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Report No: PAD4161

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$32 MILLION

TO

INDIA

FOR A

MIZORAM HEALTH SYSTEMS STRENGTHENING PROJECT

March 09, 2021

Health, Nutrition, and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 28, 2021)

Currency Unit =	Indian Rupees (INR)
INR 73.91 =	US$1

FISCAL YEAR
April 1 – March 31

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ABBREVIATIONS AND ACRONYMS

AB-PMJAY	*Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna*
ADB	Asian Development Bank
AMC	Aizawl Municipal Council
APL	Above the Poverty Line
BMWM	Biomedical Waste Management
BPL	Below the Poverty Line
CAG	Comptroller and Auditor General
CBO	Community-based Organization
CERC	Contingent Emergency Response Component
CHC	Community Health Center
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
CTF	Common Treatment Facility
DALY	Disability-adjusted Life Year
DC	Direct Contracting
DHME	Directorate of Hospital and Medical Education
DHS	Directorate of Health Services
DMPH	Directorate of Medical and Public Health
DoHFW	Department of Health and Family Welfare
DPO	Development Policy Operation
E&S	Environmental and Social
ESMF	Environmental and Social Management Framework
ESS	Environmental and Social Standards
F&AO	Finance and Accounts Officer
FM	Financial Management
GDP	Gross Domestic Product
GoI	Government of India
GRM	Grievance Redress Mechanism
GSDP	Gross State Domestic Product
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
HRD	Human Resource Development
HRH	Human Resources for Health

HWC	Health and Wellness Center
ICT	Information and Communication Technology
IEC	Information, Education, and Communication
IFR	Interim Financial Report
IMF	International Monetary Fund
IPA	Internal Performance Agreement
IPF	Investment Project Financing
IT	Information Technology
JDA	Joint Director of Accounts
JICA	Japanese International Cooperation Agency
LDHF	Low-dose High-frequency
LTRO	Long-term Repo Operation
MFE	Micro-food Enterprise
MIS	Management Information System
MoHFW	Ministry of Health and Family Welfare
MPCB	Mizoram Pollution Control Board
MSHCS	Mizoram State Health Care Scheme
MSMEs	Micro, Small, and Medium Enterprises
NCD	Noncommunicable Disease
NGO	Nongovernmental Organization
NHM	National Health Mission
NITI	National Institutions for Transforming India
NQAS	National Quality Assurance Standards
OOPE	Out-of-Pocket Expenditure
PBF	Performance-based Financing
PDO	Project Development Objective
PHC	Primary Health Center
PIU	Project Implementation Unit
PMA	Performance-based Management Agreement
PMU	Project Management Unit
PPP	Purchasing Power Parity
PSC	Project Steering Committee
QA	Quality Assurance
RBF	Results-based Financing
SBCC	Social and Behavior Change Communication
SDH	Subdivisional Hospital

SEA	Sexual Exploitation and Abuse
SEP	Stakeholder Engagement Plan
SHG	Self-Help Group
SORT	Systematic Operations Risk-rating Tool
TA	Technical Assistance
UN	United Nations
VHND	Village Health and Nutrition Day
VHSNC	Village Health, Sanitation, and Nutrition Committee
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
India	Mizoram Health Systems Strengthening Project	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P173958	Investment Project Financing	Moderate

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
31-Mar-2021	31-Mar-2026

Bank/IFC Collaboration

No

Proposed Development Objective(s)

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

Components

Component Name	Cost (US$, millions)
Component 1. Strengthen management and accountability through Internal Performance Agreements (IPAs)	13.50
Component 2: Improve design and management of state health insurance programs.	2.50
Component 3: Enhance quality of health services and support innovations.	15.92
Component 4: Contingent Emergency Response Component.	0.00

Organizations

Borrower:	India (Department of Economic Affairs, Government of India)
Implementing Agency:	Health and Family Welfare Department, Government of Mizoram

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	40.00
Total Financing	40.00
of which IBRD/IDA	32.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	32.00

Non-World Bank Group Financing

Counterpart Funding	8.00
Borrower/Recipient	8.00

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2021	2022	2023	2024	2025	2026	2027

Annual	0.00	1.41	2.23	5.50	6.35	7.94	8.57
Cumulative	0.00	1.41	3.64	9.14	15.49	23.43	32.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
Cultural Heritage	Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description

No withdrawal shall be made for payments made prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed $ 6,400,000 may be made for payments made prior to this date but on or after July 1, 2020 for Eligible Expenditures under Category (1).

Sections and Description

No withdrawal shall be made under Category (2) unless and until the Project Implementing Entity has prepared, approved and adopted the Project Operations Manual (POM) in a manner and substance satisfactory to the Bank.

Sections and Description

No withdrawal shall be made under Category (3), unless and until the Bank is satisfied, and has notified the Borrower and the Project Implementing Entity of its satisfaction, that all of the following conditions have been met:

(i) the Borrower and/or the Project Implementing Entity have determined that an Eligible Crisis or Health Emergency has occurred, have furnished to the Bank a request to include certain activities in the Contingent Emergency Response Component (CER Component) in order to respond to said Eligible Crisis or Health Emergency, and the Bank has agreed with such determination, accepted said request, and notified the Borrower and the Project Implementing Entity thereof;

(ii) the Project Implementing Entity has prepared and disclosed all environmental and social instruments, acceptable to the Bank, required for said activities, and has implemented any actions which are required to be taken under said instruments all in accordance with the provisions of Section I.E.4(b) of the Schedule to the Project Agreement;

(iii) the Project Implementing Entity has provided sufficient evidence satisfactory to the Bank that the Coordinating Authority has adequate staff and resources in accordance with the provision of Section I.E.3 of the Schedule to the Project Agreement, for the purposes of said activities; and

(iv) the Project Implementing Entity has adopted a CERCM in form, substance and manner acceptable to the Bank and the provisions of the CERCM remain, or have been updated in accordance with the provisions of Section I.E.1(a) of the Schedule to the Project Agreement, so as to be appropriate for the inclusion and implementation of said activities under the respective CER Component.

Sections and Description

The Borrower shall, through the Project Implementing Entity, ensure that no drones are procured and/or used under the Project unless the Project Implementing Entity has implemented the risk mitigation measures pursuant to paragraph 1 of Section III of the Schedule to the Project Agreement, in form and manner satisfactory to the Bank.

Sections and Description

The Project Implementing Entity shall maintain throughout the period of Project implementation, the Project Steering Committee, chaired by the chief secretary of Mizoram; which committee shall have composition, functions and responsibilities acceptable to the Bank, including providing oversight on Project implementation; approving and monitoring annual work plans and budgets; and approving the Project Operations Manual.

Sections and Description

The Project Implementing Entity shall maintain throughout the period of Project implementation, the Project Executive Committee, chaired by the principal secretary of DoHFW; which committee shall have composition, functions and responsibilities acceptable to the Bank, including providing regular monitoring and necessary approvals for day-to-day implementation of the Project.

Sections and Description

The Project Implementing Entity shall, not later than three (3) months after the Effective Date, prepare, approve and adopt a Project Operations Manual in a manner and substance satisfactory to the Bank, and thereafter carry out the Project in accordance with the provisions of the Project Operations Manual, which manual shall include,

inter alia: (i) the details of the Project activities including results framework and overall budget; (ii) the Project implementation arrangements; (iii) details on the Performance Incentive Grants, including selection criteria and procedure, template for the Internal Performance Agreement, implementation arrangements and monitoring and reporting mechanisms; (iv) the format of the interim unaudited financial reports to be submitted under the Project; (v) the Project's administrative, accounting, auditing, reporting, financial management and procurement requirements; (vi) the Project's environmental and social requirements; and (vii) the Project's monitoring and evaluation, and reporting requirements.

Sections and Description

The Project Implementing Entity shall maintain throughout the period of Project implementation, the Project Management Unit (PMU), headed by a Project director and comprising of experienced and qualified staff and consultants, in sufficient numbers and under terms of reference acceptable to the Bank, which unit shall be responsible for day-to-day Project implementation and monitoring, and shall have functions and responsibilities acceptable to the Bank, including, inter alia: (a) preparing annual work plans and budgets and ensuring all Project activities are planned, financed and implemented accordingly; (b) preparing the Project Operations Manual and ensuring Project implementation is in accordance with the Project Operations Manual; (c) ensuring that procurement and financial management activities are carried out in timely manner in accordance with the Project Operations Manual; (d) ensuring compliance with social and environmental instruments; (e) monitoring Project activities; and (f) preparing Project progress reports and ensuring their timely submission to the Bank.

Sections and Description

The Project Implementing Entity shall, not later than three (3) months after the Effective Date, recruit, and maintain throughout Project implementation, a Project management and technical agency, under terms of reference and with qualifications and experience acceptable to the Bank, to provide fiduciary support, technical support to the PMU for the implementation of the Project.

Sections and Description

The Project Implementing Entity shall, not later than three (3) months after the Effective Date, recruit, and maintain throughout Project implementation, an external verification agency, under terms of reference and with qualifications and experience acceptable to the Bank, to verify the achievement of indicators/results achieved by the Beneficiaries under the Performance Incentive Grant.

Sections and Description

Prior to procurement and/or use of drones under the Project, the Project Implementing Entity shall:

(a) notify the Bank of such proposed procurement and/or use, and afford the Bank a reasonable opportunity to assess any risks related to such procurement and/or use, including operational, legal and regulatory, institutional, technical, social and environmental, and fiduciary risks, and to recommend appropriate mitigation measures; and

(b) develop a risk mitigation plan for the procurement and use of drones, in form and substance acceptable to the Bank.

No drones shall be procured and/or used under the Project unless the Project Implementing Entity has implemented the risk mitigation measures in accordance with paragraph 1 above, in form and manner satisfactory to the Bank.

No drones procured under the Project shall be used for any purpose other than those set out in Schedule 1 to the Loan Agreement and for which the risk mitigation plan referred to in paragraph 1(b) above has been developed and implemented.

Sections and Description

For purposes of carrying out the activities under Part 1 of the Project, the Project Implementing Entity shall select Health Agencies and Health Facilities ("Beneficiaries") for receiving Performance Incentive Grants, in accordance with the eligibility criteria, procedures and requirements set forth in the Project Operations Manual.

Upon selection of Beneficiaries, the Project Implementing Entity shall enter into a written agreement (the "Internal Performance Agreement") with the respective Beneficiary, under terms and conditions acceptable to the Bank, as forth in the Project Operations Manual, and pursuant to the respective template agreements prescribed in the Project Operations Manual.

Sections and Description

The Project Implementing Entity shall:

(a) ensure that the Project's activities involving collection, storage, usage, and/or processing of Personal Data are carried out with due regard to the Borrower's existing legal framework and appropriate international data protection and privacy standards and practices;

(b) in the event that, during the implementation of the Project, the approval of any new legislation regarding Personal Data protection may have an impact on the activities financed by the Project, ensure that a technical analysis of said impact is conducted, and that the necessary recommendations and adjustments, are implemented, as appropriate; and

(c) except as may otherwise be explicitly required or permitted under this Agreement and/or the Loan Agreement, or as may be explicitly requested by the Bank, in sharing any information, report or document related to the activities described in Schedule 1 to the Loan Agreement, ensure that such information, report or document does not include Personal Data.

Sections and Description

The Project Implementing Entity shall ensure that the audit of the Financial Statements referred to in Section 5.09(b)(i) of the General Conditions shall be carried out by the office of the Comptroller and Auditor General of India through the Office of Accountant General, Mizoram.

Sections and Description

The Project Implementing Entity shall ensure that it provides counterpart funding of 20% of the estimated Project cost for implementation of Project activities, and share the corresponding financial information with the Bank at the end of every fiscal year for the Bank's review and monitoring of such contribution.

Conditions

I. STRATEGIC CONTEXT

A. Country Context

1. **India's Gross Domestic Product (GDP) growth has slowed in the past three years, and the COVID-19 outbreak has put significant additional strain on the economy.** Growth has moderated from an average of 7.4 percent during FY15/16-FY18/19 to an estimated 4.0 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. 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, as well as robust capital inflows, India's foreign exchange reserves have risen sharply and are expected to remain comfortable. Going forward, as per the latest projections of the Government of India, growth is expected to be above 10 percent and India to be among the world's fastest growing economies[1].

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. However, the economic slowdown triggered by the COVID outbreak is believed to have had a significant impact on poor and vulnerable households[2]. The extent of vulnerability is reflected in labor market indicators from high frequency surveys. 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. Short-term employment outlook is contingent on whether these temporarily unemployed workers can fully re-enter the labor force. 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.

B. Sectoral and Institutional Context

3. **The health sector in India in the past decade has witnessed major reforms, especially in-service delivery and financing.** The National Health Mission (NHM) has increased the states' fiscal space for investments in health services and has established mechanisms for accountability between the center and states through annual project implementation plans and budgets. Additionally, the 14th Finance Commission recommendations increased the share of central tax devolution (from 32 to 42 percent), providing states with greater flexible

[1] The IMF projects that India's economy will grow at 11.5 in FY22.
[2] To address them, the Government of India has deployed significant resources toward social assistance, including toward urban poor households and migrants.

funds to finance their priorities while 15th Finance Commission reduced the devolution from 42 percent to 41 percent. 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 for40 percent India's population. 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. Although this is higher than the average of south-Asia region but there are challenges that need to be addressed. Further it is imperative to note that India spends merely 1.2 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%). Further, around 25 percent[3] of the population incurs catastrophic health expenditure measured as out-of-pocket spending exceeding 10 percent of household consumption or income.

4. **Mizoram is in the North-East region of India with mixed outcomes on key health indicators and significant urban-rural disparities.** The state was established in 1987 and currently has 3 autonomous hill councils covering all 8 districts and 23 blocks with a population of 1.09 million. About 20 percent of the households live below the poverty line (BPL)[4] and 95 percent belong to the category of scheduled tribes.[5] Per capita income is US$1,708 (INR 168,626) (2018-19), 33 percent higher than the national figure[6] and only 10 percent of the state government's revenue is from local revenue collection. While 48 percent of the population are rural, 37 percent reside in the capital city Aizawl, and urbanization is increasing.[7] Under-five mortality in rural areas was 58 per 1,000, compared to 35 in urban areas, and prevalence of child stunting was 33.7 percent in rural areas, compared to 22.7 percent in urban areas.[8] In 2014–15, the total fertility rate 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. NCDs account for more than 50 percent of the disease burden in the state[9], while Mizoram is estimated to suffer from the highest prevalence of cancer in the country.[10]

5. **Indicators for coverage of basic health services are mixed.** In 2015–16, 61.4 percent of mothers had at least four antenatal care visits and 79.7 percent gave birth in a health facility, compared to national figures of 51.2 and 78.9 percent, respectively. Full immunization coverage in Mizoram was 50.7 percent, compared to 62.0 percent nationally. While maternal health care coverage in rural areas of Mizoram was lower than in urban areas, child immunization coverage levels were similar. In rural areas, 61.4 percent of births were in health

[3] Anamika Pandey George B Ploubidis, Lynda Clarke & Lalit Dandona. Trends in catastrophic health expenditure in India: 1993 to 2014. Bull World Health Organ 2018;96:18–28 | doi: http://dx.doi.org/10.2471/BLT.17.191759
[4] https://planning.mizoram.gov.in/uploads/attachments/e69d83919b9a45a04e7252f58f106bf6/mizoram-vision-2030.pdf.
[5] Census 2011.
[6] Economic Survey of Mizoram 2019–20, Government of Mizoram.
[7] Singh, A. K. 2017. "Urbanization in Mizoram: Characteristics and Correlates." *The Geographer* 64 (1): 21–31.
[8] International Institute for Population Sciences (IIPS) and ICF. 2017. *National Family Health Survey (NFHS-4), 2015–16: India.*
[9] 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.
[10] 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.

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.[11]

6. **Government health spending is comparatively high, although out-of-pocket spending/expenditure on health services by households remains significant.** Health expenditure as a share of total state government expenditure in 2015–16 was 8.3 percent, highest among the North-Eastern states and second highest nationally. At US$84 (INR 2,872) per capita, government health spending in Mizoram in 2015–16 was highest in the country, whereas the national average was US$16 (INR 1,112).[12] The state budget estimate for health in 2020–21 is US$89 million (INR 6.26 billion).[13] Nonetheless, out-of-pocket expenditures (OOPE) by households for health services are significant. In 2017–18, a hospitalization episode costs patients in Mizoram an average of US$188 (INR 12,109), although this is significantly lower than the national average of US$312 (INR 20,135).[14]

7. **The government health system encompasses services from the primary to hospital levels.** The Department of Health and Family Welfare (DoHFW) includes two directorates. The Directorate of Medical and Public Health (DMPH) is responsible for public health functions and primary health care services provided by 9 community health centers (CHCs), 58 primary health centers (PHCs), 372 subcenters, and 171 clinics. The Directorate of Hospital and Medical Education (DHME) manages nine district hospitals, five subdistrict hospitals, and one medical college. While the state meets national facility-to-population norms, more than half of the government hospitals are concentrated in the most urbanized Aizawl District, while the dispersed population and hilly terrain in rural areas impede geographic access to services. Nonetheless, because most private health care providers are in the larger urban centers, the state population is more dependent on government health services than is usual in the rest of India. The DoHFW at the state level is responsible for all policy formulation, financing, and oversight. The DMPH and DHME are responsible for providing technical leadership and administrative control of service delivery units in the state. While the former is responsible for all primary care facilities and service delivery, the latter is responsible for all secondary and tertiary care facilities. In addition to the two directorates at the state level, the State Health Society provides stewardship and financing for almost all public health services, outreach, and interventions and for systems strengthening interventions. Also, the state insurance agency provides financial protection against hospitalization costs through the insurance program. Each district has a District Health Society, a quasi-autonomous organization, that manages all public health interventions in the district. These organizational structures are responsible for the clinical and public health services that are offered at service delivery units and outreach functions. Most of the procurement and infrastructure repair and maintenance functions are managed at the state level, with limited flexibility to the districts and service delivery units for local procurement.

8. **While Mizoram performs well on a composite measure of health system performance, there are challenges due to fragmented structures and weaknesses in planning, budgeting, management, and monitoring of resources, directly affecting service delivery.** The national government monitors state-level performance with a composite index that reflects outcomes, service coverage, and processes. In 2017–18, Mizoram ranked first among eight smaller states on this index, with a score (73.70) significantly higher than the second-ranked

[11] IIPS and ICF 2017.
[12] GoI (Government of India). 2019a. *National Health Profile 2019*, *14th Issue.* Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, GoI.
[13] Mizoram budget documents 2020–21, Department of Finance, Government of Mizoram.
[14] IIPS and ICF (2017); GoI. 2019b. *Key Indicators of Social Consumption in India: Health - NSS 75th Round (July 2017–June 2018).* Ministry of Statistics and Programme Implementation. National Statistical Office.

state (Manipur, with a score of 60.60).[15] Nonetheless, the system faces significant management challenges. Along with the two directorates, there are separate agencies managing the NHM and the state health insurance schemes. Financing channels and accounting systems are fragmented at the state, district, and facility levels. The budget process shows weaknesses in planning and utilization of resources; for example, in 2016–18, the DMPH spent 80–85 percent of its revised budget estimates.[16]

9. **Fragmented organizational structure and financing patterns in the DoHFW combined with weak management and accountability structures severely affect health services.** Health service outcomes are a result of a set of interrelated systems that must function optimally. In Mizoram, service delivery operations and their management are fragmented between the two directorates, resulting in lack of efficiency gains. Weak capacity for indenting for medicines and weak demand forecasting capacity lead to suboptimal planning and budgeting for medicines, causing medicine stock-outs. Directorates do not have enough human resource information to project human resource requirements leading to critical vacancies. Lack of biomedical waste management (BMWM) committees at the state and district levels and inadequate intergovernmental coordination lead to weaknesses in infection control and therefore patient safety. The Quality Assurance (QA) Program is another area where lack of accountability causes large backlogs for the QA assessors' team and resources deployed for this purpose. Absence of accountability mechanisms also results in significant delays in reimbursement of medical claims to beneficiaries under the state scheme. Further, lack of evidence-based planning has led to poor tertiary-level medical services within the state. This is evidenced by high-volume claims under the state insurance programs out of the state from private hospitals. Each of these areas is further detailed in the following paragraphs.

10. **High dependence of the population on the public health facilities.** There is an urgent need to improve the management capacity of the health service administrative setup and health facilities in the state because the general population predominantly depends on the public health facilities for treatment. The latest NSS[17] 75th Round data indicate that in Mizoram almost 86 percent of the ailments in rural areas and around 53 percent of ailments in urban areas are treated in government hospitals (as against the all-India average of 32 percent and 26 percent, respectively). The private sector is almost nonexistent in rural areas, with limited presence in urban areas.

11. **There are important gaps in human resources for health (HRH), resulting in suboptimal utilization of health infrastructure and delivery of services.** In 2017, there were 437 doctors in government service in the state, with no specialists working in CHCs.[18] In 2017–18, 16 percent of specialist positions in district hospitals were vacant, while 20 percent of auxiliary nurse-midwife positions in subcenters were vacant. On the other hand, paramedical staff are reported to be numerous in rural areas. The average tenure of three key state-level administrative positions was only 14 months, while that of district chief medical officers was about 24 months.[19] To address human resource gaps, the state has introduced 'task-shifting' among paramedical staff and has started filling specialist positions. Nonetheless, the absence of a robust HRH strategy and weak management policies and systems continue to pose challenges.

[15] GoI. 2019c. *Healthy States Progressive India: Report on the Ranks of States and Union Territories, Health Index June 2019.* NITI Aayog. http://social.niti.gov.in/.
[16] Demand for Grant, Health and Family Welfare Department, Government of Mizoram.
[17] NSS = National Sample Survey.
[18] GoI 2019a.
[19] GoI 2019c.

