decade. Infant, under-five, and maternal mortality rates have declined, and progress has been made in controlling communicable diseases, but the burden of non-communicable diseases (NCDs) is growing. While government spending on health has remained around one percent of GDP, rapid growth in GDP has increased resources available for investment in health services by the national and state governments, notably through the National Health Mission (NHM). A national scheme, Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna (AB-PMJAY) covers inpatient hospital care for the poor and supports investments in a network of health and wellness centers to deliver comprehensive primary health care services, including for NCDs, under the NHM.



4. Mizoram is part of the North East region, geographically isolated with a distinct identity. In contrast with other North Eastern states, in Mizoram, people identify with a common language (Mizo) rather than with tribal groupings. This landlocked state has 3 autonomous Hill Councils covering all 8 Districts and 23 Blocks. The state has a population of 1.09 million with more than 90 percent literacy and around 95 percent belonging to the category of scheduled tribes.¹ Nearly 40 percent of the state population lives in the capital city Aizawl. As per the 2011 census, 48 percent of the population lives in rural areas.

Sectoral and Institutional Context

5. Key health indicators in Mizoram are comparable to or better than national averages. In 2014-15, the total fertility rate (TFR) of 2.3 in Mizoram was similar to the rate of 2.2 nationally; under-five mortality in Mizoram was 46 per 1,000 live births, compared to 50 nationally; and the prevalence of stunting among under-five children was 28.1 percent, compared to the national figure of 38.4 percent. At the same time, there are significant rural-urban disparities in Mizoram: under-five mortality in rural areas was 58 per 1,000, compared to 35 in rural areas; and prevalence of child stunting was 33.7 percent in rural areas, compared to 22.7 percent in urban areas. While coverage of maternal health care services in Mizoram is comparable to or better than national averages, child immunization coverage is significantly lower. The maternal health care coverage in rural areas of Mizoram is lower than in urban areas, child immunization coverage levels are similar. In rural areas, 61.4 percent of births were in health facilities, compared to 97.2 percent in urban areas; while full immunization coverage was 51.6 percent among rural children and 49.8 percent among urban children.²

6. An outbreak of the novel COVID-19 has been spreading rapidly across the world since December 2019. As of May 20, 2020, there were no COVID-19 cases diagnosed in Mizoram. The national program has provided funding of US\$0.51 million (INR 3.71 crores) to Mizoram to support its preparedness and response. In response, the State have developed the quarantine facility, mobilized the local resources with the help of other non-health departments for contact tracing, equipped the existing health facilities with HR and medical equipment for treatment (if any) and formed state level task force for close monitoring of reported cases if any and for preparedness as per central government policy for lockdown.

7. The burden of communicable diseases persists along-side the threat of resurgent infectious diseases. The state has the highest estimated HIV prevalence (2.04 percent among adults) and among the highest cancer incidence in the country,^{3,4} with age-adjusted rates of 175 and 136 per 100,000 population for male and female, respectively. The district of Aizawl has the highest cancer burden in anywhere in India with 270 and 207 for 100,00 male and female, respectively.^{5,6} According to the India State-level Disease Burden Initiative, Malaria, Lower respiratory tract infection and COPD are the top three causes of years of life lost in both male and female, the top two causes of deaths among the age groups 0-14 years (accounting for 12 per cent of total deaths) includes diarrhea, lower respiratory infections (36 per cent), neonatal disorders (34 per cent). In the age group, 15-39 (13.7 per cent of total deaths) includes

¹ Census 2011

² 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

³ Government of India. 2017. India HIV Estimations 2017: Technical Report. National AIDS Control Organization and Indian Council for Medical Research – National Institute of Medical Statistics, Ministry of Health and Family Welfare. http://naco.gov.in/sites/default/files/HIV%20Estimations%202017%20Report_1.pdf

⁴ Government of India. 2017. A Report on Cancer Burden in North Eastern States of India, 2017. National Centre for Disease Informatics and Research and Indian Council of Medical Research. http://www.ncdirindia.org/NE_report.aspx

