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Report No: PAD4928

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$500 MILLION

TO

INDIA

FOR AN

INDIA'S ENHANCED HEALTH SERVICE DELIVERY PROGRAM (EHSDP)

June 4, 2022

Health, Nutrition, and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2022)

Currency Unit =	Indian Rupees (INR)
INR 76.52 =	US$1
US$ 0.013 =	INR 1

FISCAL YEAR
April 1 – March 31

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ABBREVIATIONS AND ACRONYMS

AB	Ayushman Bharat
ACG	Anti-Corruption Guidelines
ANC	Antenatal Care
ASHA	Accredited Social Health Activist
BMW	Biomedical Waste
BPHU	Block Public Health Unit
CBAC	Community-Based Assessment Checklist
CPF	Country Partnership Framework
COVID-19	Coronavirus Disease 2019
CPHC	Comprehensive Primary Health Care
CSS	Centrally Sponsored Scheme
DALY	Disability-Adjusted Life Year
DLI	Disbursement-Linked Indicator
DLR	Disbursement-Linked Results
DH	District Hospital
DoHFW	Department of Health and Family Welfare
EHSDP	Essential Health Service Delivery Program
ESSA	Environmental and Social Systems Assessment
FM	Financial Management
FMG	Financial Management Group
GDP	Gross Domestic Product
GoI	Government of India
GRS	Grievance Redress Service
GST	Goods and Services Tax
HMIS	Health Management Information System
HQSS	Lancet Global Health Commission on High Quality Health Systems in the SDG Era
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSC	Health Sub-Center
HVC	High-Value Contract
HWC	Health and Wellness Center
IFSA	Integrated Fiduciary Systems Assessment
ITDA	Integrated Tribal Development Agency
IVA	Independent Verification Agency
JAS	Jan Arogya Samitis
JS	Joint Secretary
KPI	Key Performance Indicator
MAS	Mahila Arogya Samitis
MoHFW	Ministry of Health and Family Welfare
NCD	Noncommunicable Disease
NHM	National Health Mission
NHP	National Health Policy
NITI Aayog	National Institution for Transforming India

NQAS	National Quality Assurance Standards
OOPE	Out-of-Pocket Expenditure
PAP	Program Action Plan
PDO	Program Development Objectives
PEF	Program Expenditure Framework
PFM	Public Financial Management
PFMS	Public Financial Management System
PforR	Program-for-Results
PHC	Primary Health Center
PHSPP	Public Health Systems for Pandemic Preparedness Program
PIP	Program Implementation Plan
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PM-JAY	Pradhan Mantri Jan Arogya Yojana
QOC	Quality of Care
QOCS	Quality of Care Strategy
RA	Results Area
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SC/ST	Scheduled caste and scheduled tribe (SC/ST)
SHS	State Health Society
SPMU	State Program Management Unit
TA	Technical Assistance
UCHC	Urban Community Health Center
UPHC	Urban Primary Health Center
VHSNC	Village Health Sanitation and Nutrition Committee
XV-FC	Fifteenth Finance Commission

TABLE OF CONTENTS

DATASHEET I
I. STRATEGIC CONTEXT 1
A. Country Context 1
B. Sectoral and Institutional Context of the Program 1
C. Relationship to CPF and Rationale for Use of Instrument 5
II. PROGRAM DESCRIPTION 6
A. Government program ("p") 6
B. Theory of Change 8
C. PforR Program Scope ("P") 8
D. Program Development Objective(s) (PDO) and PDO-Level Results Indicators 15
E. Disbursement Linked Indicators and Verification Protocols 16
III. PROGRAM IMPLEMENTATION 17
A. Institutional and Implementation Arrangements 17
B. Results Monitoring and Evaluation 19
C. Disbursement Arrangements 20
D. Capacity Building 20
IV. ASSESSMENT SUMMARY 20
A. Technical (including Program economic evaluation) 20
B. Fiduciary 23
C. Environmental and Social 24
V. GRIEVANCE REDRESS SERVICES 26
VI. RISK 26
ANNEX 1. RESULTS FRAMEWORK MATRIX 28
ANNEX 2. DISBURSEMENT LINKED INDICATORS, DISBURSEMENT ARRANGEMENTS AND VERIFICATION PROTOCOLS 39
ANNEX 3. TECHNICAL ASSESSMENT 65
ANNEX 4. FIDUCIARY SYSTEMS ASSESSMENT 68
ANNEX 5. SUMMARY ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT 71
ANNEX 6. PROGRAM ACTION PLAN 74

DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
India	India's Enhanced Health Service Delivery Program	
Project ID	**Financing Instrument**	**Does this operation have an IPF component?**
P178146	Program-for-Results Financing	No

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Fragile State(s)
[ ] Contingent Emergency Response Component (CERC)	[ ] Fragile within a non-fragile Country
[ ] Small State(s)	[ ] Conflict
[ ] Alternate Procurement Arrangements (APA)	[ ] Responding to Natural or Man-made Disaster
[ ] Hands-on Enhanced Implementation Support (HEIS)	

Expected Project Approval Date	Expected Closing Date
28-Jun-2022	30-Jun-2027

Bank/IFC Collaboration

No

Proposed Program Development Objective(s)

To increase utilization of comprehensive primary health care services, improve quality of care, and strengthen governance of the health sector in India.

Organizations

Borrower :	India
Implementing Agency :	Department of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India

Contact:	Ms. Roli Singh
Title:	Additional Secretary and Mission Director NHM
Telephone No:	01123063693
Email:	roli.singh@ias.nic.in
Implementing Agency :	Ministry of Health and Family Welfare, Government of India
Contact:	Mr. Vishal Chauhan
Title:	Joint Secretary (Policy)
Telephone No:	01123063585
Email:	js.policy-mohfw@gov.in

COST & FINANCING

SUMMARY

Government program Cost	42,000.00
Total Operation Cost	1,223.00
Total Program Cost	1,221.75
Other Costs	1.25
Total Financing	1,223.00
Financing Gap	0.00

Financing (USD Millions)

Counterpart Funding	**723.00**
Borrower/Recipient	723.00
International Bank for Reconstruction and Development (IBRD)	**500.00**

Expected Disbursements (USD Millions)

Fiscal Year	2022	2023	2024	2025	2026	2027

Absolute	0.00	74.30	88.14	138.08	143.47	54.76
Cumulative	0.00	74.30	162.44	300.52	443.99	498.75

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	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Moderate

COMPLIANCE

Policy

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

[ ] Yes [✔] No

Does the program require any waivers of Bank policies?

[ ] Yes [✔] No

Legal Operational Policies

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

Legal Covenants

Sections and Description

The Borrower, through MoHFW, shall maintain throughout the implementation of the Program, the National Steering Committee, chaired by the Secretary Health and Family Welfare (MoHFW), which shall, inter alia, scrutinize financial proposals, provide policy direction and review the overall Program performance.

Sections and Description

The Borrower, through MoHFW, shall cause each Priority State to: (i) implement the Program through its respective State Health Society in collaboration with the respective DoHFW; (ii) ensure its respective State Health Society has competent, experienced and qualified staff, in sufficient numbers and under terms of reference and with qualifications acceptable to the Bank, responsible for, inter alia, monitoring and tracking implementation of Program activities in the respective Priority State.

Sections and Description

The Borrower, through MoHFW, shall issue a memorandum (Office Memorandum) which shall contain, inter alia: (i) the implementation arrangements for the Program at the state level; (ii) actions to be undertaken by each Priority State in accordance with the Program Action Plan (as applicable), the ESSA and the IFSA; (iii) activities to be undertaken by each Priority State to achieve the DLIs; (iv) the modalities to implement Anti-Corruption Guidelines; and (v) financial management and procurement arrangements at the state level, all in accordance with the provisions of this Agreement.

Sections and Description

The Borrower, through MoHFW, shall:

I. Ensure that the Program'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;

II. In the event that, during the implementation of the Program, the approval of any new legislation regarding Personal Data protection may have an impact on the activities financed by the Program, ensure that a technical analysis of said impact is conducted, and that the necessary recommendations concluding the assessment and adjustments deemed necessary to efficiently protect Personal Data, are implemented, as appropriate; and

III. Except as may otherwise be explicitly required or permitted under this Agreement and/or one or more of the Program Agreements, 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.