12. **Inadequate supply of medicines to government health services undermines service 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. 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 intradepartmental coordination, lead to purchasing of high-cost medicines. Lack of medicines and diagnostic services in government hospitals leads to out-of-pocket spending by patients. The directorates at the state level have primary responsibility for procuring medicines, with service delivery units having limited provisions for local and emergency procurement.

13. **The state has made a concerted effort on quality improvement that requires further strengthening.** The quality of health care is critical to achieve the universal health coverage, in absence of quality, the improvement of access does not yield desired results. The DoHFW's QA Program was initiated in 2015. Two hospitals received the National Quality Assurance Standards (NQAS) certification in 2017, while others are under process. The state has successfully implemented a national health care hygiene program (*Kayakalp*), receiving awards and incentives for maintaining cleanliness in several facilities, which contributed to its score on the National Government's composite health system performance index. However, these efforts require additional technical support and investment, including tools for improving clinical care quality, particularly in rural areas. Suboptimal financing of BMWM activities, weak structure to provide oversight on regulatory compliance, and lack of training on segregation of waste at source and on waste transportation, disposal, and treatment further accentuate the problem. These challenges assume more serious proportions in the post-COVID-19 world and has a direct impact on patient safety and quality of care they receive. Therefore, poor-quality care – is not only harmful but also wastes precious resources that can be invested in other important drivers of social and economic development to improve the lives of citizens and need to be addressed on priority for better health outcomes.

14. **The state has taken several initiatives to leverage private sector capacity.** The state government has outsourced diagnostic services as well as maintenance of biomedical equipment. It also engages with private providers under the national tuberculosis program, as well as for cataract surgeries, and has provided grants to nongovernmental organizations (NGOs) for eye care services in semi-urban and rural areas.[20] The state's policy framework, notably a Public-Private Partnership Policy adopted in 2016 by the Planning and Program Implementation Department, could allow for more comprehensive initiatives in the health sector.

15. **The Mizoram State Health Care Scheme (MSHCS) aims to reduce the financial burden of health care on households, but coverage, management capacity, and financial sustainability remain key challenges.** Despite the emergence of a number of health insurance programs and health schemes, only 55 percent of households have any kind of health insurance that covers at least one member of the household. Health insurance coverage is somewhat higher in rural areas (50 percent) than in urban areas (42 percent). The MSHCS started in 2008 as a scheme covering limited critical care services based on a US$25 million loan from the Asian Development Bank (ADB). The scheme is free of charge to households below the poverty line and costs US$14 (INR 1,000) for enrollment by households above the poverty line (APL). The number of beneficiaries enrolled under the state scheme in 2018–19 was 112,732. In 2018, the AB-PMJAY program of the Government of India (GoI) was launched in Mizoram. As of September 2020, 352,339 beneficiaries were verified and enrolled under the program. With the launch of the Central Government's AB-PMJAY program,

[20] NHM Record of Proceedings: 2020–21. https://nhmmizoram.org/upload/Mizoram%20RoP%202020%2021%20Part%20II.pdf.

the state is implementing two parallel schemes. While the AB-PMJAY has no enrollment fee, the enrollment fee for the state scheme is INR 1,000 per year per family for the APL population and INR 100 per year per family for the BPL families. Each scheme has its own benefit package though the packages and the exclusion criteria are similar. Both the state and central schemes are managed by the same state insurance agency. Coverage of the scheme and enrollment is a challenge, with only about 55 percent of eligible beneficiaries enrolled. Low beneficiary awareness is a major demand-side challenge. Parallel schemes operating with the same objective but with fragmentation in design, beneficiary packages, and operational processes make the schemes' administration inefficient and weak. There is a need for technical support on converging the schemes, increasing coverage, and improving its management and efficiency.

16. **Health care expenditure on females is systematically lower than on males across all demographic and socioeconomic groups in India.** Between India Human Development Survey - I (2004–2005) and II (2011–2012), the male–female gap in major morbidity-related expenditure increased from INR 1,298 to INR 4,172.[21] Access to health insurance and health care expenditure are intrinsically linked. Gender gaps in access and usage of health insurance and related benefits are well-reflected in gender disparities in health care expenditure. Only 17 percent of women against 44 percent of men ages 15–49 years in Mizoram are covered by any health scheme or health insurance.[22] More women (19 percent) and men (51 percent) in rural areas are covered by any health scheme or health insurance than women (15 percent) and men (39 percent) in urban areas.

17. **The COVID-19 has affected the health sector of Mizoram and further the low capacity and absence of strong institutional systems and structures in the state makes it vulnerable to the ill-effects of crisis and pandemics.** As of December 17, 2020, there were 4,085 COVID-19 cases diagnosed in Mizoram, lowest among all states in India, with only seven COVID-related deaths reported.[23] For Mizoram, data from the April to June Quarter of 2020 shows that the OPD, IPD, Major and Minor Surgeries, hysterectomy have declined by 33 per cent, 36 per cent, 56 per cent, 45 per cent, 75 per cent respectively, from the same time period of previous year. Coverage of antenatal care was 5 percent lower, and there were 18 percent fewer deliveries in government health facilities, 10 percent fewer deliveries in private health facilities, and 28 percent fewer cesarean sections. Child immunization coverage declined by 28–40 percent. In-patient services and surgeries were reduced by one-third to one-half. The national COVID-19 program has provided funding of US$0.51 million (INR 37.1 million) to Mizoram 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. Although, the state has formed a task force, developed a contact tracing system, established quarantine facilities, and supplemented health services with medical equipment and human resources., there still remains gaps due to inherent systemic gaps affecting the service delivery.

18. **World Bank assistance is being sought to support the state address some of the key challenges outlined above and strengthen its 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. Thus, the current operation will focus on specific challenges and investments will be made to strengthen the management capacity and governance at all levels. The program will prioritize strengthening design and coverage of the health insurance program; and

[21] Gender Difference in Health-Care Expenditure: Evidence from India Human Development Survey, 2016.
[22] National Family Health Survey 2015–2016.
[23] https://www.covid19india.org.

improving quality of health services through certification, human resource strengthening, and improved access to medicines and diagnostics. Given the nature of challenge and need for investment and improvement of management capacity at different levels, the project would like to follow combination of Results based Financing approach and inputs based financing for meeting the basic standards on infrastructure, that will strengthen conjoint efforts that lies in multiple interlinked reinforcing loops to address management capacity and quality of service. Further, Internal Performance Agreements (IPA) will be introduced under RBF for achieving better results (more details on IPA are provided in section below). The current operation will target on bringing systemic improvements in the state health sector which in the long run will lead to positive outcomes including improved service outcomes for beneficiaries.

C. Relevance to Higher Level Objectives

19. **The project will contribute to the India Country Partnership Framework (CPF) FY18–22 (Report No. 1266667-IN; 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.

20. **The project is expected to contribute to the World Bank's twin goals; the health Sustainable Development Goals and the mission of the Health, Nutrition, and Population (HNP) Global Practice.** Project investments in improving the quality and responsiveness of public health services and increasing access of the population to an expanded package of health services are expected to contribute to improved health outcomes and consequently to the World Bank's twin goals of ending extreme poverty and promoting shared prosperity. The project strengthens public health institutions in Mizoram by addressing critical aspects of health care management and accountability.

Selectivity, Complementarity, Partnerships

21. The International Monetary Fund (IMF) does not have an active lending program in India. However, it carries out regular macroeconomic supervision and Article IV consultations twice yearly. The World Bank and IMF teams regularly exchange views and information. The partnership with other donors was brought to fruition in both the social protection and MSME COVID response Development Policy Operations (DPOs). Within the social protection DPO, the World Bank has worked in collaboration with the ADB, *Agence Française de Développement*, and *Kreditanstalt Für Wiederaufbau*. The Japanese International Cooperation Agency (JICA) and the New Development Bank are also exploring potential parallel financing. In parallel, the ADB and JICA are exploring support for the MSME sector.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

22. The Project Development Objective (PDO) is to improve management capacity and quality of health services in Mizoram.

PDO Level Indicators

(a) The percentage point increase in average performance score in targeted administrative units as per internal performance agreement from baseline. (percentage) (management capacity)

(b) Cumulative Number of districts hospitals which are NQAS certified. (number) (quality)

(c) The percentage point increase in average quality index score for CHCs and PHC from baseline. (Percentage) (quality)

(d) The percentage point increase in score among those who participated in clinical vignettes. (percentage) (quality)

(e) Improve management and efficiency of Health insurance program by Convergence between the MHCS and AB-PMJAY. (text) (management capacity)

B. Project Components

23. The Mizoram Health Systems Strengthening Project combines results-based financing (RBF) and input-based financing approaches to achieve enhanced performance management in the public sector. It uses a system's approach and is broken down into three individual components which need to be appreciated as forming part of a whole system's approach complimenting each other – the first component strives for results, while the second and third components are designed for input-based financing and are critical for achieving the project objectives. A rigorous performance management approach will align incentives to support planning from top to bottom to move incrementally towards improving the management capacities and quality of health services at district hospitals, CHCs, and PHCs.

24. Inputs required to assist health facilities to reach accreditation standards will be sourced from both performance-based incentives and input-based financing. Strengthening the management and organization of the health insurance program to boost utilization and a swifter reimbursement to providers will lead to efficiency in the overall health insurance program. The improved system will also contribute to the immediate needs of the COVID-19 preparedness and for content of care quality. Using the language of system thinking,[24] the strength of this conjoint inputs—planning and results-based approach—lies in multiple interlinked reinforcing loops. As an example of reinforced interlinks, though quality improvement lies at the point of care facility level, the district administration and state have critical role to play for monitoring, mentoring and resource allocations to improve quality service delivery. Therefore, it needs to be understood that all levels in the health system are collectively responsible to improve the overall quality of services.

[24] Senge, P., et al. 1994. *The Fifth Discipline Fieldbook. Strategies and Tools to Build Learning Organizations.* Doubleday; Savigny, D. de, and T. Adam. 2009. *Systems Thinking for Health Systems Strengthening.*

25. **The project is supported by an IBRD loan in the amount of US$32 million using an Investment Project Financing (IPF) instrument structured in four components.** The first three will address different elements of the PDO (management capacity, and quality) and the fourth will be a Contingent Emergency Response Component (CERC). Component 1 will focus on strengthening management and accountability, creating the environment for reforms, enhancing performance of the DoHFW and its subsidiaries, improving efficiency of the public health administration while health facilities are the ultimate target, and strengthening content of care quality and key structural quality areas while assisting health facilities in the planning for national accreditation. Component 2 will invest in the state health insurance program to improve its overall design, management, and effectiveness. Component 3 will focus on health systems development, structural quality improvements, and pilot health innovations. A combination of results-based approaches (Component 1) and input-based financing (Components 2 and 3) will address the key challenges related to management structures, planning and budget process, human resources, medicine supply, and quality of care referred to in section I.B.

Component 1: Strengthen Management and Accountability through Internal Performance Agreements (cost US$13.5 million)

26. This component provides Provision of Performance Incentive Grants to Health Agencies and Health Facilities to improve governance and management structures. The component will use IPAs[25] between the DoHFW and its subsidiaries at the state and substate levels. The project envisages IPAs as a tool to infuse new way of operations by moving from input-based financing to performance-based financing systems. This component will follow the RBF approach that is expected to strengthen the management and accountability relationships between the state - and the substate-level implementing units. Fund transfers to institutions and health facilities would be made against the achievement of performance indicators specified in IPAs. The IPAs aim to foster a spirit of more accountable government, along with results-based monitoring, contributing to improvements in management of the system and delivery of quality health services.[26]

27. **IPAs will be implemented at the state, district, and health facility levels.** Each of these levels will contribute to system strengthening, improve the health insurance programs and the quality of health services. Entities with which the DoHFW will sign agreements are (a) the state-level Directorate of Health Services (DHS), the Directorate of Hospital and Medical Education (DHME), their subsidiary departments, and the Mizoram State Health Care Scheme (MSHCS); (b) district-level health administrations and district hospitals; and (c) health facilities, at both the primary (PHCs) and first-referral (CHCs) levels. Agreements will be signed between different levels of the system, as described in table 1.

Table 1. Entities and Contracting Relationship under IPAs

No.	Contracting authority	Entities
Principal Agreement (Level 1)		
1	DoHFW	DHS
2	DoHFW	DHME

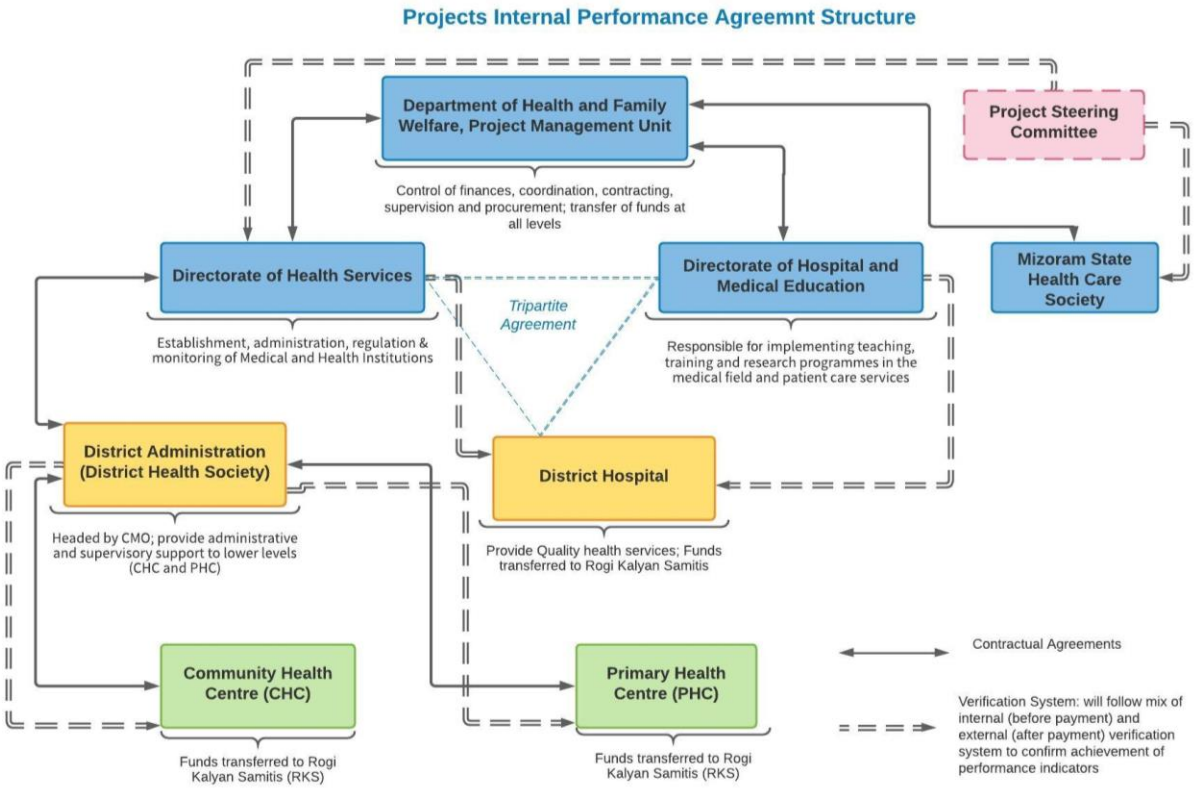
[25] Internal Performance Agreement is the inter-departmental non-legal agreement to list the performance indicators against which the grant will be provided to the beneficiaries such as Department of Health and Family welfare, Directorates, District Administration, District Hospital and health facilities (CHC and PHC).

[26] Fritsche, G., et al. 2014. *Performance-Based Financing Toolkit.* Chapter 8, page 165. Washington, DC: World Bank. https://openknowledge.worldbank.org/handle/10986/17194 License: CC BY 3.0 IGO.

3	DoHFW	State insurance agency/ MSHCS
Sub-agreements (Level 2)		
5	DMPH and DHME (tripartite agreement)	Selected district hospitals and higher-level facilities
6	State insurance agency	Selected district hospitals and higher-level facilities
Sub-sub-agreements (Level 3)		
7	District administration	Selected CHCs and PHCs

28. At the health facility level, this approach will provide flexible resources and management autonomy. A system of geographic equity adjustments will be put in place to ensure that the low performing health facility will be prioritized to receive largest performance budget. Measures that will govern these geographic equity adjustments will include travel time to the state capital, human resources density, poverty scores, and immunization coverage. At the health facility level, the IPA will be focused on key structural quality elements such as planning, budgeting, and coordination; user experience targeting women patients; and core metrics for content-of-care quality such as knowledge and competency tests of providers, etc.

29. The detail IPA strategy is described in annex 3, including design, funds flow, and roles at different levels. Additionally, a capacity building vehicle will be prioritized for the implementation of IPA by build the local institutional capacity to sustain the management systems and practices beyond the project. The capacity building vehicle consist of “champions” from health department at different level who will play key role in internal assessment of results and provide mentoring support, secondly, the local level institution (academic or think tank) will be identified who will be involved in the project activities as an advisor and mentor the department. The State will identify local institutions with qualification to provide continues technical support to Department and provide concurrent assistance for building their capacity. The detail eligibility criteria will be defined for identification of such agency, the same will be defined in POM. Also, please refer to the conceptual framework of Project’s Internal Performance Agreement structure in the Box given below.



30. **Implementation will use an iterative adaptive learning approach where attention will be given to identifying and nurturing change agents at each level of implementation.** Processes which draw in key interlocutors at each level (health facilities; district health administration; State MOH departmental levels) through purposeful design, will yield tools that will achieve their intent. IPA design will start with PHC and CHCs and DHs, after which district health administration will be targeted. Finally, the IPAs at State level with select department and entities will be designed. These processes will include virtual tours of health facilities after which a calendar will be created for technical working groups (TWG). TWG sessions will start with defining key performance gaps and will share experience from select successful performance enhancement approaches from comparable contexts. Tools and methods will be crafted collaboratively with the health facilities / district health administration officials, after which a plan will be created to pilot test and scale these tools and methods. An adaptive learning approach will be used to ensure lessons learned in the initial roll-out in selected districts which will be incorporated before scaling. Attention will be paid to identifying and nurturing change agents at each level.

31. **The performance metrics in the IPA are determinants of improved management capacity and quality of health services at all levels.** Distinct performance metrics are designed for the levels as per their roles and responsibilities that contribute to enhanced access to and quality of health services. The various metrics in the performance frameworks are designed and weighted using a bottom-up process with the client. The state-level indicators (for directorates) are to improve timely resource allocation to districts and health facilities, for policy reforms in human resources and their deployment, and to ensure procurement and supply of drugs and medical equipment as per the need. District-level performance indicators contribute to improved monitoring and supervision, coordination support for supply of drugs,

institutional-level review for biomedical waste, and facilitation of quality improvement and accreditation processes. At the health facility levels, performance indicators are targeted to improve quality of service delivery including content of care quality, patient satisfaction, satisfaction and user experience of women patients, biomedical waste implementation, use of energy efficient resources at the facility level, reporting and documentation, and clinical skills of the medical staff including knowledge enhancement on climate-related diseases and disasters.

32. **The directorates will be supported in identifying existing sector wide gaps in management, delivery, and quality of health services, as well as in coverage and operation of the health insurance program.** They will be supported in determining the most suitable approaches to address these gaps, developing action plans, and operationalizing those plans. A first phase of performance-based funding will be provided to the directorates, district-level health offices, eligible subsidiary divisions, and the health insurance program, which will meet preconditions reflecting a minimum level of capacity and interest, including development of action plans with agreed targets and these latter will be a precondition for this first phase of funding. This process will build institutional capacity of the decentralized health administrative units at the state and substate levels in need-based planning and management of health services. Strengthening the department managing the insurance program, is expected to lead to more beneficiaries covered, in addition to strengthening the reimbursement mechanism for health facilities which will enhance the trust of providers in the insurance system. The health insurance program will be restructured to ensure coordination and synergy with the national program and to improve its design and implementation, with IPA indicators reflecting progress. Also, the district level internal performance agreements will be adjusted to consider geographic equity; district furthest from the center, and most low performing will receive a relatively larger IPA budget.

33. **The IPAs will encompass objectives, key results, and indicators reflecting those results, as well as financing tied to the composite performance score of the IPA.** Action plans will be defined for accomplishing the results, with implementation of the action plans supported by a first phase of funding, followed by funds transferred based on results. Indicator definitions and reporting procedures will be specified, with reporting aligned to the existing health management information system (HMIS) and other reporting or documentation systems, while the IPA results will be assessed each quarter by certified assessors. Internal and external verification procedures will also be specified in the IPAs. The Contracting Authority at each level will be responsible for oversight, mentoring, and financing the contracted parties. Capacities of the Contracting Authorities to manage the IPAs will be developed with support from the project. Regular results assessments will be institutionalized, and data availability will be enhanced through the creation of a dashboard.

34. **Though NQAS certification comes with a monetary award, getting health facilities prepared for accreditation has significant up-front costs, and this is where the health facility IPA comes in.** The health facility IPA will provide funding based on quality performance. Part of the health facility quality index will be metrics measuring progress on accreditation planning and implementation. Furthermore, low-quality health services have an immediate impact on health benefits, and it seems imperative to tackle this as a matter of some urgency. Also, in times of the COVID-19 epidemic, strengthened attention to infection control and prevention, in general, is urgent. Process quality in the Donabedian sense[27], the 'content of care quality', which is what happens between the provider and the patient, is significantly related to

[27] Donabedian, A. 2005. "Evaluating the Quality of Medical Care." *Milbank Memorial Fund Quarterly* 83 (4): 691–729.

outcomes of health services. A significant weight within the quality index will come from anonymized health worker knowledge scores.

35. **The achievement of performance indicators reported by the administrative units and health facilities which are parties to the IPAs will be verified in two ways:**

    (a) An internal verification mechanism will use an existing pool of human resources who are currently tasked with various QA activities. These individuals will be mapped organizationally to departments and units that will be under IPAs. These "champions" will be the "change agents" at different levels in the system will also operationalize and prioritize implementation of IPA in the State.