⁵ HIV Estimation report – 2017, National AIDS Control Organization, Government of India

⁶ Three-year report of population-based cancer registry 2012-14, Indian council of medical research.

http://ncdirindia.org/NCRP/ALL_NCRP_REPORTS/PBCR_REPORT_2012_2014/ALL_CONTENT/PDF_Printed_Version/Chapter1_Printed.pdf



diarrhea, lower respiratory infections (13.8 per cent) and HIV/AIDS and TB (13.8 per cent).⁷ Although anemia levels in the state are not very high (22.5 per cent in women; 17.7 per cent in children below 5 years; 10 per cent in men), 21 per cent of men and women in the state belong to overweight or obese category which is higher than the national average.. Overall, NCDs are responsible for more than 50 per cent of the disease burden in the state.⁸ It is pertinent to note that NSSO 75 indicates 3.4% people responding as ailing, highest among all the North Eastern states.

8. In 2015-16, annual government expenditure on health per capita in Mizoram was US\$90 (INR 5,862) highest among the North Eastern states. The same was true for annual state government health spending (US\$99 million, INR 645 crores) as a share of total state expenditures (8.34 percent) and of the gross state domestic product (4.2 percent).¹⁰ Further, presence of two directorates within the state health department has increased overhead costs and made the whole system less agile. As per the NSSO 75, out of pocket expenditure per episode of hospitalization including, medicines and diagnostics related expenses vary between 75 percent and 67 percent respectively in urban and rural public health institutions in the state, with average out of pocket medical expenditure per hospitalization nearly INR 6415 in the public hospitals which is way more than national average Rs 4,452. In 2017-18, Mizoram ranked first among eight smaller states on this index, with a score (73.70), significantly higher than the second-ranked state (Manipur, with 60.60).⁹ The government health system is composed of 9 District Hospitals, 5 Sub-District Hospitals, 9 Community Health Centres, 58 functional Primary Health Centres, 372 Sub-Centres and 171 Clinics. Spatial distribution of health facilities is not always aligned with population requirements. NCD care is limited at the primary health service delivery level and community level. NCD services and palliative care at hospitals are also severely constrained. Penetration of the emergency transport system is low at 0.17 ambulances per 100,000 population. Management of the system faces significant challenges, including duplication and coordination gaps, along with fragmented information systems. For example, the state has invested in a robust electronic human resource management information system, but it is not linked to the financial management system. There are concerns about the reliability of the health management information system (HMIS) as well.

9. The Mizoram State Health Care Scheme (MSHCS) started in 2008 as a health reimbursement scheme providing cover of pre-identified critical care treatments. The scheme has an annual enrolment amount of Rs. 1000 per family that needs to be paid directly by the enrolled beneficiaries. In 2018, with the launch of Government of India's Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), the state has two parallel schemes with some fundamental design differences. There is a need for immediate technical support on integration of the two schemes to the extent possible to reduce the administrative burden of the state, to increase coverage, avoid demand-level confusions on account of multiple schemes, and to strengthen the program, improving its scope, coverage, management and efficiency.

10. In 2017, there were 437 doctors in government service in the state. Among these, there were only 59 generalists and no specialists working in Community Health Centres (CHC), hampering referral care in rural areas.¹⁰ In 2017-18, while 16 percent of specialist positions at District Hospitals (DH), and 20 percent of auxiliary nurse-midwife positions

⁷ The burden of Disease initiative report: Mizoram http://www.healthdata.org/sites/default/files/files/Mizoram_-_Disease_Burden_Profile%5B1%5D.pdf

¹⁰ [health expenditure-http://www.cbhidghs.nic.in/WriteReadData/1892s/Chapter%204.pdf](http://www.cbhidghs.nic.in/WriteReadData/1892s/Chapter%204.pdf)