Conditions

Type	Financing source	Description
Disbursement	IBRD/IDA	No withdrawal shall be made: (i) on the basis of DLRs achieved prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed US$24,760,000 may be made on the basis of DLRs achieved prior to this date but on or after November 29, 2021; or (ii) for any DLR until and unless the Borrower has furnished evidence satisfactory to the Bank that said DLR has been achieved.
Type	Financing source	Description
Disbursement	IBRD/IDA	Notwithstanding the provisions of Part B.1(b) of this Section, the Borrower may withdraw an amount not to exceed USD125,000,000 as an advance; provided, however, that if the DLRs in the opinion of the Bank, are not achieved (or only partially achieved) by the Closing Date, the Borrower shall refund such advance (or portion of such advance as determined by the Bank in accordance with the formula for allocated amounts for the DLRs a set forth in the table in Schedule 4 to the Agreement) to the Bank promptly upon notice thereof by the Bank. Except as otherwise agreed with the Borrower, the Bank shall cancel the amount so refunded. Any further withdrawals requested as an advance under any Category shall be permitted only on such terms and conditions as the

		Bank shall specify by notice to the Borrower.

I. STRATEGIC CONTEXT

A. Country Context

1. **Growth rebound in FY22 has been quick, pulled up by investment, recovering consumer demand and, more importantly, a low base.** Real Gross Domestic Product (GDP) growth moderated from an average of 7.4 percent during FY14/15-FY18/19 to an estimated 3.7 percent in FY19/20, mostly due to (i) shocks to the financial sector, and (ii) decline in private consumption growth.[1] Against this backdrop, the outbreak of Coronavirus Disease (COVID-19) had a significant impact, with real GDP contracting by 6.6 percent in FY20/21.[2] On the fiscal side, the general government deficit widened significantly in FY20/21, owing to higher spending and low revenues.[3] However, with the easing of COVID-19 restrictions, Goods and Services Tax (GST) collections have crossed INR 1.1 trillion mark every month since July 2021 reaching as high as INR 1.67 trillion mark as of April 2022. The robust GST revenues are expected to continue as the economic recovery gathers momentum. World Bank (WB) forecasts that real GDP growth for FY21/22 is likely to be 8.3 percent,[4] on the back of increased capital expenditure by the government and recovering consumer demand. The real GDP in FY21/22 is expected to reach the FY19/20 level. Given the global concerns on significant uncertainty around the pandemic, elevated inflation, geo-political tensions, and extended supply disruptions, growth in FY22/23 is expected to be 8 percent. Nonetheless, the expected recovery will put India among the world's fastest-growing economies over the next two years.

2. **Although India has made remarkable progress in reducing absolute poverty in recent years, including due to the allocation of significant resources for social assistance programs, the COVID-19 outbreak has delayed the course of poverty reduction.** Between 2011-12 and 2020-21, India's poverty rate has declined from 22.5 percent to values estimated to range between 9 to 12.3 percent.[5] However, projections of GDP per capita growth suggest that this estimated decline also includes a reversal of poverty reduction due to the pandemic. Labor market indicators from high frequency surveys -including from the Centre for Monitoring Indian Economy- suggest that vulnerability has increased after the pandemic, particularly for urban households, with a moderate recovery in 2021. Overall, the pandemic and its economic impacts are estimated to have raised urban poverty, creating a set of "new poor" that are relatively more likely to be engaged in the non-farm sector and to have received at least secondary education. To respond to the pandemic, the Government of India (GoI) has deployed significant resources as part of the Prime Minister Garib Kalyan Yojana for social assistance, including for urban poor households and migrants.

B. Sectoral and Institutional Context of the Program

3. **India's performance in health has improved substantially over time, yet wide variation exists across states and indicators**. According to WB estimates, India's life expectancy—at 69.8 in 2020, up from 58 in 1990—is higher than the average for its income level. Under-five mortality rate (36 per 1,000 live births), infant mortality rate (30 per 1,000 live births), and maternal mortality ratio (103 per 100,000 live births) are all close to the average for India's income level, reflecting significant achievements in access to skilled birth attendance, immunizations, and other priority services.[6] However, India lags global trends on

[1] National Accounts Data, National Statistical Office, Ministry of Statistics and Programme Implementation (MOSPI).
[2] Ibid.
[3] Union budget 2021, 2022, Ministry of Finance, GoI.
[4] World Bank estimate compared to the GoI's second advance estimate of 8.9 percent.
[5] Consumption Expenditure Survey 2011-12, National Sample Survey Office (NSSO), GoI.
[6] Office of the Registrar General & Census Commissioner, India, Sample Registration System (SRS).

other key indicators, such as stunting (35.5 percent).[7] The country faces a double burden of disease: (i) an unfinished agenda related to reproductive, maternal, newborn, child, and adolescent health (RMNCAH), malnutrition, and communicable diseases; and (ii) a rapidly growing prevalence of chronic non-communicable diseases (NCDs). The NCDs are now the dominant share of the overall disease burden in the country. This has long-term implications for health, learning, employability, and economic performance.