    (b) An external verification mechanism will involve an external agency which will independently counter verify sample of the reported results as well as the use of financial incentives by different levels. The results reported by the external verification agency will also be used for further revision of indicators.

36. The IPA is a highly effective way for all stakeholders to collectively think beyond inputs. Moreover, it promotes defining the results together, compelling health officials at different levels to be more mutually accountable for shared goals. This approach emphasizes working backwards by focusing on desired outcomes, identifying binding constraints, and using financing as a way to unlock those constraints.

37. Under Component 1, the project will finance the incentives to institutions and health facilities against achievement of results as per the IPA. The invectives will be used for implementation of activities that support approved improvement plans to increase the quality of health services and overall accountability in the health system.

Component 2: Improve Design and Management of the State Health Insurance Programs (US$2.5 million)

38. This component will strengthen the design, systems, and operations of the health insurance schemes in the state. This will be achieved through Strengthening of policy and design of health insurance schemes in Mizoram for increased operational efficiency; Strengthening of institutional capacity, systems and processes of the Mizoram State Health Care Society for greater accountability; and Support for community interventions to spread awareness, improve enrolment and increase demand and utilization of health insurance schemes. This component will focus on reducing fragmentation between schemes, promoting synergy and convergence for efficiency gains, and augmenting the management capacity of the state insurance agency, thereby contributing to improved coverage and increased service utilization. Also, support the state health insurance programs and their links with AB-PMJAY, contributing to reducing financial barriers in accessing hospital services, preventing catastrophic OOPE for health by poor families, and expanding coverage. These investments will be complementary is nature as it will help reduce fragmentation and operational synergies across multiple health insurance schemes in the state thereby bringing in efficiency gains. Convergence shall be both at the policy and at operational levels while ensuring that the identity of the state scheme remains intact. Details of convergence are outlined in sub-para (a) and (b) below.

    (a) **Strengthening of policy and design.** This will include reviewing benefit packages, exploring options for converging benefit packages across the two schemes using standardized uniform coding structure following ICD or SNOWMED CT classification system (standard international disease classification systems), converting the state schemes into a cashless benefit for end users like the central scheme,

and maximizing use of the provisions of AB-PMJAY to reduce the financial burden on the MSHCS. Strategies for progressive reduction of enrollment fees under the state schemes will be explored as part of design restructuring. The project will incorporate future events and their effect on populations, such as disease patterns and potential disease outbreaks in policy designs that are influenced due to lifestyle and climate change.

(b) **Strengthening of institutional capacity, systems, and processes to enable operational convergence of both State and Central health insurance program.** Investments will be made in strengthening operational convergence of the two schemes. The operational convergence will support investments in information technology (IT) architecture and capacity to convert the MSHCS into a paperless transaction system such as the central scheme (AB-PMJAY) and to improve other functions such as beneficiary identification, hospital empanelment, referrals, portability mechanisms, claim adjudication, financial management (FM), grievance redressal, service quality audits, and monitoring in par with central government's health insurance scheme (PM-JAY) and cross fertilize the good practices between these two schemes. Systems, tools, and skills (technical and managerial) will be developed among scheme administrators at the state, district, and facility levels, including investments in additional human resources and infrastructure and learning exchanges with other states and countries with mature government-financed health insurance programs. This will ensure quality improvement of scheme administration processes and thereby in the longer-term result in efficiency gains within the scheme administering agency. Using common / similar systems, processes and tools to administer both the state and central schemes shall promote synergies leading to efficiency gains.

(c) **Community interventions for improving coverage, demand, and utilization.** Comprehensive communication campaigns and demand-side interventions will be supported to improve enrollment under the schemes and increase demand for services. Interventions would include household enumeration in targeted villages to improve enrollment in the health insurance program and community-driven pilots to increase awareness about health issues, including the benefits of enrolling in the health insurance schemes. Such interventions will leverage existing platforms for engaging with communities, including Village Health, Sanitation, and Nutrition Committees (VHSNCs), women's Self-Help Groups (SHGs), and Village Health and Nutrition Days (VHNDs). Increased coverage and intensive demand-side efforts including, but not limited to, communication campaigns will lead to improved utilization that would be measured through increase in the share of government hospital in-patients who are insured.

39. **Targeting women beneficiaries and women-headed households in accessing health insurance.** The component will support development of a bouquet of services to improve women's access, enrollment, and usage of health insurance. First, the component will develop and roll out targeted communication/behavior change modules to disseminate information among women beneficiaries, particularly women-headed households. Second, the component will undertake a review to identify districts/blocks with poor enrollment of women beneficiaries in health insurance schemes. To bridge this gap, the component will support capacity-building measures and offer performance-based incentives to insurance enumerators in select districts/blocks. Third, the component will leverage the power of women-led groups to enforce village-level monitoring and uptake of health insurance among women. The proposed intervention will also identify targeted blocks/villages to demonstrate the positive impact of women's improved access to health insurance on their overall health and well-being.

40. Under Component 2, the project will finance (a) hiring of individual consultants, (b) training, (c) hiring of consultancy and non-consultancy services, and (d) investments in office and IT infrastructures that are climate smart and energy efficient.

Component 3: Enhance Quality of Health Services and Support Innovations (US$15.92 million)

41. This component will improve the quality of health services by developing a comprehensive QA system, improving BMWM, enhancing human resource management, and piloting innovations. The investment under this component will: (i) Support for improvements in delivery and quality of health services, through: development and implementation of quality assurance programs at health centers and hospitals, preparation of additional health facilities for accreditation, repair and upgradation of infrastructure at health centers and hospitals, and strengthening of diagnostic services; (ii) Improvement in management of biomedical waste generated by government and private health services; (iii) Strengthening of human resources system for the health sector; and (iv) Design, development and piloting of innovative models to improve health service delivery, including engaging community platforms and frontline workers, supporting community and home-based palliative care, screening for non-communicable diseases, developing comprehensive primary care services through health and wellness centers, and use of commercial drones for emergency supplies and telemedicine to improve access to services.

42. These investments will also improve the capacity of the health facilities to respond to the ongoing COVID-19 pandemic as well as increased preparedness for future outbreaks. The selection of targeted health facilities will address the equity issues between rural and urban. The investments in the areas which are hard to reach and neglected will be prioritized. Under this component, the project will support the development of a gender-informed human resource policy that will define career pathways, roles, and competencies. This component involves various information and communication technology (ICT) activities to improve the overall efficiency and will also pilot ICT solutions under innovations.

(a) **Improvements in the delivery and quality of health services provided by district hospitals, CHCs, and PHCs.** The project will support QA programs at the PHC, CHC, and district hospital levels. This will involve development and implementation of health facility improvement plans, training of teams responsible for periodic assessments, and training of district-level administrators. The project will build on other initiatives supported by the state and central governments, notably the NQAS. The project will support preparation of additional health facilities for accreditation. This will involve gap analysis and the necessary training (including sessions on health emergency response systems) and investments to fill the identified gaps. Under the infrastructure revamping, the repairs and retrofitting of the health centers will move toward being ecofriendly and energy efficient. The project will support facility improvement teams to implement quality initiatives, recruitment of hospital managers, and strengthening of district teams. The NQAS quality index used to measure results includes indicators related to major and minor surgeries, cesarean sections, other in-patient procedures, and quality of facility-based NCDs screening. The efficacious use of diagnostics has become the cornerstone of evidence-based medicine. The project will finance models for strengthening diagnostic (laboratory/radiology) services through private sector participation.

(b) **Strengthening of BMWM.** 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. Improving the BMWM system will include developing evidence-based strategies and plans; investing in infrastructure and equipment (including maintenance); exploring private sector engagement options; building capacity; and deploying personal protective equipment, infection prevention measures, and immunization for health care providers.

(c) **HRH development.** The project will support a multipronged approach to institutionalize and strengthen HRH, starting with support to development of a state-level policy and management framework for HRH. The project will support improvements in pre- and in-service training, including quality accreditation through the National Assessment and Accreditation Council for the college of nursing, infrastructure revamping of nursing and training institutions, and development of programs for continuing medical and paramedical education. The project will also support the state in developing and implementing strategies to address human resource shortages, especially specialists. Human resource management systems will be improved, through developing and implementing performance metrics for health cadres and building the capacity of the DoHFW for data-based management of human resources.

(d) **Testing innovations in service delivery through pilot interventions.** The project will support design, development, and piloting of innovative models for outreach and service delivery outreach. Activities may include engaging community platforms and frontline workers, supporting community and home-based palliative care, screening for NCDs (including for breast and cervical cancers), developing comprehensive primary care services through health and wellness centers (HWCs), and using drones for emergency supplies and telemedicine to improve access to services. The pilot interventions will be undertaken in two districts of the state namely Kolasib in northern part and Lawngtlai in the Southern part of the State.

43. Under Component 3, the project will finance (a) hiring of consultant support, (b) minor civil works, (c) goods and equipment, (d) training, (e) hiring of additional human resource (such as hospital managers and other technical staff), and (f) hiring of non-consultancy services for clinical and nonclinical work.

Component 4: Contingent Emergency Response Component (US$0 million)

44. In the event of an Eligible Crisis or Emergency, the Contingent Emergency Response Component (CERC) provides an immediate and effective response to said crisis or emergency. The component provides Provision of immediate response to an Eligible Crisis or Health Emergency.

Project Cost and Financing

45. The World Bank financing will reimburse the Government up to US$32 million of defined eligible expenditures and incentives. The Government of Mizoram will contribute US$8 million as counterpart financing to project activities.

Table 2. Project Cost and Financing (US$, millions)

Project Components	Project Cost	IBRD Financing	State Government Parallel Financing
Component 1: Strengthen Management and	13.5	13.5	0.0

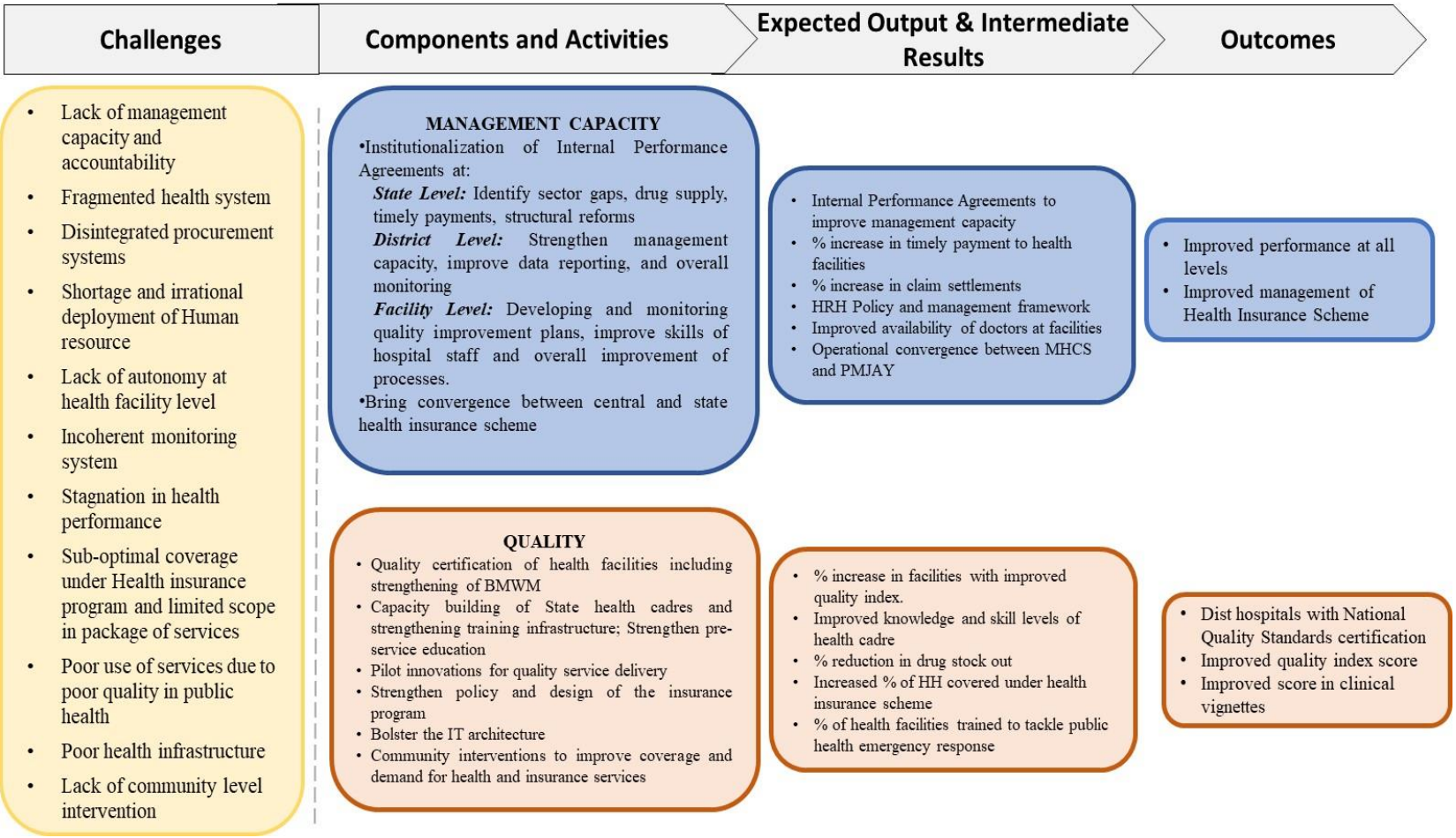
Accountability through Internal Performance Agreements			
Component 2: Improve Design and Management of State Health Insurance Programs	5.0	2.5	2.5
Component 3: Enhance Quality of Health Services and Support Innovations	21.5	15.92	5.5
Component 4: Contingent Emergency Response Component	0.0	0.0	0.0
Other Costs (Front-End Fee)	.08	.08	
Total	**40.0**	**32.0**	**8.0**

C. Project Beneficiaries

46. The proposed project will benefit the population of Mizoram by improving the management, quality, and coverage of services delivered by the government health system, including all health facilities. The MSHCS, which currently covers approximately 56 percent of households, will also be strengthened. The project will also benefit health sector staff, specifically at the secondary and primary levels, by strengthening their capacity and providing them skill-based training. Investments at the health facility level to enhance infrastructure, private sector partnerships, technology solutions, and working conditions will improve their efficiency and satisfaction levels and lead to better quality care.

D. Results Chain

Figure 1. Results Chain



Note: HH = Households

E. Rationale for Bank Involvement and Role of Partners

47. **There are compelling reasons for the World Bank to support the Mizoram health sector.** The proposed project shall enable and capacitate the state government to achieve improved health outcomes from its existing investments for health. The World Bank will fund need-based innovations and provide sound TA, drawing on extensive experience on health reforms worldwide and on the lessons learned from more than two decades of assistance through the World Bank's central and state projects in India.

48. **The World Bank is well positioned to support Mizoram in strengthening its health sector with its long and strong engagement in the North-East region.** The operation would contribute to generation of knowledge in the region, especially through the technical work and innovation in health service delivery and in providing evidence for effective leveraging of central government grant resources. The implementation experience will not only be relevant for other states in the North-East region that face similar challenges in improving health service accountability, management, and delivery but also offer workable solutions to other countries in the region with similar demographic and capacity constraints.

49. **The state has leveraged resources from multiple organizations**. The ADB is supporting the state to create fiscal space to improve health service delivery in the state. JICA is supporting the state to establish a specialized cancer care hospital. The state has further initiated several partnerships through arrangements with several United Nations (UN) agencies, national and international NGOs, and academic institutions. The state has a UN Joint initiative with four UN agencies, namely the Food and Agriculture Organization of the UN, International Labour Organization, United Nations Development Programme, and United Nations Industrial Development Organization, for systematic and sustainable development in the state. The World Health Organization (WHO) also provides technical guidance to the state based on specific requests. Although the International Finance Corporation and World Bank have provided TA for strengthening the state's health insurance program, the proposed project will be the first state-level World Bank-financed project for the health sector in the state.

F. Lessons Learned and Reflected in the Project Design

50. The project design has benefited from lessons drawn from the World Bank's experience in financing health system development projects in several states of India (especially in the North-East region) and from the TA support in the state. More specifically, the project design has benefitted from the following lessons:

    (a) The focus of building systems' capacity and introduction of accountability system are built on experience of implementing systems strengthening projects in the states of Uttar Pradesh, Karnataka, and Tamil Nadu and more relevant experience drawn from Uttarakhand and Nagaland.

    (b) World Bank financing has had the best results when it has supported and leveraged improvements in state systems, fostered innovation and new strategies, and met investment needs that could not be addressed by other sources (particularly central government programs). The proposed project draws upon these lessons and leverages existing government investments to make them more accountable and sustainable.

    (c) The proposed focus on enhancing quality of care by adopting simplified accreditation approaches and other systems-strengthening efforts builds upon the World Bank's state-specific support for projects in states such as Uttar Pradesh, Uttarakhand, Andhra Pradesh, Tamil Nadu, Nagaland, and Karnataka.

(d) The project has drawn learnings from the incentive scheme of the Ministry of Health and Family Welfare (MoHFW) which uses health index rankings by the National Institutions for Transforming India (NITI) Aayog. This allows the high performing states to receive additional grants. The project aims to extend this practice, beyond state level, to incentivize the district and facility level, who are the actual performers contributing to the overall state performance.

(e) Performance-based financing (PBF) projects have been implemented in public health systems in low- and middle-income countries for over 15 years, with significant success as documented in peer-reviewed journals. It is less well known that these successful PBF projects work with performance contracts at all levels of the public health administration. IPAs for public health units and departments are crafted with care to consider key supportive functions of the specific department. Unique features of these performance frameworks are as follows: (i) they are focused on the specific deliverables of the targeted department; (ii) they are weighted, that is, some metrics are weighted more than others; (iii) they are measured typically once a quarter; and (iv) the departments under contract are held accountable for their work, which includes applying the quantified quality supervisory checklists to health centers. This accountability is ensured through a third-party mechanism and includes penalties for gaming. Income gained from these IPAs is typically split into funds used for recurrent costs and performance bonuses for staff.

(f) The technical work on health insurance at the central level through support to the National Health Authority for AB-PMJAY and hands-on experience of health insurance program reform in Karnataka provide significant learnings that have been used during the project design.

(g) Finally, the project benefits from specific technical work in several areas. Analysis of North-Eastern states in 2014 as part of a global knowledge product on Influencing Multisectoral Action for Health Outcomes (P145691) identified the importance of risk factors that can be addressed through behavior changes at the community level. HNP TA to North-East States (P146929) has involved in-depth analysis of several areas of project investment (community-level strategy, HRH, off-grid energy, water and sanitation, supply chain management, and IT), drawing on lessons from elsewhere in the world.

51. **The project design has benefitted from the World Bank's experience of implementing an LDHF training approach in Kyrgyzstan and Cambodia.** The LDHF approach to training presents a unique opportunity to build lasting capacity for cadres of frontline health workers who currently receive only basic training under national programs. The LDHF approaches in the Kyrgyz Republic and Cambodia are embedded in nationwide quality enhancement approaches, using RBF methods while leveraging government funding and systems for sustainability.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

52. **The DoHFW will be responsible for the implementation of the project.** The existing DoHFW governance and management structures and departments will be used for project implementation. A Project Steering Committee (PSC) under the Chairmanship of the Chief Secretary will provide oversight to the project. The committee will also include the Principal Secretary (Health and Family Welfare) and secretaries of other relevant departments. The committee will oversee the project implementation and results and will be responsible for approving and monitoring the annual project plans and budgets and preparing the project's Operations Manual. The Principal Secretary (Health and Family Welfare) will lead the Project Executive Committee to provide regular monitoring and necessary approvals for day-to-day implementation of project activities. Given the results focus of the project,

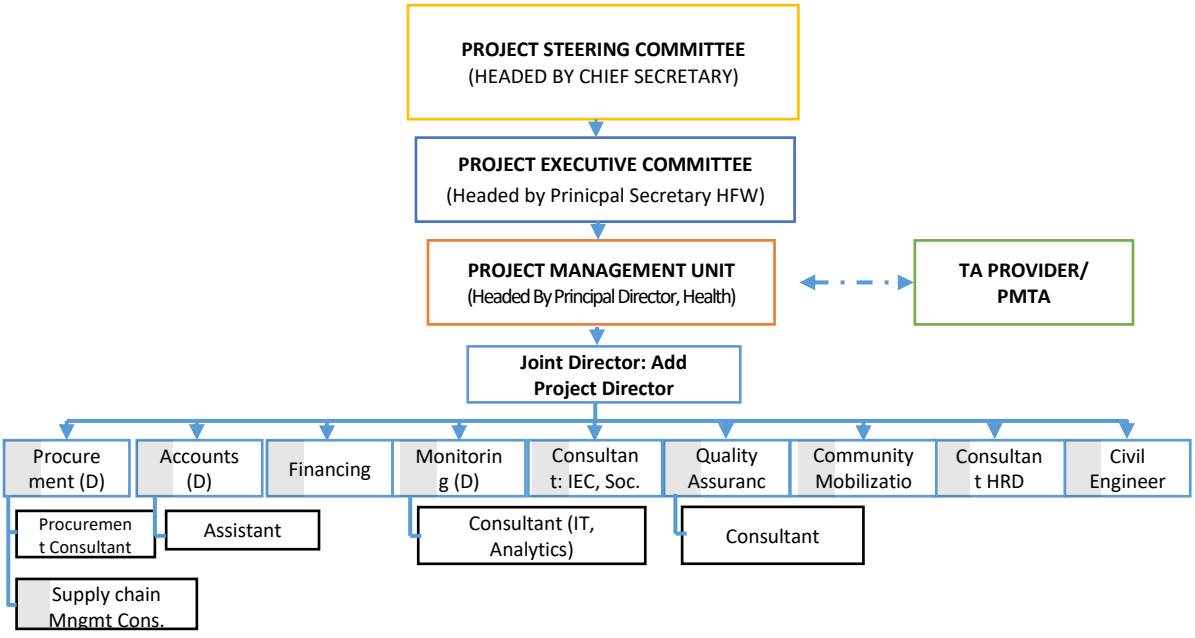
which requires coordinated action by directorates within the DoHFW, the designation of a senior official within the department is critical to effective implementation.