⁸ 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. Mizoram: Disease Burden Profile, 1990 to 2016. http://www.healthdata.org/sites/default/files/files/Mizoram_-_Disease_Burden_Profile%5B1%5D.pdf

¹⁰ Government of India. 2019a. National Health Profile 2019, 14th Issue. Central Bureau of Health Intelligence, Ministry of Health and Family Welfare. <https://www.cbhidghs.nic.in/index1.php?lang=1&level=1&sublinkid=75&lid=1135>

⁹ Government of India. 2019b. Healthy States Progressive India: Report on the Ranks of States and Union Territories, Health Index June 2019. NITI Aayog. <http://social.niti.gov.in/>

¹⁰ Government of India. 2019a.



in Sub-Centres were vacant, only 2 percent of Medical Officer positions in Primary Health Centres (PHC) and only 7 percent of staff nurse positions in Primary Health Centres and Community Health Centres were unfilled. The average tenure of three key state-level administrative positions was only 14 months, while that of District Chief Medical Officers was about two years.¹¹

11. The state initiated the Quality Assurance Program in 2015. Two hospitals received National Quality Assurance Standards (NQAS) Certification in 2017, while others are under the process. The state has successfully implemented a national health care hygiene program (*Kayakalp*), receiving awards and incentives for maintaining cleanliness in public health facilities. Eight out of nine district hospitals; five out of 11 SDH/CHC (46%); 48 out of 57 PHCs (85 per cent) and five out of eight UPHC (63 per cent) have received incentive grant amount under Kayakalp Award. Currently all the human resource and district level trainings are focused on Kayakalp. This has also resulted in a net increment in performance against the quality indicator “Proportion of District Hospital / Sub Divisional Hospital with Quality Accreditation Certificates” in the NITI Aayog Health Index for the year 2017-18. The state has appointed the Mizoram Pollution Control Board for enforcing the Bio-Medical Waste (Management and Handling) Rules (1998) in the state since 2002. There is wide variation between facilities in the amount of waste generated but the waste collection system is not volume-based. The state is not equipped with a common bio-medical waste treatment facility while existing incinerators are reportedly non-functional. The design of deep-burial pits for medical waste in facilities does not follow guidelines. Overall, there is a need for systemic improvement in bio-medical waste management in the state.

12. Inadequate supply of medicines to government health services is a major factor in discouraging quality and utilization. The state is implementing several national schemes to improve access to medicines, although the branded generic medicines and the low-cost Amrit pharmacy programs are yet to start in the state. The medicines initiative is hampered by a lack of timely consumption data to inform planning, leading to inadequate and inappropriate supply. Weak procurement and supply chain management systems, along with poor intra-departmental coordination, lead to purchasing of high-cost medicines. Vaccine supply chain, inventory management, and real-time stock monitoring are some of the other major challenges. Although the state is known for strong community linkages, current support is limited to activities prescribed by national programs, such as community-level meetings, and is insufficient for other initiatives. The state is implementing the National Program for the Healthcare of the Elderly (NPHCE), providing dedicated services through the health service delivery network. Building on experience with community mobilization in other parts of India and the North East, harnessing the potential for community participation could improve care for the elderly, cancer patients, and those requiring palliative care.

13. In last few years, the state have initiated capacity building programs to introduce Task-shifting among paramedical staff to address maternal and child health services, the medical college has been started to fill specialists gap in health, piloted service delivery models for covering remote & hard to reach areas and significantly expanded the health insurance programs to reduce out-of-pocket expenditures. However, the State is unable to achieve incremental progress in health outcomes, which is mainly due to weak organizational performance and financing gap (i.e. efficiency in resource utilization and upgradation of infrastructure to meet increasing demand for services). This in turn is due to the poor institutional and governance systems at the Directorate along with inadequate finances and poor management capacity.

¹¹ Government of India. 2019b.