4. **Significant progress has been made in India's health system, but some areas need further strengthening.** First, *access to health care services is not equal or equitable.* Wide disparities in all key health outcome indicators exist across states as reflected in the health index of the National Institution for Transforming India (NITI Aayog). Poor and scheduled caste and scheduled tribe populations have far worse outcomes than average. Access to care also varies by types of services (for example, there is less access to NCD services compared to RMNCAH services) and residence (for example, urban poor have limited access to health services as compared with rural population). There are still pockets of low immunization coverage with some children receiving not even a single vaccine dose ("zero-dose children"). Second, *quality of care remains a key challenge.* Despite progress on structural quality, more efforts are required to address competent care processes and patient experience to optimize patient outcomes. Comprehensive family planning counseling and a wide contraceptive method mix remain elusive. While in some states, Caesarean sections (C-sections) are not being performed due to structural quality issues, in other states, C-section rates are higher than global recommendations. Third, India faces *systemic challenges with the adequacy, distribution, and competencies of its health workforce*. There is shortage as well as numerical and distributional imbalances of the health workforce. Fourth, *while in real per capita terms levels of public financing for health have increased, they remain extremely low as a share of GDP*. Public spending on health in India is only 1.35 percent of GDP (approximately US$21 per person); global benchmarks indicate that this should be higher to accelerate progress towards UHC, with some in the literature recommending that this should be at least as much as 5 percent.[8] Last, India's population has *inadequate financial risk protection* against catastrophic and impoverishing medical expenses. An estimated 60 million Indians are pushed into poverty each year due to high out-of-pocket expenditure (OOPE) on health, currently 48.8 percent of total health expenditure.[9]

5. **These health system performance challenges can be traced to several key bottlenecks.** At the national level, lack of streamlined data systems to monitor performance, fragmented vertical programs, inadequate coordination and learning across states, insufficient technical and operational support to states, and weak public financial management impede performance. Insufficient focus on competent clinical care processes and patient experience that lead to quality improvement and ultimately better health outcomes is another key bottleneck impeding performance. At the state level, there is also variable implementation of national programs and policies, absence of human resources for health (HRH) strategies to plan and budget for current and future needs, inadequate attention to quality, and limited capacity to monitor and reward performance. As a result, India ranks 6 (out of 8 countries) in South Asia on the Healthcare Access and Quality Index.[10]

[7] International Institute for Population Sciences (IIPS), 2022. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS.
[8] McIntyre, Meheus and Rottingen. What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law* (2017), 12, 125–137.
[9] National Health Systems Resource Centre (2021). National Health Accounts Estimates for India (2017-18). New Delhi: MoHFW, GoI.
[10] Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2015 (GBD 2015) Healthcare Access and Quality Index Based on Amenable Mortality 1990–2015. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2017.

6. **India's performance in health is the result of various factors, including several that are outside the immediate purview of the health sector.** The role of women in society, access to adequate housing, water, and sanitation, and educational attainment are some examples of extraneous factors that impact health outcomes. Exposure to risk factors due to climate change, urbanization, changing lifestyles, air and water pollution, and road traffic accidents are rising dramatically. India faces increasing climate-related vulnerabilities and disasters, and the Global Climate Risk Index 2021 ranks India as the 7th most affected nation.[11] Thus, any investments in health will have to account for climate impacts and ensure mitigation of such effects.