53. **The Principal Director (Health) 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. The PMU will have staff deputed from the two directorates: (a) the Directorate of Health Services (DHS); and (b) the DHME. Approximately 10 staff and consultants will be included in the PMU and will be responsible for procurement and FM; social and environmental safeguards; and technical areas including community mobilization, QA, monitoring, information, education and communication (IEC), human resource development (HRD), and a civil engineer. The PMU's capacity in administrative and technical areas including procurement, FM, hospital quality improvement, management of information systems and other technical areas will be augmented through PMTA (details in para 54). Technical and knowledge partnerships as well as multi-stakeholder engagement will be established to augment technical capacity of the department.

54. To address the capacity constraints, the project will contract the project management and technical agency (PMTA) that will provide the fiduciary support and technical support in different areas of project components. The expanded scope of PMTA will support the various technical work that are needed for implementation of project activities that includes health facility assessment, health insurance and quality assurance work.

55. Additionally, the project will prioritize capacity building of PMU staff in specific areas of fiduciary, procurement, environmental and safeguards.

Figure 2. Implementation Mechanism



56. **The PMU will develop the Operations Manual that will provide guidelines and procedures to be used for implementation of the project.** The Operations Manual will also define the scope and technical specification of the project activities along with the monitoring system. The procedures for administrative approvals and financial

controls will also be well defined to minimize ambiguity and bring efficiency in implementation of the project. The CERC operational manual will be an annex to Operations Manual.

57. Finally, in the context of COVID-19, the limited mobility and travel restrictions will have adverse effect on implementation. The project implementation will adopt to innovative approaches such as frequent virtual meetings, simplified high frequency progress updates and virtual field visits using technology to ensure timely support in project implementation.

B. Results Monitoring and Evaluation Arrangements

58. **The DoHFW will lead the results monitoring and evaluation arrangements of the project.** Within the DoHFW, the PMU will provide overall monitoring, reporting, and benchmarking of the performance under the project. The routine data on the relevant indicators will be collected from all the targeted facilities as per the Results Framework. To provide routine comparison of the progress of the project, information on the key indicators will be collected through the routine system from the health facilities that are not targeted by the project, to provide consistent internal comparisons to monitor the progress. The project will provide six-monthly updates on the progress of the project to the World Bank, coinciding with the financial year of the state and will publish an annual report every year, capturing the progress made against the annual plans. The payment for IPAs will be made after confirming the achievement of results by internal verification by the immediate higher levels in the system (refer to Table 3. Entities and Contracting Relationship under IPAs). Additionally, an independent third-party agency will be contracted to counter verify the IPA results at a mutually agreed periodicity (every six months). This third-party assessment will facilitate taking corrective actions and appropriate administrative steps to address the issues of nonperformance and good performance and measures to reduce the reporting gaps including financial disincentive measures for the IPAs. The project will invest in building capacity of the existing workforce by training them on quality index and NQAS monitoring. The initial investments through an external quality consultant mechanism will be gradually replaced by the above peer reviewers from adjacent districts.

59. **Special studies.** Special studies will be undertaken to augment the project implementation, which includes infrastructure assessment and review of pilot initiatives toward RBF. The project will invest in systematic documentation of the investments from the early months of intervention to document the qualitative aspect of the project and develop knowledge products. In addition, the PMU will produce quarterly project progress reports and annual progress reports to be placed in the state government's website.

60. **Evaluation**. Based on the available information, the baseline data is capturing for the PDO and intermediate indicators. The detail facility level baseline including process and output level data will be collected through a rapid survey in FY20/21. Early midterm project appraisal will be undertaken after two years of project implementation to provide adequate time for course corrections and improvements if necessary. Project indicator targets will be evaluated at the project midterm consistent with the project design and calibrated as needed. The end-term appraisal will be undertaken in the early periods of the final year of the project. In addition, the project will invest in undertaking evaluation of the innovations which include internal contracting, RBF, clinical vignettes, community interventions, and quality improvement investments. These study findings will be disseminated widely, sharing the knowledge with other states.

C. Sustainability

61. **There exists a high level of political commitment and government ownership for improving the health systems in Mizoram.** Mizoram continues to be the highest ranked state among the smaller states in the NITI Aayog health index that measures strength of the health system. As per the National Health Profile 2019, the expenditure on health was 8.3 percent of total state expenditure and 4.2 percent of GSDP, which is higher than the national health policy (2017) goal for 2025, that is, 8 percent and 2.5 percent, respectively, for the same indicators, which also demonstrates the state's commitment to an improved health system. The state is continuously increasing its investment in the health sector with recent budget allocation of INR 500 million toward corpus fund for the state health insurance program and INR 5 billion to manage the increasing burden of cancer through an advanced cancer care institution. The World Bank funding will support the state to realize its vision and further expand its programs. In terms of financing, sustainability of interventions financed out of this investment is estimated to be at approximately 10 percent of the government existing annual outlay for health. The investments in the state is expected to bring better accountability, improve quality of care, and rationalize the required health policy to support a robust health system. Therefore, with improved planning and better resource allocation strategies, sustaining even those interventions that have direct cost implications is not anticipated to be a challenge.

62. **The project investment will complement the ongoing programs, strengthen the public health system, and build the capacity, thus enhancing the sustainability of the interventions.** The project will build upon the state's existing structures for implementation and budget allocation and involve the directorates under Health Department for implementation of the project activities, instead of creating a parallel system. The identification of "Champions" as change agents at different level will maintain the continuity of results-based approach and the exclusive effort for building the capacity of local institutions will sustain the practice of results-based financing beyond the project. Implementation of IPAs will introduce a culture of PBF that will be adapted for resource allocation to districts and health facilities that have strong synergy with the GoI approach of using health index ranking for resource allocation and incentive programs linked to performance. The project will help the state leverage more such grants from the Central Government on the account of better performance.

63. **The effectiveness of the incentive program will determine the sustainability and financing for the continuity of project activities.** The current poor fiscal situation of the state government indicates substantial risk to financial sustainability of activities initiated by the project. However, the commitment and support from the government to operations and maintenance of investments at the local level will be fostered. In a context of continued economic growth, government health spending will continue to grow, so that the amount allocated to these incentives (planned at less than 5 percent of current annual government health spending in the state) should be fiscally sustainable. Upon project completion, activities will be sustained by the state government through the existing framework.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis (if applicable)

Technical Analysis

64. **Despite Mizoram showing significant improvements in health outcomes over the years, its performance is mixed when compared to national averages.** Though the health expenditure as a share of total state expenditure

in Mizoram (8.34 percent in 2015–16[28]) is the highest in the country except Delhi and Puducherry, there are issues on equity, access, and quality of health services as described in section I.B. Focused interventions at the systemic level along with focus on increasing accountability are likely to improve the health outcomes.

65. **Although performance-based incentive is a novel approach for India, it has shown to promote accountability for results in health elsewhere.** Input-based financing of public services detracts focus from outputs and outcomes. The concept of financing results is yet to be institutionalized, though seeds of this approach are already sown within the existing implementation structure. Performance incentives under the NHM and package-based reimbursement of claims under the insurance scheme provide a good launching pad to strengthen RBF of health services. The project proposes to innovate a model of state- and substate-level instrumentalities within the Health Department entering into performance agreements for additional (in addition to input-based financing) financing against agreed results. The Performance Agreements promote accountability for results and will be a major reform in the management setup entrusted with delivering health outcomes. Investments in building the capacity and coverage of the insurance program shall further strengthen the payment mechanism that finances providers for results. In Ghana, Performance-based Management Agreements (PMAs) have demonstrated that they increased commitment, improved teamwork, enhanced local ownership, and ensured prudent use of resources despite insufficient staff training, inappropriate budget allocation, weak monitoring, and lack of consultation in setting PMA targets. Lessons from the global RBF approaches that extensively use IPAs in the public sector have shown that (a) focusing on key public health functions under the control of targeted institutions is essential, (b) clients need to be involved in the design of these IPAs, and (c) IPAs need to be changed regularly (for example, annually) to incorporate lessons learned. These lessons have been factored into the proposed design of the project.[29]

66. **QA mechanisms in hospitals are weak and investments under the project are expected to improve service and infrastructure quality measures.** Review of literature suggests positive impact of hospital accreditation on service quality measures.[30] Therefore, focus of the project on developing QA mechanisms leading to accreditation and incentivizing quality through facility-level RBF is likely to result in improved quality of care by the end of the project period. Once institutionalized, sustainability of the incentive scheme is likely to continue as it will be financed out of a flexible pool of funds available for hospitals under the NHM and under the insurance program, in the form of claims reimbursement amounts. To conclude, through investments in improving management outcomes through RBF, strengthening service delivery, augmenting human resource capacity, improving quality of health services, increasing coverage, and strengthening the health protection scheme, the project will contribute to the higher-level objectives of increasing coverage and quality of health services.

Economic and Financial Analysis

67. **With focus on improving coverage, quality, and capacity (of health systems and services), project investments would have a leveraging effect on achieving better health outcomes from the Government's own investments**

[28] GoI 2019a.

[29] Kanmiki, E. W., et al. 2018. "An Assessment of a Performance-based Management Agreement Initiative in Ghana's Health Service." *BMC Health Services Research* 18 (1): 995; Khim, K., and P. L. Annear. 2013. "Strengthening District Health Service Management and Delivery through Internal Contracting: Lessons from Pilot Projects in Cambodia." *Social Science and Medicine* 96: 241–249.

[30] Devkaran, S., and P. N. O'Farrell. 2015. "The Impact of Hospital Accreditation on Quality Measures: An Interrupted Time Series Analysis." *BMC health services research* 15 (1): 137; Bogh, S. B., A. M. Falstie-Jensen, E. Hollnagel, R. Holst, J. Braithwaite, and S. P. Johnsen. 2016. "Improvement in Quality of Hospital Care during Accreditation: A Nationwide Stepped-wedge Study." *International Journal for Quality in Health Care* 28 (6): 715–20; Avia, I., and R. T. S. Hariyati. 2019. "Impact of Hospital Accreditation on Quality of Care: A Literature Review." *Enfermeria Clinica* 29: 315–20.

in health. Investing in increasing coverage contributes to increase in access. Investing in improving quality of health systems contributes to saving lives, reduces catastrophic health expenditures by households, and benefits the country's economy. The Lancet Commission on High Quality Health Systems estimated that 8 million people per year in low- and middle-income countries die from conditions that should be treatable by the health system. In 2015 alone, these deaths resulted in US$6 trillion in economic losses. Poor quality health care not only contributes to adverse outcomes, but it also leads to excessive OOPE as patients face persistent symptoms, loss of function, and suffering. Furthermore, it contributes to a lack of trust and confidence in health systems, contributing to poor utilization of services.[31] There is thus a strong justification for the proposed program to finance improvements in the quality of health systems in the state. Further, investments in improving HRH and skills are likely to contribute toward increased productivity and better outcomes and returns from these existing investments on health. And increasing coverage under the insurance program will provide protection against catastrophic and impoverishing health expenditure. The development impacts of this investment will be seen in enhanced quality and coverage of health services; improved health outcomes; reduced OOPE, particularly in rural areas; and meaningful community empowerment and engagement to strengthen demand.

68. **Proposed World Bank financing of US$32 million (INR 2.8 billion) for five years is equivalent to around 11 percent of the estimated annual state government spending on health.** This will provide critical investment resources, as the fiscal space for health is severely constrained with only a 2 percent nominal increase in government health spending between 2017–18 (US$72 million; INR 5.54 billion) and 2019–20 (US$73 million; INR 5.66 billion). Most of the government spending on health is devoted to salaries and establishment costs, with limited investments in upgrade of systems and health facilities. The GoI, through the NHM, is investing US$16 million in the state in 2019–20. More than sevenfold absolute increase in the government's nominal health expenditure over the last 15 years (compounded annual growth rate: 14 percent) reveals that not only is the state likely to absorb and sustain the additional financing despite constrained fiscal space, but also the net gains in systems improvement, service quality, and accountability (and therefore population health outcomes) are likely to be higher than the cost of this additional financing.

69. **An intervention is often considered cost-effective if the cost per disability-adjusted life year (DALY) averted is less than three times the national annual per capita income and highly cost-effective if it is less than the annual per capita income.**[32] Given India's per capita GDP of US$2,010 in 2018, the health services to be supported by the project are considered highly cost-effective in terms of their estimated cost per DALY averted. By this measure, maternal and child health services, prenatal and delivery care, immunization,[33] cesarean section,[34] and breast cancer screening[35] are all considered highly cost-effective. This provides a strong justification for proposed investments in improving quality of services as detailed under Component 3 of the project.

[31] Kruk, M. E., et al. 2018. "High-quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution." *The Lancet Global Health* 6 (11): PE1196–E1252.
[32] WHO. 2001. *Macroeconomics and Health: Investing in Health for Economic Development.* Geneva.
[33] Laxminarayan, R., et al. 2006. "Advancement of Global Health: Key Messages from the Disease Control Priorities Project." *The Lancet* 367 (9517): 1193–1208.
[34] Alkire, B., J. Vincent, and J. Meara. 2015. "Benefit-Cost Analysis for Selected Surgical Interventions in Low- and Middle-Income Countries." In *Disease Control Priorities (Third Edition): Volume 1, Essential Surgery*, edited by H. Debas, P. Donkor, A. Gawande, D. T. Jamison, M. Kruk, and C. N. Mock. Washington, DC: World Bank.
[35] Okonkwo, et al. 2008. "Breast Cancer Screening Policies in Developing Countries: A Cost-effectiveness Analysis for India." *J Natl Cancer Inst* 100: 1290–1300.

B. Fiduciary

(i) Financial Management

70. The project will be implemented by the Department of Health and Family Welfare (DoHFW), Government of Mizoram. Commissioner and Secretary at the Secretariat Office of H&FW Department is the Administrative Head of the Department, assisted by the Principal Director, who is the Executive Head of two main directorates i.e Directorate of Health Services (DHS) and Directorate of Hospital and Medical Education (DHME). The Project Management Unit (PMU) will manage implementation of the project, including regular monitoring and supervision. The Principal Director of Health Directorate will be appointed as the Project Director to lead the PMU. The PMU will be in the Department of Health with deputed staff from all three directorates. The finance wing of the PMU is headed by an experienced Senior Accounts officer, deputed from the DoHFW and will report to the project director and will have the overall responsibility of maintaining the financial management system.

71. **Budget, fund Flow and disbursement arrangements:** The project's funding requirements will be provided within the state budget of the DoHFW as a separate budget line under Externally Aided Project. A separate budget head will be created for the project. Once the budget proposal is approved by State Legislative Assembly, Finance Department communicates the same to the Secretary for onward communication to the Principal Director (Project) and Directors.

72. Due to weak financial position of the state, delays in processing payments through the state treasury. It is agreed to ring-fence the funds flow arrangement from the state treasury to the DoHFW, PMU has opened a project specific separate bank account. The Principal (Project) Director is authorized to draw funds and allocate funds as per the Work Plan to the Directors, who are authorized to draw funds and further allocate funds to units. The Directors monitor utilization of funds at their respective units.

73. Regard to incentive grant to contracted Entities/Units/Departments such as DHS, DHME, State Insurance agency, State Quality assurance units, District Health Administration, selected CHCs and PHC will be released by the PMU into separate bank accounts opened for this purpose. The Entities / Units /Departments will maintain cash books and registers to record financial transactions, and expenditure reports will be periodically submitted to the PMU. Internal verification process will be undertaken by the internal verification entities as described in Project operational Manual. Financial management procedures are described in the Project Operational Manual, providing guidance on accounting, internal control, and financial reporting.

74. The project will incur the expenditure though its own funds (through the budget line). The PMU will prepare consolidated quarterly Interim Unaudited Financial Reports (IUFR) based on actual expenditure received from the divisions and from the PIU and reconciled with the State Accountant General.

75. **Audit.** The CAG will be the external auditor for the project. The CAG's office will conduct an annual audit of project financial statements covering sources and uses of funds.

76. **Retroactive financing.** Payments made by the PMU on or after July 1, 2020, for contracts awarded following World Bank procurement procedures will be eligible for retroactive financing up to a limit of US$3.0 million. The PMU will submit a separate IUFR to claim such expenditures.

77. **Risk:** Implementing agency DoHFW has neither prior experience in bank funded project nor implemented any external aided project. Therefore, financial management risk rating for the Project is rated as "Substantial".

(ii) Procurement

78. Procurement for the project will be carried out in accordance with the World Bank Procurement Regulations for IPF Borrowers dated July 2016, revised November 2017, August 2018 and in November 2020, and the provisions stipulated in the Legal Agreement. Procurement will be carried out in accordance with the provisions of the PPSD and the Procurement Plan that may be updated from time to time with the World Bank's approval.

79. The project will involve contracting of services, purchase of goods and equipment, minor civil works and non-consultancy services. The Project Management Unit will include staff responsible for procurement deputed from the Health Directorate who will be supported with additional consultants hired from open market. In addition, a project management consultant agency will provide support to procurement and contract management. Procurement for activities under project will be handled by the PMU.

80. **A Project Procurement Strategy for Development (PPSD) is** currently under preparation. The strategy looks at planned procurement contracts, assesses market & implementation risks, and proposes mitigation measures for the smooth implementation of procurement under the project. A procurement plan shall be prepared that presents the methods, appropriate procurement packages and approaches for procurement under this project.

81. Component 1 will involve incentives to Directorate, District health office, district hospitals, health facilities and community, the use of which will be governed by procedures described in the Project Operational Manual. Procurement procedures may include shopping; local competitive bidding inviting prospective bidders for goods and works located in and around the local community; direct contracting (DC) for small value goods, works, and non-consulting services; and the use of community labor and resources. The Project Operational Manual describes in detail procurement arrangements, methods and procedures for these activities. Contracted consultants will assess the use of the incentives by different levels.

82. **The procurement assessment identified the following risks**: (i) lack of familiarity of procurement staff with the World Bank procurement procedures and policies; (ii) capacity limitations and weaknesses in current procurement practices, delays in decision making (iii) lack of comprehensive internal procurement manuals and, therefore, the need to improve the set of procedures to ensure fairness and transparency in the procurement process; (iv) weaknesses in the procurement review function and resolution of complaints; and (v) the need to build capacity in procurement and contract management. Based on this, the procurement risk is assessed as Substantial.

83. The proposed mitigation measures include: (i) Training of procurement staff on world Bank regulations; (iii) hiring of a Project Management consultancy to support procurement and contract management (iv) adopting a clear and fair complaint handling mechanism and disseminating the results to the bidding community; (v) improving the document filing system; vi) close monitoring with internal and external audits (by the government) and post review of contracts by the World Bank. The project will also assist the government in strengthening procurement and supply chain management systems for the DHFW as a whole.

C. Legal Operational Policies

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

D. Environmental and Social

84. The project will follow the World Bank's Environmental and Social Framework, which consists of 10 Environmental and Social Standards (ESS). From the likely activities of the proposed investment, the environmental and social (E&S) risk is classified as moderate. The project will support strengthening of health systems for human capital development in Mizoram. The relevant ESS are as follows: ESS1: Assessment and Management of Environmental and Social Risks and Impacts, ESS2: Labor and Working Conditions, ESS3: Resource Efficiency and Pollution Prevention and Management, ESS4: Community Health and Safety, ESS7: Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities, and ESS10: Stakeholder Engagement and Information Disclosure.

85. Project activities and interventions will improve management and accountability of the health care system in the state by strengthening the structure and system associated with health care delivery, enhancing capacities of health care providers and health care managers, integrating and improving the HMIS, and improving the quality of and access to health services. In hard-to-reach and remote areas, community-driven and public-private partnership approaches will be introduced to ensure access to and quality of health care services.

86. While most of the interventions have positive social impacts, the key social risks emerge from risk of exclusion and access to services by vulnerable populations in remote and hard-to-reach areas and risk to occupational and health safety issues from repair and renovation activities of health facilities—though small in nature but at dispersed locations. The project does not anticipate any land acquisition and/or involuntary resettlement as the infrastructure improvement activities are limited to repair, renovations, and minor expansion within the existing footprint of the health facilities.

87. With the improved utilization of health services through the project, the quantity of biomedical waste is expected to increase incrementally. Any improper management of wastes including biomedical waste and other hazardous wastes such as plastic waste, e-waste, and so on poses environmental risks. However, the project plans to invest in improving the overall ecosystem for BMWM (both solid and liquid waste wastes) in the state that includes segregation, disinfection, collection, and disposal that largely safeguards the environment and contributes in improving the quality of health service and patient safety.

88. To mitigate these risks, the DoHFW has prepared an ESMF that will guide the project to address the adverse E&S risks and impacts. The ESMF provides guidelines for screening of targeted healthcare facilities (HCF) for environmental and social risks and based on the E&S screening results, further HCF specific ESIAs and ESMPs will be prepared as an when necessary during the implementation of the project. Concerns and needs of the vulnerable groups (including issue of access and exclusion, occupational health and safety, stakeholder engagement and grievance redressal, and so on) will be addressed through the following interventions: (a) prioritizing the health care facilities in backward and difficult-to-reach, remote, and hilly areas and identifying the key barriers in accessing health services along with building awareness; (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 Environmental, Health, Safety Guidelines and GoI norms; and (d) strengthening the grievance redress mechanism (GRM).