Relationship to CPF

14. The project will contribute to the India Country Partnership Framework (CPF) FY18–22 (Report No. 1266667-IN, July 25, 2018, discussed at the Board on September 20, 2018). By supporting improvements in public health service delivery, this project is directly aligned to the CPF focus area of “Investing in human capital.” More specifically, it directly contributes to the CPF’s key objective 3.4 which is “to improve the quality of health service delivery and financing and access to quality health care.” In doing so, it primarily adopts two of the four catalytic approaches identified as being integral to the implementation of the CPF: (a) engaging a federal India and (b) strengthening public health institutions.

C. Proposed Development Objective(s)

Project Development Objective (PDO) is to improve utilization and quality of health services in Mizoram.

Key Results (From PCN)

- a. Enhanced package of services under health insurance program, increase in volume of claims and timely payment to empaneled hospitals (Utilization).
- b. Increase in number of outpatients utilizing government health services at the primary level, disaggregated by gender (Utilization)
- c. Reduction in stockout of essential medicines and improve efficiency in procurement systems (quality)
- d. Increase in number of public (primary and secondary care) facilities with quality certification (quality)

D. Concept Description

15. The proposed project will support the state in meeting the above-described challenges through two components mentioned below. The overall objective of the project is to improve utilization and quality of health services that will be achieved by improving the governance and management capacity at the State level that will enable timely support to health facilities (improved management and monitoring system) and the direct investment at the health facility level will enhance the utilization and quality of health service through supply and demand side interventions.

Component 1. Improving Governance, Management and Financing Systems

16. This component will focus on improvements in the state health system’s governance, management and financing, which will in turn contribute to delivery, quality and utilization of health services by the population. In doing so, the project will help fill any gaps in the state-level response to the COVID-19 pandemic, building capacity to respond to future or similar kind of pandemic and any subsequent health crises. The project will strengthen the administrative structures responsible for management of the state health system at the state and district levels, including management and financing of health programs. The project will integrate existing information systems and development of applications to improve oversight and management of the health system along with a spectrum of dashboards covering clinical, hospital, patients records, and quality and risk management. This component may also explore the feasibility of setting up of a financial management information system linked with the HMIS to provide an integrated overview of financial outlays and service delivery results. The project will support development of a strategy for health human resources through improvements in pre- and in-service



training, including revamping training institutions, implementing strategies to address human resource shortages, including specialists and building the capacity of the Department of Health for data-based management of human resources.

17. The project will support strengthening of the Department of Health's procurement and supply chain management systems in order to improve quantities, composition and timeliness of the supply of medicines and consumables, strengthening infrastructure and management of warehouses, developing a system of periodic review of procurement and supply chain management and applying information systems and technology. The project will develop a strategy for improving management and disposal of biomedical waste generated by both government and private health services, in collaboration with the state Pollution Control Board and municipalities. The project will support the Mizoram State Health Care Scheme in improving its implementation and management, thereby contributing to reducing financial barriers for access to hospital services and preventing impoverishing health care spending by households. The project will support strengthening of systems for beneficiary identification, pre-authorization and claims management, financial management, fraud risk mitigation, and grievance redressal. The project will also support development and implementation of communication and demand-side interventions to improve utilization of benefits by the poor.

Component 2: Improve health service utilization and quality at primary and secondary level health facilities

18. This component will directly invest in improvements in service delivery utilization and quality at the health facility and demand side intervention at community levels. The project will support improvements in clinical and non-clinical services and availability of medicines and diagnostics. At the referral level, it will support strengthening of neonatal and pediatric intensive care units. Capital investments will improve infrastructure and fill key equipment gaps, and include retrofitting to ensure water supply, sanitation and electrical power. The project will support improvements in referral linkages, including through local-level solutions to improve patient transportation. The project will also encourage quality improvement initiatives, including knowledge exchange with other states in India on technical areas, and a bottom-up approach for quality improvement, aiming for Quality Certification of health services at all levels. The proposed project will also support a results-based financing initiative with the aim of improving service provision and quality in selected health facilities.