7. **Gender disparities hinder women and girls' access to health care due to concerns around out-of-pocket spending trends on health care and limited autonomy in decision-making.** Intra-household dynamics skew the allocation of health care financing away from women and negatively affect women and girls' access to health care. Further, women are less likely to have much disposable income or control over finances within the household. This results in low utilization of health services by women. The proportion of pregnant women with four or more antenatal care (ANC) visits is only 58 percent.[12] Further, clinical data for outpatients show poorer access to health facilities for younger (15–18 years) and female patients 50 years and older compared to those age 19-49 years. Finally, inter-generational power dynamics within the household and restrictive social norms negatively affect young women's access to peer networks, visits to family planning clinics and access to reproductive health care, and decision-making.[13]

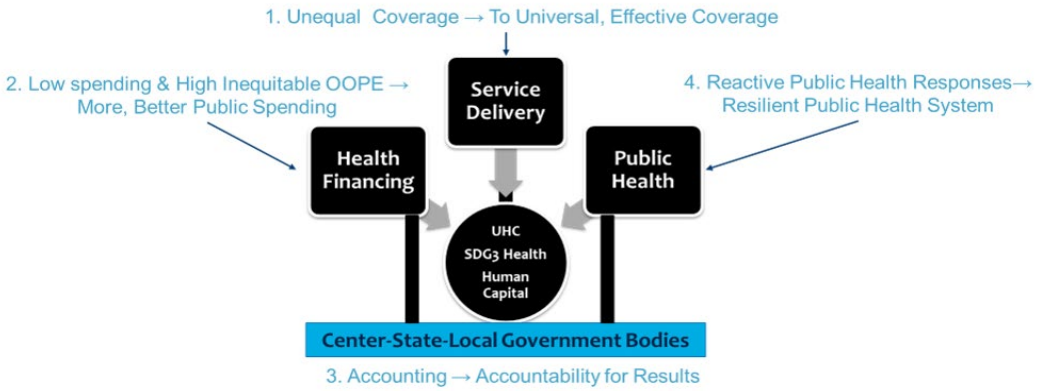
8. **The COVID-19 pandemic is reversing some of the hard-won gains and illustrating the collateral damage of the pandemic on the health system.** The health management information system (HMIS) data for 2020–21 confirmed steep year-over-year declines in the delivery of routine health services (over 30 percent for both) and an average reduction of 13 percent across 22 priority RMNCAH services.[14] Progress toward the zero-dose vaccination goal has been affected due to drop in coverage, large-scale displacement, and school closures.[15] Relatedly, there has been a major decline in hospital utilization among the poor. Pradhan Mantri Jan Arogya Yojana (PM-JAY)[16] utilization declined by 40 percent during 2020 Q2 compared to the previous quarter, and by 33 percent during 2021 Q2 compared to Q1, with sharper declines for key services such as cancer care.[17] To have a health system that can provide an increasing volume of services, manage increasingly complex conditions, and be better prepared to maintain essential service delivery even amid disease outbreaks and other emergencies, India needs to invest even more in the primary health care system and address key challenges in quality of care.

9. **The COVID-19 outbreak has re-emphasized the need and urgency for significant reforms to improve health sector performance.** Four key health system reforms need to be prioritized (Figure 1):

[11] https://germanwatch.org/sites/default/files/Global%20Climate%20Risk%20Index%202021_1.pdf.
[12] International Institute for Population Sciences (IIPS), 2022. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS.
[13] Bring a Friend: Strengthening Women's Social Networks and Reproductive Autonomy in India; World Bank Working Papers, 2021.
[14] World Bank staff analysis based on publicly available HMIS data
[15] Murhekar, M.V. and Kumar, M.S., 2021. Reaching zero-dose children in India: progress and challenges ahead. The Lancet Global Health, 9(12), pp.e1630-e1631.
[16] PM-JAY is GoI's health insurance program that provides free cash-less access to hospitalization related care to poor households, i.e, the bottom 40 percent of India's population. By offering services to 500 million people, it is the world's largest government sponsored health insurance program.
[17] Smith, O., P. Naib, P. Sehgal, S. Chhabra (2020). "PM-JAY under Lockdown: Evidence on Utilization Trends". PM-JAY Policy Brief #8.