89. The Environmental and Social Management Framework (ESMF) also 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 subject. The ESMF also dwells upon instituting the mitigation measures associated with civil works and occupational and health safety measures under the project related to BMWM. Further, ESMF proposes a set of mitigation measures to address the impacts caused by infrastructure repair and retrofitting work proposed under the project. The project will support interventions to make health facilities environmental-friendly and energy efficient including using solar power, conserving water resources through rainwater harvesting and landscaping, and improving public spaces. To ensure gradual phasing of mercury-based medical equipment, the procurement and supply chain management of State will be strengthened.

90. As part of the ESMF preparation and to inform project design, consultations with key stakeholders, including the concerns and requirements of the vulnerable and disadvantaged communities, were sought through virtual consultations through representative organizations/institutions including NGOs/community-based organizations (CBOs) working with them. Further, mechanisms to incorporate their concerns and needs in the project implementation in a continued manner and ways to engage them during the project implementation are detailed in the Stakeholder Engagement Plan (SEP). The SEP has identified and analyzed the project's key stakeholders and interested parties including officials from the DoHFW, various line departments/agencies, Autonomous Development Councils, NGOs/CBOs, traditional leaders, and health service providers; outlined a strategy for engagement; and assessed existing GRMs and information disclosure channels, as well as provision of the necessary measures for addressing identified gaps. The key concerns of the stakeholders arise from lack of doctors, mainly specialists, and nurses; quality of care including community awareness about quality; limited engagement and awareness about health facility committees; and so on. The SEP has set a systematic and inclusive approach for communication and information sharing that will be followed by the different groups of stakeholders. This is in turn expected to contribute to minimizing the potential social risks and impacts of the project and redressal of grievances and concerns. The Environmental and Social Commitment Plan sets out a time frame of measures and actions to ensure that potential adverse project risks and impacts are avoided, reduced, or mitigated.

91. The project's sexual exploitation and abuse (SEA)/sexual harassment (SH) risk has been rated as low as the project will not include any major civil works. 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. It is important to build the capacity of health care professionals by sensitizing them to SEA 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 the DoHFW and in project facilities.

92. Implementation of E&S management will be ensured by strengthening the institutional capacity of DoHFW through PMU as detailed in Institutional Arrangement. The existing DoHFW governance and management structures and departments will be used for project implementation. The DoHFW will house the PMU of the project that will have E&S specialists who will be responsible for overseeing the implementation of E&S activities

including monitoring and reporting aspects. At the health facility level, the Medical Officer in charge will be responsible for E&S due diligence under the guidance of the Chief Medical Officer at the district level.

93. An Environment and Social Commitment Plan (ESCP) and a Stakeholder Engagement Plan (SEP) have also been prepared. These documents, along with ESMF, have been disclosed on the DoHFW website locally in Mizo *[November 24, 2020 and translated versions re-disclosed on February 19, 2021]* and on the World Bank's external website *[December 10, 2020]*. The ESMF, SEP and ESCP may be updated as required during the implementation of the project when the wider stakeholder consultations are conducted.

Climate Change

94. According to the Climate Vulnerability Assessment for the Indian Himalayan Region report, out of India's 12 Himalayan states, Mizoram is the most vulnerable to climate change. The state is annually swept by cyclonic storms, floods, droughts, cloudbursts, hailstorms, landslides and geophysical hazards (Mizoram lies in seismic zone 5 and is prone to earthquake). Extreme precipitation events are expected to increase by 5-10 days in all the regions in the Northeast and the rise of about 1.8°C to 2.1°C in temperature with respect to the 1970s ranges. Also, the number of rainy days is likely to increase by 1-10 days with intensity of rainfall in the region to increase by 1-6 mm/day. This may cause wide alarm in the region as the state is prone to landslides and flash floods which are only aggravated by heavy rainfall due to steep gradient. High vulnerability leaves a region with low capacity to anticipate, resist, cope with or recover from the impact of a climate hazard.

95. A warm and humid climate triggers several vector-borne diseases, such as malaria, dengue and chikungunya. Mizoram is characterized with poor and unsafe drinking water and sanitation facilities which enhances the chances of incidence of water borne diseases. The situation of quality water availability is further worsening during the dry season due to increase of the pathogen loading of the water as well as during the over-precipitation (water contamination via flooding) period due to climate change. Of the Water borne diseases, the incidence of Diarrhoea and enteric fever are quite noticeable in the state. Assuming current emission level continue, there is high chances for deterioration of air quality in urban region as well increased exposure to ozone and other air pollutant including particulate matter projecting an increase in cardio- respiratory morbidity and mortality.

96. The proposed interventions under the project are designed to have a positive impact on building resilience of the beneficiaries through health system strengthening initiatives—at state, district, health facility, and community levels—these interventions will improve the quality of the service delivery in light of aforementioned hazards and improve the coping capacity of the health system when faced with an extreme event.

97. **Climate adaptation and mitigation activities.** The health facilities in the state are highly vulnerable to the impacts of climate change, and frequent disasters such as floods or landslides. As a result, it is expected that health service delivery will be compromised. Therefore, it is crucial to make these facilities resilient to the risks of disaster and climate change to ensure continuous access to and delivery of health services to the population. The activities designed under the project supports improvements in both the existing infrastructure and build capacity of human resources to tackle the issues. While the component 1 will ensure that the performance metrics include climate smart measures such as LEDs, energy-efficient appliance, health center staff trained on climate and disaster related issues, etc.; component 2 will sensitize the vulnerable sections to cope in case of any natural disasters or protracted crises associated with the impact of climate change such as floods; and component 3 will specifically focus on training the health cadre on emergency response systems and build their knowledge on climate-induced

diseases. The project includes several climate adaptation and mitigation measures to address the health-related vulnerabilities:

- Under the NQAS accreditation process, the performance indicators will include- (i) a comprehensive plan for BMWM (including segregation, collection, treatment, and disposal) as a critical element of infection control and to minimize negative impacts to the ecosystem and reduce population risk of exposure to diseases caused by an unsanitary environment; (ii) use of energy-efficient bulbs for lighting and energy-efficent appliances to reduce energy requirements while improving efficiency; (iii) reporting and documentation, and clinical skills of the medical staff including knowledge enhancement on climate-related diseases and disasters and (iv) availability of power backup in health facilities in case of any disaster event. The performance metrics will include these indicators to ensure that the health centers are well equipped for service delivery in case of any extreme event.

- The retrofitting and upgrade of health facilities will explore opportunities to use solar power as a clean and efficient energy source. Rainwater harvesting will also be prioritized for making health facilities cope with water availability issues due to projected droughts in the state. Renovation of health infrastructure will follow the principles of energy-efficient, disaster-resilient and climate-smart buildings such as use of LED bulbs, energy efficient appliance, use of local resources, etc. The project activities will also prioritize the use of energy-efficient storage facilities for temperature sensitive medical supplies at health centers and implement interventions in strengthening the procurement and supply chain. These improvements will ensure that the health care infrastructure is climate smart and can withstand anticipated impacts of any disaster event.

- Under Component 3, the HRH sub-component includes capacity building of the health workers to improve the knowledge and coping capacity of the health system when faced with an extreme event and climate-related diseases. This will also address issues arising out of climate change and pandemic such as emergency preparedness and response system, improving health service governance, and workforce training to ensure safe health service delivery during such events.

Citizen Engagement

98. The project includes several initiatives aimed at strengthening citizen engagement and improving the health system accountability mechanism. These include (a) capacity building of the administrative and service delivery staff to facilitate change management and effective use of information systems; (b) strengthening of the facility-level health management committee with community representatives implementing their facility development plans; (c) awareness building on the state health insurance scheme and other aspects of health services under the project; (d) use of community engagement indicators as part of the health care facilities' internal performance measurement score under PBF, which include (i) displaying citizen charter, (ii) adopting administration of patient rights forms to all in-patient admission and invasive procedures, and (iii) patient engagement by enhancing patient counselling on NCDs; and (e) support for establishment of systems for effective community engagement, particularly involving women representatives at the local level, including in planning, decision-making, and monitoring of the services of target HWCs. The project will also support annual disclosure of performance scores of the health facilities at the DoHFW's website, which will strengthen citizens' trust in the health system. This will be further strengthened with a more comprehensive SBCC strategy that includes multiple layers of engagement with target communities, patients, health service providers, and policy makers. In addition, a patient experience questionnaire will be developed to capture and monitor patient experience at the secondary care health facilities.

99. The feedback loops between citizens and providers will be strengthened through the patient experience questionnaire, and the feedback loops between providers and the state will be strengthened through the internal performance monitoring system. These are also an intermediate results indicator feeding to the PDO-level indicator on 'Improving quality of health service by investing in health systems and HRH'. The community empowerment will be achieved through strengthening the facility-level health committees, which is also an intermediate results indicator for the PDO indicator on 'Improving accountability and governance of health services'.

V. GRIEVANCE REDRESS SERVICES

100. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VI. KEY RISKS

101. Overall risk is rated Substantial. Although some of the activities to be supported by the project are new to the state government, the required institutional basis is in place and functioning. Substantial implementation risks largely stem from currently insufficient systems, experience, and capacities for implementation and risks of corruption and implementation delays due to possible pressures from political actors in the state. These risks will be mitigated by contracting a project management agency and ensuring clarity on implementation procedures. The risks and mitigation measures are detailed in the following paragraphs.

102. **Political and governance.** There is a risk that project resources could be used for purposes other than intended. The state government has created a PSC, chaired by the chief secretary, to provide high-level ownership of the project. Consultation during preparation has fostered broad consensus across the state government on the objectives and activities of the project. Consultants providing technical and management support will reduce outside pressures on state government officials implementing the project. Procurement and financial procedures have been agreed in detail in the project's Operations Manual. Political and governance risk is rated Moderate.

103. **Macroeconomic**. The macroeconomic risk is rated as moderate. The economic contraction brought about by the COVID pandemic has significantly affected subnational finances (through a combination of reduced revenues and heightened expenditure needs). However, the residual macro-fiscal risk to the achievement of project objectives is limited to the extent that this is an investment loan with small percentage of counterpart funding (USD 8m).

104. **Technical design of project or program.** Some parts of the project, notably the IPA through RBF, may be sufficiently complex to pose design and implementation risks. To manage this risk, project activities are well-defined and limited to clearly feasible activities. Several new strategies (IPAs, participatory planning for development of district hospitals, and reforms in the health insurance program) will be implemented in a phased manner, with learning from the first phase applied to subsequent scale-up. Design of project-supported activities was substantially supported by World Bank-executed nonlending TA in the region and outside. The project will contract necessary technical expertise during implementation to mitigate the risk. Further, towards the second year of implementation, the project proposes to use drones for emergency supplies in difficult or far-to-reach areas. A complete scope of this activity is yet to be defined and detailed risk assessment is yet to be completed. However, before drones are used or procured under the Project, the task team shall undertake a risk assessment and ensure that all mitigation measures are in place. The risk in this area is rated Substantial.

105. **Institutional capacity for implementation and sustainability risk is Substantial.** This is the first health project supported by the World Bank in the state, and hence, there is strong commitment to and ownership of the project by the Government of Mizoram. The state's fiscal situation may reduce its ability to provide counterpart funding. Cumbersome procedures may delay funds flow from the state treasury to the project. To mitigate this risk, the state government has created the necessary project implementation structures and is using a Project Preparation Advance to support preparatory and start-up activities. Consultants will provide technical and management support. Moreover, streamlined procedures are agreed in the project's Operations Manual. The state treasury will provide an advance to the project account. Institutional strengthening of the DoHFW, especially the PMU, will be undertaken. Additional consultant support in operational and technical areas will be provided by the project. In addition, the risk will be mitigated by intensive project support and monitoring by the World Bank team to ensure achievement of desired results. Additionally, due to COVID the continued 'lockdown' will have adverse effect on the project implementation and the task team will provide handholding support through a team of local consultants to minimize its impact on the project.

106. The fiduciary risks stem largely from currently insufficient systems, experience, and capacities for implementation and governance-related risks. These risks will be mitigated by contracting necessary capacity to support the PMU as well as ensuring clarity on implementation procedures. A Project Preparation Advance of US$1 million will be used to put in place essential implementation capacities, including PMU consultants and contracting of project management and technical support agency. The risk in this area is rated Substantial.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: India
Mizoram Health Systems Strengthening Project

Project Development Objectives(s)

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

Project Development Objective Indicators

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
To improve management capacity and quality of health services in Mizoram.							
The percentage point increase in average performance score in targeted administrative units as per internal performance agreement from baseline. (Percentage)		0.00	5.00	10.00	15.00	15.00	20.00
Cumulative Number of districts hospitals which are NQAS certified (Number)		1.00	2.00	3.00	5.00	7.00	8.00
The percentage point increase in average quality index score for CHCs and PHC from baseline. (Percentage)		0.00	5.00	10.00	15.00	15.00	20.00
The percentage point increase		0.00	5.00	10.00	15.00	20.00	25.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
in score among those who participated in clinical vignettes. (Percentage)							
Improve management and efficiency of Health insurance program by Convergence between the MHCS and PMJAY. (Text)		Fragmented benefit package. Fragmented operational systems and processes. State scheme is not cashless and is paper-based.	Design and assessment of workflow; Unified benefit package.	Converting MHCS into Paperless process and aligned with PMJAY	Development of upgraded management systems and processes. State scheme becomes cashless.	Training of all district and State level staff on newly designed management system.	ISO certification of insurance agency and Integrated beneficiary database.

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Strengthen Management and Accountability through Internal Performance Agreements.							
Percentage of administrative units and facilities signed internal performance agreement. (Percentage)		0.00	70.00	80.00	90.00	95.00	100.00
Percentage of internal performance agreements reviewed as per the operational manual. (Percentage)		0.00	80.00	90.00	95.00	100.00	100.00
Percentage of targeted facilities and administrative units that receive performance		0.00	80.00	90.00	95.00	100.00	100.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
payment, as per operations manual. (Percentage)							
Percentage point increase in average patient satisfaction score in targeted health facilities. (Percentage)		0.00	5.00	15.00	20.00	20.00	25.00
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		14,753.00	15,744.00	32,479.00	50,205.00	68,922.00	88,630.00
Number of deliveries attended by skilled health personnel (CRI, Number)		14,753.00	15,744.00	32,479.00	50,205.00	68,922.00	88,603.00
Percentage point decrease of targeted health facilities reported stock-out of essential drugs. (Percentage)		0.00	20.00	20.00	15.00	10.00	10.00
Improve Design and Management of the State Health Insurance Programs.							
Percentage households covered under health insurance scheme. (Percentage)		50.00	60.00	60.00	70.00	70.00	70.00
Percentage point increase of women headed households covered under health insurance scheme. (Percentage)		0.00	5.00	10.00	15.00	15.00	20.00
Percentage of claims for which post payment medical audit has been done. (Percentage)		0.00	3.00	4.00	5.00	6.00	6.00
Percentage of local fund utilization (including		0.00	20.00	40.00	60.00	80.00	80.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
performance grants and Insurance reimbursements) in targeted hospitals. (Percentage)							
Percentage of claims settled within agreed turnaround time. (Percentage)		50.00	55.00	60.00	70.00	80.00	90.00
Enhance Quality of Health Services and Support Innovations.							
Percentage of medical doctors and nurses from targeted facilities participated in clinical vignettes. (Percentage)		0.00	20.00	50.00	80.00	90.00	90.00
Average score for bio medical waste management in targeted health facilities at district, CHC and PHC level. (Percentage)		0.00	10.00	15.00	20.00	25.00	30.00
Percentage of targeted facilities have developed / revised quality improvement plan in last quarter. (Percentage)		0.00	80.00	80.00	85.00	90.00	95.00
Percentage of targeted facilities where quality scoring was done by higher level in last quarter. (Percentage)		0.00	80.00	80.00	85.00	90.00	95.00
Percentage of targeted facilities trained on public health system emergency response. (Percentage)		0.00	30.00	45.00	65.00	90.00	100.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
The percentage point increase in average performance score in targeted administrative units as per internal performance agreement from baseline.	Numerator: average performance score in targeted units – baseline average performance score *100 Target= 15 administrative units [5 State level and 10 district level]	Quarterly	Internal contract tracking system	Quarterly Internal Project review by project management unit.	Project Management Unit, Department of Health and Family Welfare.
Cumulative Number of districts hospitals which are NQAS certified	Numerator: Number of Targeted Health Facilities who have received unconditional national quality assurance certificate. Target= 9 District hospitals	Quarterly	Quality Division: Directorate of health, Mizoram	Certificates issued by Ministry of Health and Family Welfare, Government of India	Project Management unit, Quality Division: Health and Family Welfare Department, Mizoram
The percentage point increase in average quality index score for CHCs and PHC from baseline.	Numerator: average Quality Index score in targeted health units – baseline average quality index score *100 Target= 9 DH + 2 SDH + 9 CHC + 39 PHC	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Finance Division and MHIS, Health and Family Welfare Department
The percentage point increase in score among those who participated in clinical vignettes.	Numerator: average clinical vignette score core in health units (DH + CHC + PHC) by the state – baseline average clinical vignette score *100	Quarterly	Project Management unit: Internal MIS	Quarterly Internal Project review by project management unit.	Project Management Unit, Health and Family Welfare Department, Mizoram

	Target= Doctors and Nurses in all notified health facilities (9DH + 2 SDH + 9 CHC + 63 PHC)				
Improve management and efficiency of Health insurance program by Convergence between the MHCS and PMJAY.	Year-1: Unified benefit package (the benefits may differ based on the nature of subscription, but will be under single system) Year-2: Aligning operational processes under MHCs (paper-based) with the PM-JAY (paperless & cashless) leveraging technology and IT-based integrated architecture. Year3: Approval and notification of integrated standard protocols and operating procedures for all schemes Year 4: (a) Training of state and district level staff on new system, & (b) integrated verified beneficiary database Year-5: ISO certification of the Mizoram Health Care Society	Every six months	Management Information system: Mizoram Health Insurance	Combinations of all the government run insurance schemes under directorate of health	Mizoram Health Insurance scheme

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Percentage of administrative units and facilities signed internal performance agreement.	Numerator: Number of administrative units and targeted health facilities which have singed the internal performance contract Denominator: state level- 5 Units (HR, Health Insurance, Bio Medical waste, Quality Assurance, Community mobilisation) 10 Districts, 9 District Hospitals, 2 SDH, 9 CHC, 39 PHC	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Project Management Unit, Health and Family Welfare Department, Mizoram
Percentage of internal performance agreements reviewed as per the operational manual.	Numerator: Number of administrative units and targeted health facilities which have internal performance contract reviewed Denominator: Number of administrative units and targeted health facilities that has signed the internal performance contract Target: 5 State+ 9 Health District + 9 DH+2 SDH +9CHC+63 PHC	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Project Management Unit, Health and Family Welfare Department, Mizoram

Percentage of targeted facilities and administrative units that receive performance payment, as per operations manual.	Numerator: Number of targeted administrative units and facilities having quality assessments done through Quality Index tool and paid within 60 days of the end of the quarter Denominator: Number of Targeted Health Facilities	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Finance Division
Percentage point increase in average patient satisfaction score in targeted health facilities.	Numerator: average patient satisfaction score- patient satisfaction score in baseline *100 Targeted facilities: 9 District Hospitals, 2 SDH, 9 CHC, 39 PHC	Quarterly	Review of minute of last quarterly meeting	Quality Assurance Division, Directorate of Health	Project Management unit, Quality Division: Health and Family Welfare Department, Mizoram
People who have received essential health, nutrition, and population (HNP) services		Quarterly	HMIS	HMIS	Health and Family Welfare Department, Mizoram
Number of deliveries attended by skilled health personnel		Quarterly	HMIS	HMIS	Health and Family Welfare Department, Mizoram
Percentage point decrease of targeted health facilities reported stock-out of essential drugs.	Numerator: Number of targeted health facilities having stockout essential medicines, as reported in the HMIS (none reporting to be considered as stockout) Denominator: Number of Targeted Health Facilities	Quarterly	Existing-Health Management Information system	Quarterly Internal Project review by project management unit.	Project Managment Unit, Health and Family Welfare Department

Percentage households covered under health insurance scheme.	Numerator: Number of Families enrolled and given smart card for health insurance*100 Denominator: Estimated Number of families in the state at the beginning of the project	Every six months	Management Information system: Mizoram Health Insurance	Combinations of all the government run insurance schemes under Directorate of Health.	Mizoram Health Insurance scheme
Percentage point increase of women headed households covered under health insurance scheme.	Numerator: Number of Families (headed by women) enrolled and given smart card for health insurance*100 Denominator: Total number of families enrolled in the health insurance	Every six months	Management Information system: Mizoram Health Insurance	Combinations of all the government run insurance schemes under Directorate of Health.	Mizoram Health Insurance scheme
Percentage of claims for which post payment medical audit has been done.	Numerator: Number of Claims for which post payment audit report is submitted in last quarter Denominator: Total number of claims submitted in last quarter	Quarterly	Training report Mizoram Health Insurance	Quarterly Internal Project review by project management unit.	Project Management Unit, Health and Family Welfare Department, Mizoram
Percentage of local fund utilization (including performance grants and Insurance reimbursements) in targeted hospitals.	Numerator: Total booked expenditure Denominator: Total funds received* by the targeted facility during last quarter * Funds received from NHM, State, Insurance, world bank project and user fee, if any	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Finance Division and MHIS, Health and Family Welfare Department

Percentage of claims settled within agreed turnaround time.	Numerator: Number of claims for which the money has been transferred to beneficiary Denominator: Number of claims submitted Target: 30 days turnaround time	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Finance Division and MHIS, Health and Family Welfare Department
Percentage of medical doctors and nurses from targeted facilities participated in clinical vignettes.	Numerator: Total number of Doctors and Nurses in the targeted health facilities who have received at least one clinical vignette score in the last quarter Denominator: Total number of permanent doctors and nurses + 50% of contractual doctors and nurses in targeted health facilities in the same quarter	Quarterly	Clinical Vignette tracking system	Quarterly Internal Project review by project management unit.	Project Management Unit, Health and Family Welfare Department, Mizoram
Average score for bio medical waste management in targeted health facilities at district, CHC and PHC level.	Numerator: Biomedical waste score* under Quality Index in targeted health facility Denominator: Number of Targeted Health Facilities DH-9, SDH-2, CHC-9, PHC-39 * Bio medical waste management: Color coded bins with cover [one each in OPD, each Ward, OT,	Quarterly	Project Management unit: Internal MIS	Quarterly Internal Project review by project management unit.	Project Management Unit, Health and Family Welfare Department, Mizoram

	Dressing, Injection room, emergency, labor room and lab], Needle cutter, Hypochlorite solution in laboratory. Mops with bucket and disinfectant. [separate for each OT, labor room] and general patient care including ward. Daily Collection of waste and mopping [schedule]. Treatment of infectious waste: [hypochlorite for sharps], microwave/autoclave. Functional sharps pit and deep burial pit with cover [no spillage outside] (All or None).				
Percentage of targeted facilities have developed / revised quality improvement plan in last quarter.	Numerator: Number of targeted health facilities which have submitted the annual plan and all quarterly revisions Denominator: Number of Targeted Health Facilities; DH-9, SDH-2, CHC-9, PHC-39	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Project Management unit, Quality Division: Health and Family Welfare Department, Mizoram
Percentage of targeted facilities where quality scoring was done by higher level in last quarter.	Numerator: Number of targeted health facilities which are visited and scored using Quality Index tool by district quality management	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Project Management unit: Quality Division: Health and Family Welfare Department,

	team and showing at least 10% point improvement from the previous quarter performance Denominator: Number of Targeted Health Facilities, DH-9, SDH-2, CHC-9, PHC-39				Mizoram
Percentage of targeted facilities trained on public health system emergency response.	Numerator: Number of targeted health facilities trained in responding to natural disaster and disease outbreaks/epidemics Denominator: Number of Targeted Health Facilities; DH-9, SDH-2, CHC-9, PHC-39	Quarterly	Project Management unit: Internal MIS-new	Quarterly Internal Project review by project management unit.	Directorate of Research, Health and Family Welfare Department, Mizoram

ANNEX 1: Adjustments to the Country Program in Response to COVID-19

1. **In India, the pandemic and the national lockdown between March-May 2020 affected economic activity, with real GDP contracting by nearly 24 percent in Q1 FY21 (April-June 2020).** Until mid-March 2020, India was impacted indirectly via trade channels, as key imported inputs to domestic production were impeded, supply chains were disrupted, and global trade slowed. As of March 25, the GoI implemented a country-wide 'lockdown' to contain domestic contagion, and several states imposed additional curfew measures. As a result, economic activity, particularly industry and services, slowed sharply.