19. The project will support innovative approaches for the rollout of Health and Wellness Centers through adaptation to local needs (service package redesign and customized approaches to service delivery). The project will invest in information technology and other local innovations to improve access to services as well as service provision and quality. Community engagement, particularly involving women representatives at the local level, will include the areas of planning, decision-making, and monitoring. The burden of NCDs, especially cancer, is an area of concern, along with the overall needs of an increasing elderly population. Given the difficult terrain, dispersed population, and poor access to transport, innovative solutions are required to address these issues through community led interventions. The state through the project will also explore formulating a policy for palliative care and design pilot programs for scaling up based on results. The interventions will be designed to support behaviour and life-style changes (prevention), community mobilization for health promotion and early detection (case management) and involve of non-governmental organizations and faith-based for health services delivery.



| Legal Operational Policies | Triggered? |
|---|------------|
| Projects on International Waterways OP 7.50 | No |
| Projects in Disputed Areas OP 7.60 | No |

Summary of Screening of Environmental and Social Risks and Impacts

20. The proposed project does not envisage potential large-scale, significant or irreversible environmental and social impacts. Civil works for infrastructure repair and rehabilitation will be minor as the project will not finance construction of large hospitals or healthcare facilities. The project will invest to improve the overall ecosystem for bio-medical waste management that includes segregation, disinfection, collection and disposal that largely safeguards the environment. The major social risks of the project are the risk of exclusion and access to services to people living in remote and hard-to-reach areas. No land acquisition or involuntary resettlement is expected under the project, as the civil works is expected to be within the existing footprint of the facilities.

21. The DoHFW, the main implementing agency has not directly implemented any World Bank financed project before. However, it has been involved in implementing some of the national program supported by the World Bank. The department does not have any designated Environment & Safeguards staffs. Thus, there will be needs for training and continued capacity building assistance on ESF. Since the specific sites/health facilities where construction will take place will not be known by project appraisal stage, an Environment and Social Management Framework (ESMF) will be prepared and disclosed prior to appraisal. During the implementation, Medical Waste Management Plan (MWMP) will be prepared as required, prior to the commencement of the specific work in accordance with the ESMF.

22. The stakeholders of the project will encompass a broad range of actors: besides the implementing agencies, they will include representatives of ethnic groups, local government stakeholders (e.g. panchayat members), civil society, NGOs, media, local/neighborhood associations/clubs, youth groups/associations, medical doctors, association, private health institutions, pharmacists association, etc. Stakeholder engagement, consultation and communication, including grievance redress and disclosure of information will be required throughout the project life. It is expected that the project activities will benefit the local population with improved health care delivery system, and it is not expected that any of the activities related to the project will have any direct or indirect negative impacts on the tribal communities. An IPPF will be prepared to assess the risks and potential impacts and recommend mitigation measures to ensure activities financed by the project will respect the dignity, aspirations, identity, culture and livelihoods of the ST population.

23. Given the COVID19 situation and related travel restrictions, most of the consultations during preparation will be conducted 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 in local languages i.e. Khasi, and with rest of the stakeholders in English as that being official language in Meghalaya.



CONTACT POINT

World Bank

Amith Nagaraj Bathula
Senior Operations Officer

Borrower/Client/Recipient

Sameer Kumar Khare

Implementing Agencies

Shri H. Lalengmawia
Lalengmawia H
Secretary (H&FW)
comsecymiz@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>

APPROVAL

| | |
|----------------------|-----------------------|
| Task Team Leader(s): | Amith Nagaraj Bathula |
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Approved By

| | | |
|---|------------------|-------------|
| Environmental and Social Standards Advisor: | Shafali Rajora | 03-Jun-2020 |
| Practice Manager/Manager: | Trina S. Haque | 03-Jun-2020 |
| Country Director: | Jorge A. Coarasa | 17-Jun-2020 |



The World Bank

Mizoram Health Systems Strengthening Project (P173958)