- **Ensure universal, effective coverage.** Service delivery has been redesigned by the GoI for providing comprehensive primary health care (CPHC). This will not only strengthen the provision of quality RMNCAH services but also includes NCDs and mental health, building a people-centered health system focused on quality, with an adequate and well-equipped health workforce and robust information systems that addresses the unique challenges of urban health care delivery. Furthermore, primary health care (PHC) is the most pro-poor level of the government health system and strengthening PHC helps the most disadvantaged households. The GoI has already embarked upon this with multiple initiatives and programs to redesign CPHC, especially since 2018, which can be consolidated and further scaled up for maximum impact.
- **Spend more and spend better.** Increasing government spending on health and strengthening public sector systems and strategic engagement of the private sector will maximize the impact of health sector spending. The GoI's health expenditure increased from 1.15 to 1.35 percent of GDP between 2013–14 and 2017–18 but remains short of the MOHFW's latest National Health Policy (NHP 2017) target of 2.5 percent.[18]
- **Move toward a system of accountability for results.** The health sector's focus needs to be on the transition from inputs to outputs and outcomes at all levels, including strengthening data systems, enhancing accountability, performance-based management, and gradual shifts in payment methods. The National Health Mission (NHM),[19] a major GoI initiative that aims to strengthen health systems, has already made great strides on this, including establishing performance incentives to states (NHM Conditionality Framework) and a Program Implementation Plan (PIP) simplification/redesign. Nevertheless, similar performance incentives (whether financial or non-financial) need to be strengthened or replicated at different levels, such as the primary care (e.g. health and wellness center [HWCs]) and district levels, to enhance accountability for results across the entire system.
- **Build a resilient public health system.** The COVID-19 pandemic revealed that India needs to strengthen core public health functions to build a robust public health system resilient to shocks.

Figure 1. India's 21st century vision of "Universal and Effective Health Coverage"



[18] Ministry of Health and Family Welfare (MoHFW). GoI. National Health Accounts. Estimates for India, 2017–18. 2021.

[19] The NHM aims to strengthen health systems and improve RMNCAH, communicable diseases, and NCDs. It began in 2005 with substantial government financing from center and state budgets as well as implementation structures in place. NHM is the primary platform for health service delivery in India's public sector.

10. **The recognition that the public health system needs to respond to outbreaks while continuing to deliver other essential health services led to the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), a scheme launched in October 2021.** PM-ABHIM complements NHM and has a three-pronged approach to health sector reform. First, it seeks to strengthen the public health system, with a focus on bolstering infrastructure, to deliver universal CPHC. Second, it expands and builds an information technology (IT)-enabled disease surveillance system for detecting outbreaks, assessing disease burden and monitoring trends. Third, it supports biomedical research and the One Health approach to respond to epidemics.[20] While the PM-ABHIM is a new scheme, it builds on and utilizes the NHM implementation platform. The PM-ABHIM – building on successes of NHM – provides the opportunity for a long-term transformational reform agenda for equipping India's health system for the 21st century.

11. **Given India's federal system and the corresponding decentralized nature of health service delivery, distinguishing between center (national government) and state roles is critical for health sector reforms.** Health is a state responsibility in India as defined in its constitution, and while some functions remain largely at the national level, most others are either shared with states or rest primarily with states. The proposed Enhanced Health Service Delivery Program (EHSDP) implementation framework recognizes that the center holds responsibility for providing financing, defining the overall policy framework, identifying priority results, developing performance monitoring frameworks and providing incentives to achieve results, providing technical assistance (TA) to states, and creating a platform for implementation research, cross-state learning, and knowledge exchange. States hold the responsibility for providing financing, implementing, and achieving results, coordinating within the state (district, block, local bodies, and private sector), and convergence across sectors and programs. About 40 percent of government financing for health flows from the national level to states largely through centrally sponsored schemes (CSSs) that are co-financed and implemented by the states.[21] The overall levels of state spending, including the funding from the national level under CSSs, vary significantly by state. With respect to organization of the public health sector, there is less variation with most states delivering primary care through health sub-centers (HSCs) and PHCs, secondary care through community health centers (CHCs) and district hospitals (DHs), and tertiary care through DHs and medical colleges (MCs). The level of community and local government engagement in the management of public health facilities, organization in terms of the role of the public sector versus the private sector, and payment mechanisms and modalities for health sector staff vary substantially across states.