2. **According to the World Bank's latest forecast, economic growth is expected to decline to -9.6 percent in FY21 and recover gradually thereafter. The financing needs of the GoI are expected to rise significantly.** The sharp economic slowdown has affected revenues disproportionately (at central and state levels), with central government revenues declining by over 40 percent in the April-July period and states facing a shortfall of a similar magnitude. At the same time, expenditure needs have risen. As a result, the general government deficit is expected to rise above 12 percent in FY21 and Public and Publicly Guaranteed debt to reach above 90 percent. The bulk of the required financing is expected to be sourced from domestic markets which for the moment have sufficient liquidity, with only a minor contribution from international borrowing.

3. The COVID-19 pandemic has exacerbated the vulnerabilities for traditionally excluded groups, such as youth and women. In addition, interstate migrants are at risk of increased poverty and destitution. Estimates from the Economic Survey highlight that the magnitude of inter-state labor migration in India was close to 9 million annually between 2011 and 2016 and migrant remittances in lower-income states like Bihar accounted for 35.6 percent of gross state domestic product (GSDP) in 2011–12. MSMEs that account for the largest non-farm employment (30 percent) with about 20 percent female participation are considered to have been impacted the most due to lockdown.

4. **The GoI has unveiled a response package corresponding to 10 percent of GDP, including:**

   - **Pradhan Mantri Garib Kalyan Yojana (PMGKY), to protect the poor and vulnerable impacted by Coronavirus Containment Measures**, expected to cost approximately $23 billion.
   - **MSME support** includes Emergency Credit Line Guarantee Scheme for INR. 3 trillion[36] , INR. 200 billion subordinate debt for stressed MSMEs, INR. 100 billion to provide equity funding for MSMEs with growth potential and change in the definition of MSMEs, by increasing investment limits and firm turnover, to help incentivize firms to grow.
   - **Agriculture infrastructure** fund - proposed financing facility of INR. 1 trillion (to be funded by NABARD) to promote post-harvest management infrastructure and, Micro-food enterprise - INR. 100 billion for technical upgrade and promotion of clusters of local products.
   - **Outlay of Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)** - a universal employment guarantee program, is increased by INR. 400 billion.
   - **Increased state government borrowing-limit,** from 3 percent to 5 percent of GSDP (additional INR. 4.28 trillion).
   - **Long- Term Repo Operations (LTROs) and Special Liquidity window:** To alleviate cash flow pressures, the Reserve Bank of India has conducted LTROs and Targeted LTROs for a total amount of INR. 9.6 trillion

[36] Details: *https://pib.gov.in/PressReleasePage.aspx?PRID=1625306.*

(about 4.5 percent of GDP) since February 2020. Moreover, a Special Liquidity Facility for mutual funds of INR. 500 billion was opened on April 27, 2020, to ease liquidity pressures on mutual funds.

WBG support for responding to the crisis

5. **In alignment with its global response, the WBG has been closely supporting GoI's strategy, which consists of three phases.** In the first phase, the GoI tackled the health aspects, and partnered with the Bank for a $1 billion health project. In the second phase, GoI invested $23 billion in social protection program to support the poor and vulnerable communities during the lockdown, and the Bank provided financing of $750 million. In the third phase, GoI focused on economic stabilization and reducing the costs of the lockdown. This includes support to MSMEs and their workers during lockdown by committing about 1.5 percent of GDP to MSME finance. The Bank financing of $750 million is supporting this program to provide liquidity for their balance sheets, to mitigate against potential solvency problems and job losses, and to lay the foundations for a stronger MSME financing ecosystem in the recovery phase.

6. Additionally, the Bank activated the Contingent Emergency Response Component (CERC) in five projects to support the state governments' COVID-19 relief efforts. Moreover, many projects made special provisions for COVID-19 Assistance Packages within their project scope. Going forward, the Bank will be supporting the GoI under the following broad themes:

   i. **Saving lives**: Other than the ongoing healh programs, the Bank is a potential partner with GoI on its flagship program of Atmanirbhar Swasth Bharat Yojna which aims at strengthning the health sector in the country by strengthening healthcare services, health emergency preparedness and response and strengthen core capacities as per the International Health Regulations. In addition, the Bank is exploring innovative ways of support to the state and central governments through upcoming operations in the education (Andhra Pradesh, Gujarat) and health (Mizoram, Meghalaya) sector.

   ii. **Protecting poor and vulnerable people** The Bank will further support the efforts of the GoI under this pillar through the Development Policy Lending-II for social protection with a loan of $250m. This second phase of the Social Protection program is intended to enhance coordination across schemes and ministries to build a disaster-responsive social protection system and expand the ability of India's safety nets architecture to cater to diverse needs across states and vulnerable groups. Some upcoming projects have specific COVID-19 components supporting this pillar - Chhatisgarh Inclusive Rural and Accelerated Agriculture Growth and Fisheries Sector COVID-19 Response and Recovery.

   iii. **Sustainable growth and job creation**: The Bank is preparing for a project on raising and accelerating MSME productivity which will focus on strengthening institutions and markets to enhance MSME productivity. Job creation is a special focus under the infrastructure projects as well.

   iv. **Strengthening policies, institutions and investments for rebuilding better**: This is an all encompassing theme under India CPF and is integrated in most of the projects. The upcoming engagement with the National Disaster Management Agency on Seismic Risk Mitigation Project is one such example.

7. The IMF does not have an active lending program in India. However, it undertakes regular macroeconomic supervision and Article IV consultations twice yearly. The Bank and IMF teams regularly exchange views and information. The partnership with other donors was brought to fruition in both the Social Protection and MSME COVID-19 response DPLs. Within the Social Protection DPL, the Bank has worked in

collaboration with the Asian Development Bank (ADB), Agence Française de Développement (AFD), and Kreditanstalt Fuer Wiederaufbau (KfW). The Japanese International Cooperation Agency (JICA), Asian Infrastructure Investment Bank (AIIB), the New Development Bank (NDB) and International Fund for Agriculture (IFAD) are also exploring potential parallel financing in upcoming operations. Discussions are ongoing to expand the World Bank's TA through additional funds from the Bill and Melinda Gates Foundation (BMGF) and the United Kingdom's Foreign, Commonwealth and Development Office (FCDO).

ANNEX 2: Project Component Description

COUNTRY: India
Mizoram Health Systems Strengthening Project

Project Components Description

1. **The project is structured in four components.** The first three components will address different parts of the PDO (management capacity and quality of health services) and the fourth will be a CERC. Component 1 will focus on strengthening the accountability through IPAs and creating an environment for reforms and implementation efficiency. This component will focus on reforms in the governance and management structure to increase accountability through IPAs between the DoHFW and its subsidiaries at the state and substate levels. This ecosystem of increased accountability shall create an enabling environment for investments. Component 2 will invest in the state insurance program to improve its coverage and effectiveness by supporting the state insurance program and its links with AB-PMJAY to reduce financial barriers in accessing hospital services, prevent catastrophic OOPE for health by poor families, and expand coverage. For this, architectural corrections are required in the two health insurance schemes that are running in parallel. Component 3 will focus on system development and quality improvements, augmenting systems related to human resource management, BMWM, and project management capacity. With the accountability structures and systemic capacity in place through the previous two componets, Component 4 will provide a vehicle for financing of immediate response to an eligible crisis or emergency.

2. **The project will follow principles agreed with the MoHFW and Department of Economic Affairs where it will not duplicate existing activities of the state health system and NHM or set up a parallel monitoring system**. Rather, the project will support and complement the existing health systems, including the HMIS and other implementation mechanisms involved at different levels under the NHM. The state health system will continue to hold primary responsibility for delivery of health services to the population, including ensuring key inputs such as human resources, infrastructure, equipment, medicines, and other consumables.

Component 1: Strengthen Management and Accountability through Internal Performance Agreements (cost US$13.5 million)

3. This component will focus on reforms in governance and management structures to increase and accountability using IPAs as a tool that will be signed between the DoHFW and its subsidiaries at the state and substate levels. Performance-based contracts and RBF are proven to have a positive impact on improving the health financing and service delivery, and it has the potential to catalyze comprehensive reforms in addressing structural problems of overall public health functioning. Therefore, institutions at different levels 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 health insurance program and quality of health service.

4. Component 1 will involve incentives to directorate, state health insurance program, district health offices, district hospitals, and health facilities, the use of which will be governed by procedures described in the project's Operations Manual. Procurement procedures may include shopping; local competitive bidding inviting

prospective bidders for goods and works located in and around the local community; DC for small-value goods, works, and non-consulting services; and the use of community labour and resources. The project's Operations Manual describes in detail procurement arrangements, methods, and procedures for these activities. Contracted consultants will assess the use of the incentives by different levels. The detail design of RBF and activities are provided in annex 3.

Component 2: Improve Design and Management of State Health Insurance Programs (US$2.5 million)

5. This component will support the state insurance program and its links with AB-PMJAY to reduce financial barriers in accessing hospital services, prevent catastrophic OOPE for health by poor families, and expand coverage. For this, architectural corrections are required in the two health insurance schemes that are running in parallel. The project will finance investments in such corrections at three levels: (a) strengthening policy and design for increased operational efficiency; (b) strengthening institutional capacity, systems, and processes of the state insurance agency for greater accountability; and (c) community interventions for improving coverage and demand.

6. The state government is implementing the MSHCS, a social health insurance scheme that started in 2008 and purchases (from public and private hospitals) a package of tertiary health care services for bona fide residents of Mizoram as beneficiaries. The scheme is administered by the Mizoram State Health Care Society, a society registered under the Firms and Societies, Government of Mizoram. A benefits package and reimbursement schedule for the selected procedures have been determined, and 82 government hospitals and 70 private hospitals within state (28) and outside state (42) have been empaneled. Beneficiaries (BPL) under the MSHCS avail benefits for all hospitalized ailments, while APL families avail benefits only for selected critical illness, though the total sum insured amount was INR 300,000. Under the MSHCS, beneficiaries have to enroll themselves against an annual enrollment fee. APL beneficiaries must pay an annual enrollment fee of INR 1,000 per family. Until 2018, enrollment was free for BPL families. An enrollment fee of INR 100 is charged from 2019. The total revenues mobilized in 2019–20 through enrollment fees was INR 43.6 million, whereas the total claims reimbursement was estimated at INR 350 million. The share of revenues mobilized from BPL families is merely 2.4 percent of the total revenues mobilized through enrollment fees. Beneficiary contributions are merely 12 percent of the total claims payout, resulting in the scheme being predominantly financed by the state out of general taxes. Beneficiary contributions are used for administrative expenses of the state insurance agency.

7. The scheme is being implemented on a reimbursement basis and payments are made according to the Mizoram-notified rate. There is no system for preauthorization of cases except for cases that seek treatment in hospitals outside the state. However, two bodies have been set up at the state level: a Screening Board and a State Medical Board that review the cases and recommend authorization.

8. The Government is also implementing AB-PMJAY, which provides the total sum insured amount of INR 500,000. A benefits package and reimbursement schedule for over 1,500 procedures have been determined, and 89 government hospitals and 13 private hospitals have been empaneled. To maximize benefits, the beneficiary uses multiple schemes according to the kind of service needed and the cost of treatment.

9. Though the state is implementing the health insurance for a long time with most of the operations being handled internally by the society, there are several challenges that limit the overall functioning and efficiency of the health insurance program. The key challenges are as follows:

(a) **Institutional capacity and systems hampering the service delivery**. The implementation agency has limited human resources and a poor governance system. It also lacks a monitoring system and regulations to control the enrollment of beneficiaries and service providers. As a result, regular surveillance is not done, claims management/review is inadequate, monitoring and evaluation of network hospitals is not done to maintain quality, IEC is limited, which hampers enrollment, a fraud control system is absent, and the GRM is neglected. Hence, the utilization evaluation and review including preventive measures are not taken at the state level.

(b) **Higher risk burden on the state with poor financial sustainability.** Both the schemes are implemented under the assurance mode under which the state bears the risk and directly reimburses claims to the empaneled hospitals. The state scheme is dependent on interests earned out the corpus, which is limited, and periodic funds from the state government to augment the corpus (approximately INR 300 million has been contributed by the state to the MSHCS corpus in addition to annual transfers for reimbursement of claims). As a part of partial cost recovery, the state charges an annual enrollment fee of INR 1,000 per year per APL family. From 2019–20, the state has also started levying a nominal INR 100 per year per BPL family. The enrollment fee has become a barrier to access the scheme, especially for the poorest of the poor families. There is limited scope for increasing the enrollment fee and the corpus created for running the society may not sustain the operating cost for long. The state needs to be more strategic in terms of bringing the financial sustainability in the program by improving efficiency and strategic purchasing of services.

(c) **Poor system for preauthorization for treatment outside the state under the state scheme leads to weaknesses resulting in higher claims being paid to hospitals empaneled outside the state.** The average claim size for treatment outside the state is approximately INR 78,000 as against treatment at private hospitals in the state where the claim size is approximately INR 38,000. There is no system for preauthorization of cases except for prior approval of cases that seek treatment in hospitals outside the state. A Screening Board and a State Medical Board are established at the hospital and state levels, respectively, and make decisions on referring cases outside the state. Though there is limited objectivity in decision-making, the Screening Board verifies the medical reports and recommends the case to the State Medical Board. Patients are at liberty to go to any private hospital, which results in higher treatment expenditures.

(d) **Lack of monitoring system using IT.** The state-run health insurance program has inadequate IT-based reporting systems and hence they are highly dependent on paper-based reporting, which affects efficiency and delays the reimbursement of claims (reimbursement period varies between one and three months). On the other hand, the empaneled public hospitals have low capacity and infrastructure to maintain records and hence are unable to submit their claims on time. A robust information technology platform is a critical requirement that needs to be implemented across all levels.

(e) **Poor coverage data to target the beneficiaries.** Currently, there are no data available to define the target population. The population and the households covered under different health insurance programs are not captured in a single database, which makes it difficult to have targeted interventions to improve the coverage under government-run health insurance programs. On the other hand, this is a major equity issue between the rural and urban coverage, and the coverage in urban areas is much higher against the population than in rural areas.

10. The strengthening of health insurance program will include strengthening, monitoring, and verification functions; cost analysis and rationalizing packages and rates; improving follow-up care; conducting activities to improve awareness of the scheme; further developing and integrating the IT system; enhancing links with government hospitals, including an incentive system; improving the quality of services; and facilitating beneficiary feedback, including a grievance redressal system. Intensive support will be provided to synergize all the health insurance programs supported by the state and central governments to have efficiency gains. The following proposed activities will be supported under the project.

(a) **Strengthening policy and design for increased operational efficiency.** This will include reviewing benefit packages, exploring options for converging benefit packages between the two schemes, exploring options for convergence in the schemes, converting state schemes into a cashless benefit for end users, maximizing the provisions of AB-PMJAY, and reducing financial burden on the MSHCS, without losing the distinct identity of the MSHCS. Strategies for progressive reduction of enrollment fee under the state scheme will be explore as a part of design restructuring.

The project will provide technical support to understand the gaps in the benefit package in line with disease burden and current claim patterns and bring convergence in benefit packages between the two schemes for better service delivery. The deeper understanding of the packages and cost will help the state rationalize the coverage of beneficiaries in the appropriate scheme to reduce financial burden on the state. The improved road map for the convergence in terms of adapting the hospital empanelment, cost for procedure, and quality control on treatment protocols will ensure efficiency gains.

(b) **Strengthening institutional capacity, systems, and processes.** Investments will be made in strengthening operational convergence of the two schemes. The project will support investing in IT architecture and capacity to convert the state scheme (MSHCS) into a paperless transaction system such as the central scheme (AB-PMJAY) and improve all other systems like beneficiary identification, hospital empanelment, referrals, portability structures and mechanisms, claim adjudication, FM, grievance redressal, service quality audits, and overall monitoring. Systems, tools, and skills (technical, managerial, and soft) will be developed among scheme administrators at the state, district, and facility levels, which may include, but not be limited to, investments in additional human resource and infrastructure of the scheme administering agency and learning missions to states/countries with matured health insurance programs.

The investment for institutional capacity will largely invest in building the integrated IT platform that can interact and provide necessary information to the national program (AB-PMJAY), provide IT infrastructure at the state level, and connect the same with all the empaneled hospitals that provide services under insurance program. Special emphasis will be given to public hospitals with poor infrastructure to adapt to this change. Capacity building of staff at the district and facility levels will be carried out to understand various functions of the health insurance program, which will improve the quality of implementation. As needed, additional human resources will be supported to expand operations and coverage of the health insurance program.

The project will also support the state in institutional reforms and strengthen the implementation capacity at the district level. It will also help reengineer the state-level implementation agency to evolve as a financially sustainable program by bringing efficiency in the overall implementation of the program. Successful models of implementation from the states that run the health insurance program on a trust model will be adapted to local needs and successful interventions will be replicated.

(c) **Community interventions for improving coverage and demand.** Comprehensive communication campaigns and demand-side interventions will be supported to improve enrollment under the scheme and increase demand for services. This may include household enumeration. In addition, community-driven pilots in selected three to four districts will be supported by the project to increase awareness about health issues, including an enhanced focus on health insurance scheme. The interventions will leverage the existing platforms and structures for the same, for example, VHSNCs, women SHGs, and VHNDs.

The project will support the development and implementation of targeted communication strategies and design community-driven interventions for improving the enrollment of households in the state. The pilot intervention will be carried out in the pilot districts before taking it to scale (Kolasib and Lawngtlai – more details are provided under Component 3 description). The involvement of local community-level groups, women, and existing institutions will be at center of the intervention. The project will capitalize VHSNCs and SHGs in the targeted areas and support them with necessary capacity-building programs and resources for improved enrollment and use of the health insurance program. The key activities under this subcomponent will include the following:

- Knowledge, attitude, and practice survey to understand the health-seeking behavior among the communities and the reason for low enrollment into health insurance program.
- Develop and implement a comprehensive communication strategy at the community level to enhance health-seeking behavior, especially for women with an enhanced focus on improving enrollment. This will involve NGOs, local bodies, and institutions like SHGs and VHSNCs.
- Capacity-building program for community leaders and key members who play a critical role at the village level for community mobilization.

11. Under Component 2, the project will finance (a) part of claim paid by the MSHCS for services provided to beneficiaries (disbursement will be done against achievement of agreed results as mentioned under Component 1), (b) hiring of individual consultants, (c) training, (d) hiring of consultancy and non-consultancy services, (e) investments in office and IT infrastructures, and (f) comprehensive evaluations of the schemes.

Component 3: Enhance Quality of Health Service and Support Innovations (US$15.92 million)

12. This component will focus on improving the quality of care through a comprehensive QA for health service and augmenting systems related to human resource management, BMWM, procurement and supply chain, and project management capacity. This will be achieved through input-based financing at district hospitals, CHCs, and PHCs to achieve NQAS certification; development of a robust human resource policy; focused skill building of health cadres; and piloting initiatives that can help the state improve effectiveness of the interventions. These efforts will also lend to strengthening the capacity of facilities to respond to increasing disease incidence due to enhanced climate vulnerabilities.