C. Relationship to CPF and Rationale for Use of Instrument

12. **The proposed Program for Results (PforR) Program is directly aligned with the World Bank Group India Country Partnership Framework (CPF) FY18–22 discussed at the Board of Executive Directors on September 20, 2018 (Report No. 126667-IN).** The Program contributes to the CPF's Focus Area 3: Investing in Human Capital and is directly linked to the key objective 3.4, 'to improve the quality of health service delivery and financing and access to quality health care.' By focusing on improving and expanding the coverage, scope, and quality of primary health care delivery, the Program will support universal access to health care which is critical for improving health outcomes. In doing so, it adopts three of the four catalytic approaches outlined in the CPF: (i) engaging a federal India, by prioritizing direct

[20] One Health is a collaborative, multisectoral, and transdisciplinary approach recognizing the interconnection between people, animals, plants, and their shared environment.

[21] MoHFW, Government of India, National Health Accounts Estimates for India, 2017-18. 2021

results in select states and providing TA to support governance and accountability reforms to strengthen state capacities to deliver more effectively and efficiently; (ii) strengthening public health institutions, through innovative approaches and mechanisms for urban primary health care delivery, leveraging the private sector and urban local bodies; and (iii) supporting a "Lighthouse India", with establishment of a platform for knowledge generation and exchange being an integral part of the proposed Program.

13. **As the Program will be anchored on and enhance the efficiency and effectiveness of the GoI's existing health sector program, the PforR is considered the most suitable financing instrument**. The PforR instrument will promote a shift from inputs to outcomes, through a greater alignment of financing with results. The GoI has already embraced this results-focus through a program framework with clearly defined prioritized interventions for the PM-ABHIM scheme as well as a focus on performance in the NHM. The Program will thus build on and strengthen the existing institutional capacity and fiduciary systems of the Ministry of Health and Family Welfare (MoHFW), which is critical for the health system to move to the next level of performance and well-aligned with the principles of a PforR operation.

II. PROGRAM DESCRIPTION

A. Government program ("p")

14. **The Government program ("p") is anchored on India's National Health Policy (NHP) 2017** which calls for a paradigm shift from limited and selective PHC to provision of comprehensive services at frontline public facilities along with appropriate referral linkages. For secondary and tertiary care, NHP 2017 emphasizes the need for a move from input-based financing to output-based strategic purchasing for both public and private providers.

15. **The GoI is implementing several transformational reforms in support of NHP 2017. The first one was the Ayushman Bharat (AB) Centrally Sponsored Scheme (CSS) which was launched in 2018 with two key pillars.**[22] One of these pillars, named AB-HWC, introduced service delivery redesign to enable the provision of comprehensive primary health care, in large part through the establishment of health and wellness centers (HWCs). AB-HWC focuses on strengthening delivery of comprehensive primary health care services at health sub-centers and primary health care facilities in rural and urban areas. AB-HWC also leverages existing platforms to deliver services and information at the community level. It endeavors to expand PHC from the existing limited package of RMNCAH services to a comprehensive package that also includes communicable and non-communicable diseases, mental and oral health, ophthalmic and ear/nose/throat services, emergency services and elderly/palliative care. In addition, Accredited Social Health Activists (ASHAs) undertake home visits to ensure screening, risk factor modification, counselling, and adherence to treatment. The CPHC redesign introduced through AB-HWCs is a key step in ensuring universal and effective coverage.

16. **The AB-HWC CSS is implemented through NHM and relies on the institutional mechanisms, governance structures, and systems created under the NHM.** The AB-HWC program leverages several NHM health system reforms including decentralized decision-making to states; strengthening governance, financing, and procurement systems; providing performance and innovation incentives; using technology; deploying quality of care initiatives in public health facilities; and promoting community ownership and

[22] The two pillars of Ayushman Bharat were AB-HWC and AB-PMJAY. The first focuses on the provision of comprehensive primary health care while the second enables financial access to in-patient hospital care for the poorest 40%.

engagement initiatives. Several improvements have been made in enhancing the size, composition, competence, and management of the health workforce deployed in the public sector.

17. **As mentioned in paragraph 10, in 2021, the GoI announced the launch of the PM-ABHIM CSS, also implemented through the NHM implementation platform and complementary to the efforts of AB-HWC.** Building on lessons from the COVID-19 pandemic, the PM-ABHIM aims to create critical institutions and systems for preventing, as well as promptly detecting, and responding to future pandemics and expanding delivery of high-quality people-centric primary healthcare services. The PM-ABHIM includes strengthening health and wellness centers, especially in urban areas.