13. **Improvements in the delivery and quality of health services at district hospitals, CHCs, and PHCs.** The project will invest in improving service delivery through comprehensive QA programs leading to quality certification of health facilities; strengthening health service infrastructure to improve functionality, including water supply, sanitation, and electrical power; strengthening technical infrastructure like neonatal and pediatric

intensive care units; engaging with the private sector wherever required; strengthening forward and backward referral links; and improving knowledge exchange programs.

(a) **Strengthening planning and management capacity for continuous quality improvement at identified health facilities.** At district hospitals, specific interventions will include annual locally owned quality improvement plans focusing on patient and provider safety and quality of care and improved data collection systems using ICT solutions for monitoring. The process will involve Rogi Kalyan Samiti37 and hospital staff. Hospitals will be incentivized using quality index-based performance contracts under Component 1.

(b) **Whereas much enhanced inputs will be made available to the health sector to strengthen the overall health system and procure equipment and other items necessary for health facility upgrades**, there will be a concomitant funding, which will be performance based and will focus departments' and district's attention on key issues under their control, which will contribute to overall system strengthening.

(c) **The project will design interventions focused on making health facilities environmentally friendly and energy efficient.** This includes designing the use of solar power, conserving water resources through rainwater harvesting, and landscaping to make the spaces more pleasant and environmentally friendly.

(d) **This component will entail need-based redesigning of hospitals, fund equipment, additional human resources,** TA, and outsourcing of nonclinical and clinical support services, using performance-based contracts, in all district hospitals and targeted health facilities.

(e) Health facilities at the CHC and PHC levels will follow a similar format with low intensity but continued focus on improving the quality of health service delivery.

14. **Efforts to improve the biomedical waste.** The details of activities under the proposed project for BMWM are provided in annex 5.

15. **HRH.** The state has a chronic shortage of medical specialists. The list of issues includes the absence of a state human resource policy, lack of systems for identification of gaps in the periodic intervals, and lack of appropriate steps taken to fill the gaps strategically. The project will support improvements in pre- and in-service training, including quality accreditation of colleges of nursing, revamping of training institutions and nursing schools, and development of programs for continuing medical and paramedical education. The project will support a multipronged approach to institutionalize and strengthen HRH development and management, starting with support to the development of a state-level policy for HRH that will provide the administrative framework for the relocation of specialists, hiring of specialists from the private sector or open market, and promoting existing doctors to undergo higher-level specialized short-term training. The existing human resource management systems will be improved, including through development and implementation of performance metrics for health cadres and capacity building of the Department of Health for data-based management of human resources.

16. **In addition, the project will emphasize capacity building of hospital and health facility staff, focusing on techno-managerial skills and aligning incentives to perform better, through the medium of innovative in-service trainings and by piloting performance-based incentives and rewards**. The project will implement 'LDHF training'

[37] Rogi Kalyan Samiti consists of the following members: people representatives (Member of the Legislative Assembly/Member of Parliament), health officials, local district officials, leading members of the community, local CHCs/First Referral Unit in-charge, representatives of the Indian Medical Association, members of the local bodies, and leading donors.

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 Mizoram. These key conditions are next to key maternal and child health conditions and NCDs such as cancer, hypertension, and diabetes. The individual performance agreement between the district authorities and key health staff at the health facility level, to maintain minimum competency in clinical services, will drive the motivation levels of individuals to update their skills. The individual health worker will receive personalized feedback on his/her progress on the set of defined vignettes, whereas the (anonymized) average performance on these knowledge tests will largely drive the institution's quality index. Tests will be administered online and will also be available through smartphones. The serially administered nature of the vignettes combined with a positive incentive environment both for the institution and the individual is expected to raise content of care quality swiftly.[38]

17. Strategic investments in human resources are proven to have increased organizations capacity for resilience[39] and enable delivery of efficient and effective medical services.[40] The component will also strengthen the pre-service education provided by government nursing schools, including investments in infrastructure improvement, capacity building of nurse tutors, and establishment of an MSc college of nursing and accreditation of the existing BSc college of nursing. In the process of improving the pre-service training, the project will also support the state in overall improvement of governance and management systems in these colleges and build their network, which will enable cross-learning and provide a great opportunity for students' exposure to wider knowledge.

18. **Innovations- pilot interventions.** The state has many unique challenges, such as hilly topography, nearly half the population in one district, and one of the highest burdens of cancer in India. The state also provides unique opportunities, such as high literacy (more than 90 percent of women are literate), one language, one community identity, and a small population base. Though the national support and the state initiatives are meeting the health needs of the community, there is still a lot of scope to pilot some of the proven methods, which are yet to be implemented in the state. This will not only test the effectiveness of these methods but also will provide evidence of moving forward more scientifically. Following pilot innovations will be undertaken in two districts of the state namely Kolasib (northern Mizoram) and Lawngtlai (Southern Mizoram). Both the districts do not have any elderly care program, dialysis program or any investments in Bio medical equipment. Further, both the district do not have investments from NUHM. Also to note that the two of the three Autonomous Hill Councils are present in the Lawngtlai district.

(a) **Point to point - enhancing regular service.** Telemedicine and tele-diagnostics are bridging the gap of specialist services, which is particularly noticed during the ongoing COVID-19 pandemic. Similar concepts have been implemented in other states of India like Andhra Pradesh through World Bank support. Considering the large dispersed rural population in difficult-to-reach areas, the project will make

[38] Fritsche, G. and J. Peabody.2018. "Methods to Improve Quality Performance at Scale in Lower -, and Middle-Income Countries." *Journal of Global Health* 8 (2); Peabody, J., et al. 2011. "Financial Incentives and Measurement Physicians Improved Quality of Care in the Philippines." *Health Affairs* 30 (4): 773–781; Peabody, J., et al. 2013. "The Importance of Performance Incentives on Child Health Outcomes: Results from a Cluster-randomized Controlled Trial in the Philippines." *Health Policy and Planning*; Peabody, J. W., et al. 2017. "Large-Scale Evaluation of Quality of Care in 6 Countries of Eastern Europe and Central Asia Using Clinical Performance and Value Vignettes." *Global Health: Science and Practice* 5: 173.

[39] Lengnick-Hall C.A., T.E. Beck, and M.L. Lengnick-Hall. Developing a Capacity for Organizational Resilience through Strategic Human Resource Management. *Human Resource Management Review* 2011 21 (3): 243–55.

[40] Elarabi, H. M., and F. Johari. 2014. The Impact of Human Resources Management on Health Care Quality. *Asian Journal of Management Sciences and Education,* 3 (1): 13–22.

investments to pilot this concept in select HWCs that are designed to provide NCD care. Though the challenges of internet connectivity exists in the state, this experience will provide the much-needed evidence of the new generation of HWCs and enhancement of their functionality by bringing the services to the community level.

(b) **Point to point - enhancing emergency service.** Drone technology is in use in African conditions with a proven system to support rural hospitals with blood and other similar essential lifesaving medicines. This reduced the time taken by ambulances to get the patient and come back to the appropriate hospital. Drone technology has been used in India during the ongoing COVID-19 crisis to provide augmented ability for contact tracing too. As the state has a limited number of blood banks and most of the CHCs do not have a blood bank facility and are placed in difficult-to-reach areas without essential lifesaving medicines, using drone technology can be a game changer. This technology will be piloted by connecting the existing blood banks with CHCs to understand the usefulness and practical issues that can be learned from the pilot experiment.

(c) **The state has a high level of community togetherness.** It is the only state in North-East India where one language is the predominant identity, with all people speaking 'Mizo' language. Community ownership and togetherness are observed in many aspects of life. Piggybacking on the strong community systems, the project will pilot models to extend cancer screening and palliative care services (which are nonexistent) in two rural districts. It is expected that the success and the learning from these districts will open up state-level policy dialogue for enhanced cancer screening and palliative care programs in the state, to address the growing burden of cancer.

ANNEX 3: Mizoram's Internal Performance Agreement and Quality Enhancement Approach

1. **Component 1 focuses on strategic investments in improving governance and reforming management systems and is designed to bring changes in the way health institutions are financed in Mizoram state.** Besides, the investments under this component aim at bringing transformative change in the quality of services and access to these services. The project envisages IPAs as a tool to infuse new way of operations by moving from budget line item-based systems to performance-based systems.

2. **Creating medium- and long-term visions and mechanisms for the state through a series of IPAs between the state and the key departments aims at bringing a series of policy-level and administrative reforms**. Funds will be provided to all the three key departments in Mizoram targeting to achieve the first-ever state health policy and road map for the state health system, human resource policy, and policy changes for improving health insurance coverage and reducing OOPE. These departments hold key operating divisions/units, which will be targeted through these IPAs. These are the Human Resources Division, the Health Management Information System Division, Health Insurance Department, Health Finance Division, Procurement Division, and State Quality Assurance Unit. The challenge of multiple divisions will be addressed through a shared responsibility mechanism. The IPAs and the incentives linked to the results will be reviewed six-monthly. The payments will be made against agreed indicators, which will be verified internally by the PMU and validated externally by a third-party agency. The incentives under this agreement will be partly given to staff for recognizing their contributions and the remainder will be used for improving the capacity of the department, such as workshops, soft skills enhancement, diagnostic assessments, and so on. To address capacity issues, departments may use the funds to hire high-end consultants to provide initial support.

3. **Decentralizing responsibility and delegation of finances to the district level.** Though districts are units of administration, most of the responsibility and financial authority is at the state level. The districts differ significantly in population size, health facilities, and ease of access. The district health administrations/district health societies will be engaged through IPAs to make decisions for improvement in BMWM, hospital quality improvement, and health insurance-related indicators. An equity-based approach will be used while providing financial support through IPAs to each of the districts. The internal performance reports of the districts will be validated by the state before payment for results. Third-party verification will use a defined protocol to counter-verify reported (as assessed by the state) district-level performance indicators. Regular payment for results will be ensured, to enable districts to play their key role in coaching and enabling health facility quality improvement plans.

4. **Mizoram state has limited exposure to implementation of accreditation and QA systems. While targeting system-level constraints, the project will be introducing performance management and a quality enhancement approach to optimize the use of these system-level inputs.** Gaps in major health system components all have effects on service quality. Despite the efforts by the QA teams for implementing the NQAS, only 1 PHC (out of 57 PHCs) and 1 district-level hospital (out of 10 district-level hospitals) have been awarded the NQAS certification. None of the seven CHCs and two SDHs have the NQAS certification. Other similar indicators, such as star rating of CHC and PHC improvements, have not shown any encouraging improvements. Investments to address identified gaps in quality have been limited, with a limited number of human resource and complex time-consuming systems for financing for quality improvement.

5. **Mizoram has achieved a high health index ranking for the past two years, but lack of improvement of quality of services remains concerning.** Low-quality health services yield lesser health benefits and therefore are less effective.[41] The WHO estimates that between 20 and 40 percent of all health spending is wasted due to inefficiencies and poor quality.[42] Besides, low-quality health services have a significant negative effect on demand for and utilization of health services. As achieving the NQAS certification for the targeted health facilities needs intensive resources for medium to longer term, the existing resource management system along with poor planning has not helped in improving the quality of services. While the NQAS accreditation is a desirable goal, it will need to be achieved through systematic achievement of a series of targets that facilitate short-term achievement and long-term sustainability. Specific interventions that will have a rapid impact on the quality of care exist and are being envisaged at the health facility level.[43] Relatively new insights on how to strengthen provider performance come from the literature of serial application of knowledge and competency tests, sometimes referred to as LDHF training.[44] There is evidence that aligning incentives to improve knowledge and competency within a system of strengthened performance management will yield intended results.[45] From the PBF literature, it is known that providers who know more provide better efforts under an incentive scheme.[46]

6. **Though the NQAS certification comes with a monetary award, getting health facilities prepared for accreditation has significant up-front costs, and this is where the health facility IPA comes in.** The health facility IPA will provide funding based on quality performance. Part of the health facility quality index will be metrics measuring progress on accreditation planning and implementation. Furthermore, low-quality health services have an immediate impact on health benefits, and it seems imperative to tackle this as a matter of some urgency. Also, in times of the COVID-19 epidemic, strengthened attention to infection control and prevention, in general, is urgent. Process quality in the Donabedian sense, the 'content of care quality', which is what happens between the provider and the patient, is significantly related to outcomes of health services. A significant weight within the quality index will come from anonymized health worker knowledge scores.

7. **The quality improvements in the health facility will be achieved through IPAs, which will be a quality Index** composed of (a) a quantified quality checklist as applied by certified assessors from the district health team and (b) serial knowledge testing of health workers. Different levels of facilities will have slightly different IPAs and quality metrics linked to the expected package of services that these specific health units are designed to provide. The quality index is composed of three critical areas: (a) resource planning and management, (b) improvement in practice through knowledge enhancement, and (c) improvement in the content of services.

(a) The agreement on the quality index will ensure that facilities receive advanced resources to plan along with the local community members, pool the resources available from other sources, and strategically

[41] Leslie, H. H., et al. 2016. "Training and Supervision Did Not Meaningfully Improve Quality of Care for Pregnant Women or Sick Children in Sub-Saharan Africa." *Health Affairs* 35 (9): 1726–1724.
[42] World Health Organization. 2010. *The World Health Report: Health Systems Financing: The Path to Universal Coverage*. Geneva: WHO.
[43] Fritsche, G. and J. Peabody. 2018. "Methods to Improve Quality Performance at Scale in Lower - and Middle-income Countries." *Journal of Global Health* 8 (2).
[44] Peabody, J. W. et al. 2017. "Large-scale Evaluation of Quality of Care in 6 Countries of Eastern Europe and Central Asia Using Clinical Performance and Value Vignettes." *Global Health: Science and Practice* 5: 173.
[45] Peabody, J., et al. 2011. "Financial Incentives and Measurement Physicians Improved Quality of Care in the Philippines." *Health Affairs* 30 (4): 773–781.
[46] Basinga, P., et al. 2011. "Effect on Maternal and Child Health Services in Rwanda of Payment to Primary Health-care Providers for Performance: An Impact Evaluation." *The Lancet* 377: 1421–1428.

improve the comprehensive indicators in the quality index. This will bring confidence in the local hospital management to move forward.

(b) Investment in the improvement of clinical knowledge and standardizing the clinical practices at various levels is an essential element of the health system service delivery. This will be achieved through a series of targeted clinical vignettes for medical and paramedical staff. As mentioned earlier, this approach has been proven to be one of the most effective methods for improving clinical practice among the in-service staff. Local medical practitioners will be involved in developing the relevant clinical vignettes for the most relevant diseases in the Mizoram context and managing the system, leading to the transfer of knowledge and skills to continue with the same even after the completion of the project. In parallel, efforts will be made to recognize clinical vignettes as one of the approved methods of continued medical education in the state medical council.

(c) The other parts of the quality index will focus on improving the quality of service through a series of measures to improve the processes of service delivery which will include patient satisfaction.

8. **Health facility quality metrics will focus on a select set of quality metrics that will assist in working toward NQAS accreditation, while having a swift impact on the content of care quality.** An established quality framework describes quality metrics as structural, process, and outcome type.[47] The NQAS has elaborate metrics across these three dimensions; however, the accreditation process is an arduous path, and once the NQAS certification has been obtained it will be repeated only once every three years.

9. **Building local resources is essential for future progress.** The quality enhancement at facilities will be supported by limited available internal resources initially. However, investments will be made to develop a pool of quality evaluators mix of retired and existing health care staff to provide continuous hand-holding support to the facilities within their district and undertaking peer assessments in other districts. A similar mechanism for continuous quality improvement is also encouraged by the NQAS system and may provide a sustainable mechanism to verify the results toward the end of the project.

[47] Donabedian, A. 2005. "Evaluating the Quality of Medical Care." *Milbank Memorial Fund Quarterly* (83): 691–729.

ANNEX 4: Mizoram's detailed Financial Assessment

Implementing arrangements:

1. The project will be implemented by the Department of Health and Family Welfare (DoHFW**)**, Government of Mizoram. Commissioner and Secretary at the Secretariat Office of H&FW Department is the Administrative Head of the Department, assisted by the Principal Director, who is the Executive Head of two main directorates i.e Directorate of Health Services (DHS) and Directorate of Hospital and Medical Education (DHME). The Project Management Unit (PMU) will be created to manage implementation of the project, including regular monitoring and supervision. The Principal Director of Health Directorate will be appointed as the Project Director to lead the PMU. The PMU will be in the Department of Health with deputed staff from all three directorates. The finance wing of the Project Management Unit is headed by an experienced finance officer, deputed from the Department of Health and Family Welfare, and will be responsible for all financial management functions.

2. **Budget:** The project's funding requirements will be provided within the state budget of the DoHFW as a separate budget line under Externally Aided Project. A separate budget head with object wise code will be created for the project. The Budget estimates prepared by the PMU in consultation with other directorates will be scrutinized by the Project director/Project Steering committee and will be approved by the Secretary of the Administrative Department and thereafter forwarded to the Finance Department. After Finance Department examination, the proposal will be placed before the State Legislative Assembly for approval. The department will ensure that the adequacy of budget provision throughout project implementation.

3. **Fund Flow:** Once the budget proposal is approved by State Legislative Assembly, Finance Department communicates the same to the Secretary for onward communication to the Principal Director (Project) and Directors. The Principal (Project) Director is authorized to draw funds and allocate funds as per the Work Plan to the Directors, who are authorized to draw funds and further allocate funds to units. The Directors monitor utilization of funds at their respective units. Given the weak financial position of the state, significant delays are currently experienced in processing payments through the state treasury. It has therefore been agreed to ring-fence the funds flow arrangement from the state treasury to the Department of Health and Family Welfare. The PMU has opened a separate bank account for the project. The applicable disbursement method will be 'reimbursement'. The state government will use its budgetary resources to finance project expenditures. The project will submit quarterly interim financial reports to the Aid, Accounts, and Audit Division (Controller of Aid, Accounts, and Audit) of the Department of Economic Affairs, Ministry of Finance, Government of India. These financial reports will be submitted by the Controller of Aid, Accounts, and Audit to the World Bank for seeking reimbursement of project expenditures.

4. **Accounting and Internal controls:** The project will follow cash-basis accounting for recording project expenditures. At present the accounts are maintained manually. The PMU will purchase an accounting system for recording financial transactions. The chart of accounts will be appropriately developed to classify project expenditures based on project components/major activities. The accounting and procurement function will be centralized at the PMU.

5. The accounting and procurement function will be centralized at the PMU. The payment function will be centralized at PMU. The project PMU will follow the procedures of DoHFW for payments and payments will be made online payments/RTGS transfers directly into contractor's /consultant's Bank account and contracted

Entities/units/Departments with appropriate controls put in place to process such payments and described in the Project Operational Manual.

6. Category 2 of legal agreement is exclusively for IPA payments, Incentive grant Agreements will be signed between the PMU and Entities/Units/Departments such as DHS, DHME, State Insurance agency, State Quality assurance units, District Health Administration, selected CHCs and PHCs to govern the provision of incentives and their use. Incentive grant to Entities/units/Departments under Category 2 will be directly deposited by the PMU into separate bank accounts created for this purpose by the Entities/units/Departments. These accounts are operated under the joint signature of the Chairman and the Member Secretary of various institutions. The State and District Health Societies and RKS maintain separate cash books and registers while the DoH&FW undertakes periodic inspection by the medical officer. Internal verification process will be undertaken by the internal verification entities as described in Project Operational Manual.

7. The Entities/units/Departments will be identified and selected in accordance with criteria described in the Project Operational Manual approved by Project Steering Committee and the World Bank. Contracted Entities/units/Departments will use this financing for activities as agreed in Incentive Grant Agreement, within guidelines set out in the Project Operational Manual. The Entities/units/Departments will maintain separate books for account to record financial transactions for the project. At the district level, the office of the chief medical officer and the project's district coordinators will monitor activities and ensure that expenditure reports are periodically submitted to PMU.

8. After initial start-up funding, incentives to Entities/units/Departments will be conditional on achievement of certain agreed indicators and targets. Incentive grant released by the PMU will be treated as expenditure and can be claimed from the bank only after submission of utilization certificate. At the end of the project, incentive proceeds that have remained unspent in the bank accounts of committees will be either refunded to the PMU. Incentive results will be verified by the project's coordinators as described in the Project Operational Manual.

9. The DoHFW's existing internal control and administrative rules and regulations will be applicable to the project transactions. These include the procedures for budgeting, financial delegation, internal controls, reporting and record keeping, and audit. All project related receipts and payments/ withdrawals would be reconciled monthly.

10. **Finance staffing:** A Senior Accounts Officer, experience in handling government accounting and financial management matters from the DoHFW posted by State Finance Department will be deputed to the project. The Senior Accounts officer will report to the project director and will have the overall responsibility of maintaining the financial management system and ensuring that these functions are carried out in accordance with the project's legal agreements. The PMU will hire a Financial Management and Technical Support Consultant (Chartered Accountant) on a contract basis to support financial management functions. These functions will include (a) adequate annual budgetary provision and effective utilization; (b) sufficient and timely flow of funds for project activities; (c) maintenance of adequate and competent financial management staff; (d) appropriate accounting of project expenditures; (e) preparation and timely submission of interim financial reports; and (f) timely submission of audit reports and project financial statements to the World Bank. These functions will be carried out in accordance with the project's legal agreements.

11. **Operations Manual:** A Financial Management Manual for State Schemes is in place. PMU has prepared a

project Operation manual in which they have captured FM functions as per the existing state FM manual.

12. **Financial reporting and Disbursement:** The project will incur the expenditure though its own funds (through the budget line) and IUFR (Interim Unaudited Financial Report) will be the basis for the reimbursement. The PMU will prepare quarterly IUFR based on actual incurred expenditure to claim eligible expenditures under category 1 and category 2 Incentive program.

13. The expenditure reported in the IUFRs will be subject to confirmation /certification by the annual audit reports. The IUFR will reflect only actual expenditure incurred and paid as per the agreement, no advances or commitments made will/can be claimed as expenditure. The consolidated IUFR will be submitted by the PMU to World Bank and Controller of Aid, Accounts and Audit (CAAA) within 45 days from the end of each calendar quarter. To maintain cash flow of the project, PMU can submit out of turn IUFRs as and when substantial expenditures are incurred under the project.

14. **Internal audit:** The internal audit for the project will be conducted by a firm of chartered accountants. The terms of reference for the audit will be agreed with the Bank. The audit will review accounting and internal control processes adopted by the PMU in executing payments. Additionally, it will provide comments on procurement and contract management functions adopted by the PMU in awarding contracts. The audits will be conducted semi-annually and will provide feedback to management on control weaknesses and issues that require management attention. The internal audit reports along with the corrective actions taken by the project to address the control weaknesses (if any) will be shared with the Bank.

15. **External audit.** The CAG will be the external auditor for the project. The CAG's office will conduct an annual audit of project financial statements covering sources and uses of funds. The audit will be conducted according to terms of reference agreed with the World Bank, and the audit report will be submitted within nine months from the close of each GOI financial year. The audit report for expenditures incurred under the Project Preparation Advance and retroactive financing will be combined with the first-year audit report. The annual audit report will consist of (a) audit opinion; (b) project financial statements; and (c) management letter highlighting weaknesses, if any. The annual audit reports and financial statements will be disclosed on the H&FW website. Below table lists the audit reports that will be monitored.

Implementing Agency	Audit report	Auditor	Due date
Project Management Unit, Department of Health and Family Welfare, Government of Mizoram	Audit report and project financial statements	CAG of India	December 31 of each year

16. **Agreed actions:** will complete the following agreed actions:

Action	Responsibility	Timeline
Budget head creation and provision for 2020-21 for project expenditure	PMU	Negotiation
Assigning / Identify PMU Senior Accounts officer preferably from State Finance and accounts, and supporting Accounts and Finance support staff	PMU	Negotiation
Hiring Financial Management and Technical Support consultant (FMTSC)	PMU	Within 6 months from the Loan agreement signing

		date
Finalize of Terms of reference for hiring Internal Audit	PMU	Within 6 months from the Loan agreement signing date

17. **Implementation Support proposed Plan** - The objective of the implementation support plan is to ensure the project maintains a satisfactory financial management system throughout the project's period.

FM Activities

Activity	**Frequency**	**Method**
Interim Unaudited financial reports review	Quarterly	Desk review
Project Audit reports	Annually	Desk review
Review of other relevant information such as interim financial reports and Internal Audit report reports etc.	Continuous as they become available	Desk review
Review of overall operation of the FM system	per Implementation Support Mission schedule	On site visit
Monitoring the actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed	Desk review / On site visit
Transaction reviews (if needed)	As needed	On site visit
FM training sessions (Capacity Building support)	Before implementation and as and when needed.	On site visit

18. **Risk:** Implementing agency DH&FW has neither prior experience in bank funded project nor implemented any external aided project. Therefore, the financial management risk rating is considered "Substantial".

ANNEX 5: Biomedical Waste Management

1. The health care system by function generates biomedical waste, which includes human body parts, blood and blood-related products, sharps used, used bandages gauze, and medicines, to name a few. Unless they are treated appropriately, these wastes have the potential to spread infection and chemicals, putting the health workers and community at risk. The BMWM Plan is a management tool for effective management of BMW and associated risks on health functionaries and communities. It is an essential requirement for managing environmental aspects and their impacts under the ESMF of the health sector project funded by the World Bank and are fundamental requirements to meet multiple regulatory frameworks to advance the safeguards system.

2. **All hospital wastes are not infectious.** Between 80 percent and 85 percent of waste generated at health care facilities is 'general' or non-hazardous waste. It includes waste generated during administrative activities, housekeeping activities, kitchen and food related, packaging, maintenance functions, and so on. Only 15 percent to 20 percent of the waste generated during the delivery of patient care is 'infectious' in nature and carries various health risks. The ongoing COVID-19-related restrictions have changed the dynamics of inpatient and outpatient care with a significant reduction in services; thus, the quantification may not provide accurate information. However, in general, approximately 1–1.50 kg of biomedical waste is generated per bed at the health care facilities, which is hazardous and requires further treatment and disposal. Therefore, the total quantities of biomedical wastes generated at different state health care facilities are estimated at district hospitals (average 100 beds) as 150 kg per day (at 100 percent bed occupancy) and CHC (30 beds) as 45 kg per day (at 100 percent bed occupancy).

3. **The regulatory frameworks for BMW in Mizoram.** The key regulatory frameworks that are in use in the state of Mizoram are the Bio-Medical Waste Management Rules 2016 (and as amended in 2018). These rules regulate the generation, handling, collection, storage, transport, and treatment of BMW and are in concurrence with other national and international regulatory frameworks like international multilateral environmental agreements such as Minamata Convention; Stockholm Convention; and environmental regulations, for example, Air Act 1974, Water Act 1981, and WHO norms for BMWM. Recently, more guidelines have been added to address the COVID-19-related challenges with substantial guidance on the personal protective equipment and dead body management.[48]

4. In February 2000, the Governor of Mizoram appointed/constituted Prescribed Authority, that is, Secretary, Environment and Forests, Government of Mizoram and an advisory Committee with 12 committee members for implementation of the said rules in Mizoram. According to the amendment dated June 2, 2000, of the said rule, the Mizoram Pollution Control Board (MPCB) was appointed as the Prescribed Authority for enforcing the rules within the state.

5. **Existing institutional structures and systems in Mizoram need strengthening.** The DoHFW is the nodal department, responsible for the implementation of BMW rules. The MPCB is concerned with monitoring whether the rules are complied with. The MPCB is also the agency that collects, reports, and compiles incoming reports for submission to the Central Pollution Control Board. The State and District Advisory Committee formed for the management of BMWM holds meetings but not at fixed intervals. While a majority of the waste handlers are immunized, and regular investments are made to improve the cleanliness of the hospital under 'Kayakalp'

[48] https://www.mohfw.gov.in/pdf//National%20Guidelines%20for%20IPC%20in%20HCF%20-%20final%281%29.pdf; https://www.mohfw.gov.in/pdf/1584423700568_COVID19GuidelinesonDeadbodymanagement.pdf.

program, the hospitals are using the deep burial pits and sharps pits system. One functional incinerator is attached to the new medical college hospital. Most of the hospitals do not have an effluent treatment (liquid waste management) system that should be in place in all health facilities. Information on the waste management system in the private setup was not better than the public institutions. At present, there is no common treatment facility (CTF) in the state. One CTF is in the pipeline for the city of Aizwal. However, the state needs more than one CTF to provide coverage to dispersed health care units.

6. With regard to the management of solid wastes, Aizawl Municipal Council (AMC) is the implementing agency. Urban Development and Poverty Alleviation Department is the nodal department responsible for the formulation of rules and guidelines for solid waste management. They are expected to submit timely reports to the MPCB. However, effort needs to be made to get a report from AMC/UD&PA. With regard to other hazardous wastes, the commerce and industries department is supposed to have implemented treatment facilities. This remains to be done. Protection of laborers from industrial hazardous wastes (labor safety) is the responsibility of the labor, employment, skill development, and entrepreneurship department.

7. **Insufficient funding for BMW management in the state.** A system for funding the biomedical waste in the state exists but is still at a nascent stage and overall BMW receives minimal funding. The NHM funds are allocated for immunization of staff and incentives for improving BMWM system in the existing facilities. An improved BMWM system will be able to tap more resources from the central grant, through the existing incentive schemes.

8. **Irregular/insufficient capacity-building efforts for ensuring occupational safety of staff. The** MPCB provides in-house awareness/training programs for the staff. Due to resources constraints, these programs are not regular. Efforts are being made to make the guidelines and other awareness materials available through the MPCB's website.

9. **The ongoing COVID-19 pandemic response in the state is guided by guidance given by the national authorities to the state.**[49] The state has aptly used the significant time lag between the detection of first case in the end of March to continuous dialogue for case identification in June 2020. This includes training of health care workers and non-health staff, volunteers, and civil society involved in the COVID-19 response. These trainings include personal protective measures and handling of biomedical waste at the different setups, including disposal of the PPEs. According to the requirements, the COVID-19 hospital details are constantly getting updated in the application developed for the same. The Aizawl municipal corporation has also designated staff and vehicles for collection of COVID-19 waste in COVID-19 quarantine and treatment facilities. All COVID-19 quarantine facilities were exempted from obtaining authorization on March 20,2020. Deep burial is permitted in places where incinerators were not available. The state-level BMWM committee members are undertaking a routine inspection of the COVID-19 facilities, quarantine centers, and waste disposal mechanisms.

10. **Strategic and systematic investments can bring the desired changes in the BMWM.** The project intends to address the BMW challenges in the state in a holistic manner by supporting interventions right from the state to the substate till facility level, using the existing financing tools.

11. A stepwise investment plan for BMWM at the facility level includes the following:

[49] https://www.mohfw.gov.in/.

(a) **Systems-level investments to improve the management functions at the state and district levels will be implemented through Component 1 of the project.** This will strengthen the existing multisectoral, multi-departmental management and regulatory systems at the policy and higher management level by bringing swift and stepwise policy decisions to improve the safety of staff, transport of biomedical waste, and final disposals, which are outside the purview of hospitals. Bringing innovative approaches and flexibility to address the challenges of low volume and large geographic spread of the health institutions will add value to the financial viability and sustainability of the common treatment facilities. Further incentives will be paid to district-level functionaries for improving the mid-management-level functions to improve the coordination between the public, private hospitals, municipalities, or other urban bodies responsible for implementing the rules and regulations. The key outputs from these investments will be (i) constitution of BMWM committees at the state and the district level, (ii) regular review of the evidence and reports in these meetings, (iii) appropriate actions/decisions that can be taken to advance implementation and sustainability, (iv) identification and provision of space for the CTF, (v) notifications and arrangements regarding the safe transport of biomedical waste from the hospitals to the CTF, and (vi) authorization and periodic inspection of the hospitals by the committee.

(b) **Facility-level infrastructure development and training will be implemented under the input-based financing in Component 1.** At present, the autoclaves are used only for pre-surgery or inpatient care services, not for disinfection of biomedical waste. Personal protective equipment for each staff, color-coded bins, transport/collection trolleys, and immunization of the staff will be reviewed periodically, including needle stick injury of staff.

(c) **Direct investments will be made to disinfect the biomedical waste before segregation through autoclave and microwaves.** Rigorous training of all the staff periodically through induction and refresher training will be undertaken to ensure proper collection, transportation within hospital, storage, and disposal. IEC material in the local language will be prepared to mark the bio-hazard areas along with instructions on the handling procedures. In district hospitals, where a significant number of surgeries and inpatients are provided service, effluent treatment plants will be established to treat the wastewater from the laboratory, operation theatres, and labor rooms before disposing it to general sewage. Building on the current spirit of added efforts from the state to open CTF in Aizawl, from internal resources, the project will invest in making two more CTFs for the rest of the state and linking them with multiple districts to ensure most of the hospitals are linked to the CTF for final disposal of bio medical waste. For other hospitals, similar local disposal mechanisms will be established. In situ disposal facilities will be developed for (i) areas where it is not viable for CTF to operate or in remote areas and (ii) the existing facilities till the CTF is being made available, with due approval from the state regulatory authority. Smaller items like needle cutters and consumables like hypochlorite solutions, for continuity of the BMWM functions at the facility level, will be purchased from the local funds made available by the state through the Rogi Kalyan Samiti (RKS) and the quality index-based financing from Component 1. These funds will also be used for developing temporary solutions for BMWM at the local sites.

(d) **Funds through the Component 1 will** augment daily functioning of BMWM at the facility level, documentation, and reporting of the same routinely. This will also include periodic health checkups of all the staff and maintenance of their health records at the facility level.

(e) **The work of the staff involved at the facility level will be recognized** with appropriate commendation letters and financial incentives, which are built into the project.

(f) **Technical inputs will be provided** to accelerate the implementation of an ongoing effort by the state to start the first CTF. Besides, the project will provide technical and financial resources to establish more common treatment facilities in the state to ensure that the maximum number of health facilities are linked to the CTF.

(g) **Considering the constantly evolving COVID-19 situation** and the response to the pandemic, the MoHFW, GoI, has provided a series of guidance to the states in line with the WHO guidance, which apply to Mizoram. The state is constantly trying to comply with the guidance received. As both the pandemic and the response are evolving, a waste characterization exercise covering identification of types and quantities of different wastes generated during health care activities in the health facilities is required. This exercise will be conducted at the initiation of implementation to understand the compliance and gaps in the implementation of the guidelines, which can further strengthen the World Bank's investment in the project.

ANNEX 6: Procurement under the Project

1. Based on the preliminary assessment, the major procurements under the project shall be minor civil works (repair, renovation, solar installations and construction of warehouses), goods (biomedical equipment, vehicles, computers accessories and software) and consultancy services. The project will follow the approach to the national market using Request for Bids for goods and works (item rate contract) and RFP for consultancy services. The project shall not use Best and Final Offer or Negotiations. The project is developing an operations manual conforming to World Bank procurement regulations for all procurement under the project. In case of any inconsistency between the procurement manual and the World Bank's Procurement Regulations for Investment Project Financing (IPF) Borrowers, July 2016, revised November 2017, August 2018 and November 2020, the latter shall prevail.

Table 4.1. Selection Method for Major Categories

Category	Description	Selection Method
Works	Including supply and installation works	RFB-National; RFQ-National
Goods	Vehicles, IT system, computers and accessories, software and related items, etc.	RFB- National, RFQ- National including GeM; a few may be DS
Consultancy	Project Management Consultants, technical consultancies, internal audit, and so on and research activities, capacity-building activities	QCBS, LCS, FBS, QBS, CQS, a few may be DS

Note: CQS = Selection based on Consultant's Qualifications; DS = Direct Selection; FBS = Selection under a Fixed Budget; LCS = Least-Cost Selection; QCBS = Quality- and Cost-Based Selection; RFB = Request for Bids; RFQ = Request for Quotations

2. **Procurement Plan:** The project shall use the Bank's online procurement planning and tracking tool (viz. Systematic tracking of exchanges in Procurement (STEP)) to record all procurement actions under IPF operations, including preparing, updating and clearing its Procurement Plan, and seeking and receiving the Bank's review and No-objection to procurement actions as required. The current project team will be trained on use of Bank's Systematic Tracking of Exchanges in Procurement (STEP). The Procurement Plan submitted by the PMU during preparation (5th November 2020) covers the activities planned during first year of the project implementation and will be updated at least annually or as required to reflect the actual project implementation needs and improvements in procurement capacity.

3. **Procurement Types, methods and Prior review Thresholds**: Table below lists the thresholds for the various procurement methods.

Table: Procurement Thresholds

Procurement Type	Method Threshold (US$ million)	Bank's Prior Review Threshold (US$ million)
Works	Open National < 40 National Request for Quotation < 0.1	All contracts > 10

Goods, IT and non-consulting services	Open National < 10 National Request for Quotation < 0.1	*Goods and Information Technology*: All contracts > 2 *Non-Consulting Services*: All contracts > 2
Consulting Firms	CQS < 0.3 LCS, FBS – in Justified cases QCBS, QBS – in all other packages	All contracts > 1
Shortlist of National Consultants	Up to 800,000	
Individual consultants	No threshold	All contracts > 0.3
Direct Selection	No threshold	With prior agreement based on justification • For Goods / Works / non-consulting services: As per paragraph 6.8-6.10 of Procurement Regulations. • For Consultants: As per paragraph 7.13-7.15 of Procurement Regulations

4. **Post Review**: All contracts not subject to prior review by the World Bank will be subject to post review during the project's Implementation Support Missions (ISM) and/or special post review missions including missions by consultants hired by the Bank. The World Bank may conduct, at any time, independent procurement reviews of all the contracts financed under the loan.

5. **E-procurement System**: The State has introduced e-Procurement on the National Informatics Center portal (*https://etender.up.nic.in/nicgep/app*), however, this is not fully used in the Health department. The portal is assessed by the World Bank against Multilateral Development Bank requirements and is cleared to use for world bank projects. The project will implement e-procurement in phased manner, and by the mid-term of the project, all the procurements will be done using e-procurement portal.

6. **Complaint Handling Mechanism**: To address procurement complaints received by the proposed Project, a complaint handling mechanism will be implemented by PMU. The PMU is required to ensure recording of procurement-related complaints in the STEP system. Both the World Bank and borrowers will use STEP to track complaints. The borrower will be responsible for performing the following actions in STEP: (a) promptly record all complaints relating to procurement process in IPF operations; (b) for procurement process complaints received on contracts subject to the World Bank's prior review, submit the borrower's proposed response to each complaint before issuing it to the complainant(s); (c) record the borrower's response to the procurement process complaints upon issuance to the complainant(s); and (d) promptly register requests for debriefings and update STEP with the record of the debriefings to interested parties.

7. **Record Keeping**: All records pertaining to award of contracts, including bid notification, bid opening minutes, bid evaluation reports and all correspondence pertaining to bid evaluation, communication exchanged with the Bank and the bidders/consultants in the process, bid securities, approval of invitation/evaluation of bids

must be retained by the PMU.

8. **National Procurement Procedures**: National competition for the procurement of goods, works and non-consulting services according to the established thresholds will be conducted in accordance with paragraphs 5.3 – 5.6 of Section V of the Regulations and the following provisions:

    1. Only the model bidding documents for National Competitive Procurement (NCP) agreed with the GOI Task Force (and as amended for time to time), shall be used for bidding.
    2. Invitations to bid shall be advertised on a widely used website or electronic portal with free open access at least 30 days prior to the deadline for the submission of bids, unless otherwise agreed in the approved procurement plan.
    3. No special preference will be accorded to any bidder either for price or for other terms and conditions when competing with foreign bidders, state-owned enterprises, small-scale enterprises or enterprises from any given State.
    4. Except with the prior concurrence of the Bank, there shall be no negotiation of price with the bidders, even with the lowest evaluated bidder.
    5. Government e-Marketplace (GeM)* set-up by Ministry of Commerce, Government of India will be acceptable for procurement under Request for Quotations (RFQ) method.
    6. At the Borrower's request, the Bank may agree to the Borrower's use, in whole or in part, of its electronic procurement system, provided that the Bank is satisfied with the adequacy of such system.
    7. Procurement will be open to eligible firms from any country. This eligibility shall be as defined under Section III of the Procurement Regulations. Accordingly, no bidder or potential bidder shall be declared ineligible for contracts financed by the Bank for reasons other than those provided in Section III of the Procurement Regulations.
    8. The request for bids/request for proposals document shall require that Bidders/Proposers submitting Bids/Proposals include a signed acceptance in the bid, to be incorporated in any resulting contracts, confirming application of, and compliance with, the Bank's Anti-Corruption Guidelines, including without limitation the Bank's right to sanction and the Bank's inspection and audit rights.
    9. The Borrower shall use an effective complaints mechanism for handling procurement related complaints in a timely manner.
    10. Procurement Documents will include provisions, as agreed with the Bank, intended to adequately mitigate against environmental, social (including sexual exploitation and abuse and gender-based violence), health and safety ("ESHS") risks and impacts.

    *Use of GeM will be allowed in lieu of RFQ/Shopping as per following details:

- up to INR 50,000 in catalog mode (viz. any available item could be selected by IA without further competition), provided selected Item/Supplier meeting the requisite quality, specification and delivery period.
- up to INR 3 Million from the Supplier having lowest price amongst at least three Suppliers meeting the requisite quality, specification and delivery period. The tools for online bidding and online reverse auction available on GeM may be used by the Purchaser.
- up to INR equivalent of US$100,000 from the Supplier having lowest price and meeting the requisite quality, specification and delivery period after mandatorily obtaining bids from at least three Suppliers, using online bidding or reverse auction tool provided on GeM.

ANNEX 7: Implementation Arrangements and Support Plan

COUNTRY: India
Mizoram Health Systems Strengthening Project

The Implementation Support Plan for the project has been developed based on the specific nature of the project activities, lessons learned from past operations in the country and sector. The plan will be reviewed once a year to ensure that it continues to meet the implementation support needs of the project.

1. **Approach to implementation support**. The implementation support strategy is based on the combination of several mechanisms that will enable enhanced implementation support to the Government of Mizoram and timely and effective monitoring. This will include: (a) intensive supervision and hand-holding in the first two years; (b) regular technical meetings and field visits by the World Bank team; (c) internal audit, procurement, and financial management reporting; and (d) independent third-party monitoring/validation to assess and monitor progress of the project throughout its implementation. Most information would be collected through the state's system (routine MIS, facility-based assessments, evaluations) and the remaining information will be collected either directly by the PMU or validation of data using data triangulation.

2. During the first year, the World Bank team will undertake at least two implementation support mission, and field visits (subject to lifting of travel restrictions due to COVID-19). The purpose of the mission will be to review the project performance against the Results Framework, progress made towards targets, and agreement on planned actions. The mission will also include monitoring compliance with financial management, procurement, and safeguards requirements. In case of travel restrictions, more frequent (3-4 per year) virtual missions will be undertaken by the team with the same objective. One month before the formal review mission, the Project Management Unit will provide to the World Bank a progress report on project activities. In addition to this formal mission, punctual technical missions to Mizoram by the World Bank team (in person or virtually) will be undertaken to provide focused support to start-up and implementation.

3. The World Bank FM, procurement, social, and environmental specialists who are based in the country office will play a vital role in successful project implementation support, given that the project includes capacity building in these areas for the department/directorate, hospitals, and/or communities. These World Bank specialists, in collaboration with the task team leader and team, are expected to provide timely, effective, and intensive support to the client.

4. The first year of implementation will be critical in ensuring that project human resources and technical capacity are in place to improve organizational performance and enable implementation of project activities. The focus in the first year will need to be on the following issues: consolidating the Project Management Unit; recruiting consultants to support the Project Management Unit; establishing coordination mechanisms within directorates and other departments; contracting organizations; setting up mechanisms to improve accountability and monitoring.