18. **In addition, in 2021, the GoI launched the Fifteenth Finance Commission (XV-FC) grants to local bodies to address health.** These grants are intended to support primary care, including gaps in diagnostic infrastructure for PHCs, block public health units (BPHUs), and HWCs. A substantial share of XV-FC local grants is targeted to improve infrastructure for primary care and important social determinants of health. Given the complementarity with PM-ABHIM and AB-HWCs, the XV-FC grants provide a critical contribution to the realization of CPHC transformational agenda. Effective and efficient use of the XV FC local grants requires not only coordination between the state health departments and local bodies but also improved state capacity of local bodies.

19. **The proposed Program comprises a well-defined subset of the GoI program that is anchored on PM-ABHIM and AB-HWC and will contribute to the GoI's overall and ambitious health reform agenda to achieve India's 21st century vision of "Universal and Effective Health Coverage."** Together with the Transforming India's Public Health Systems for Pandemic Preparedness Program (PHSPP; P175676), the proposed Program aims to strengthen delivery of healthcare services, including the system's underlying accountability mechanisms, across the continuum of care. *The PHSPP primarily focuses on the central sector components of PM-ABHIM to improve disease surveillance* by expanding a surveillance system and One Health coordination, enhancing bio-security capacity, and transforming core public health institutions and research agencies for strengthened pandemic response capacity. *This proposed Program (EHSDP), on the other hand, focuses on strengthening India's primary health care system* and quality of care to improve health outcomes, including the system's underlying accountability mechanisms. Table 1 illustrates the mapping of the different engagements with each priority reform (described in paragraph 9). The proposed EHSDP also builds on several ongoing state- and city-level lending operations focused on system strengthening for essential health service delivery (e.g. Tamil Nadu Health System Reform Program [P166373]; Andhra Pradesh Health Systems Strengthening Project [P167581]; and Chennai City Partnership: Sustainable Urban Services Program [P175221]). By drawing on lessons from WB-financed operations in the sector in India, and global experience and evidence, there is increased likelihood of successful reforms and Program implementation.

Table 1. Contribution of WB-financed Operations to India's Health Sector Reform Agenda

	Unequal Coverage → Universal, Effective Coverage	Low Spending, High Inequitable OOP → More, Better Public Spending	Accounting → Accountability for Results	Reactive Public Health Response → Resilient Public Health System
EHSDP (P178146)	■	■	■	
PHSPP (P175676)			■	■
State and City Level Operations	■	■	■	■

B. Theory of Change

20. **The proposed Program aims to assist India in implementing its health sector reforms,** by providing support to the immediate and medium-term agenda of enhancing CPHC service delivery and helping create a platform for longer-term sustainable interventions to improve quality of care, health sector governance and accountability. The Program Theory of Change summarizes the key health system bottlenecks as well as required inputs to achieve the expected outputs and outcomes (Figure 2).

C. PforR Program Scope ("P")

21. **The proposed PforR Program ("P") will tackle reforms related to ensuring universal and effective health care coverage; spending more and better; and moving toward a system of accountability for results.** The Government program is costed at US$42 billion; the proposed Program is costed at US$1,223 million; and the WB contribution would be US$500 million. Figure 3 illustrates the PM-ABHIM components and NHM programs that are included in the proposed PforR. The Program Expenditure Framework (PEF) includes recurrent expenditures and excludes capital expenditures.

22. **The Program has three key result areas with a combination of technical interventions related to the provision of CPHC and quality of care, and transversal interventions to strengthen governance and accountability.** Those are: (i) strengthened service delivery through redesigned CPHC model; (ii) improved comprehensive quality of care; and (iii) transformed health sector governance, accountability, and institutional and management capacity.

23. **Seven priority states have been identified to be part of the Program based on the following factors**:[23] (i) leveraging ongoing WB state health systems operations to deepen impact, (ii) providing a mix of high-performing and not-so-well-performing states based on the NITI Aayog-MoHFW Annual State Health Index, (iii) ensuring geographical representation from all four regions of India, and (iv) providing opportunities for knowledge sharing and cross-learning based on state-specific CPHC initiatives.

[23] Andhra Pradesh, Kerala, Meghalaya, Odisha, Punjab, Tamil Nadu, and Uttar Pradesh.

Figure 2. Program Theory of Change

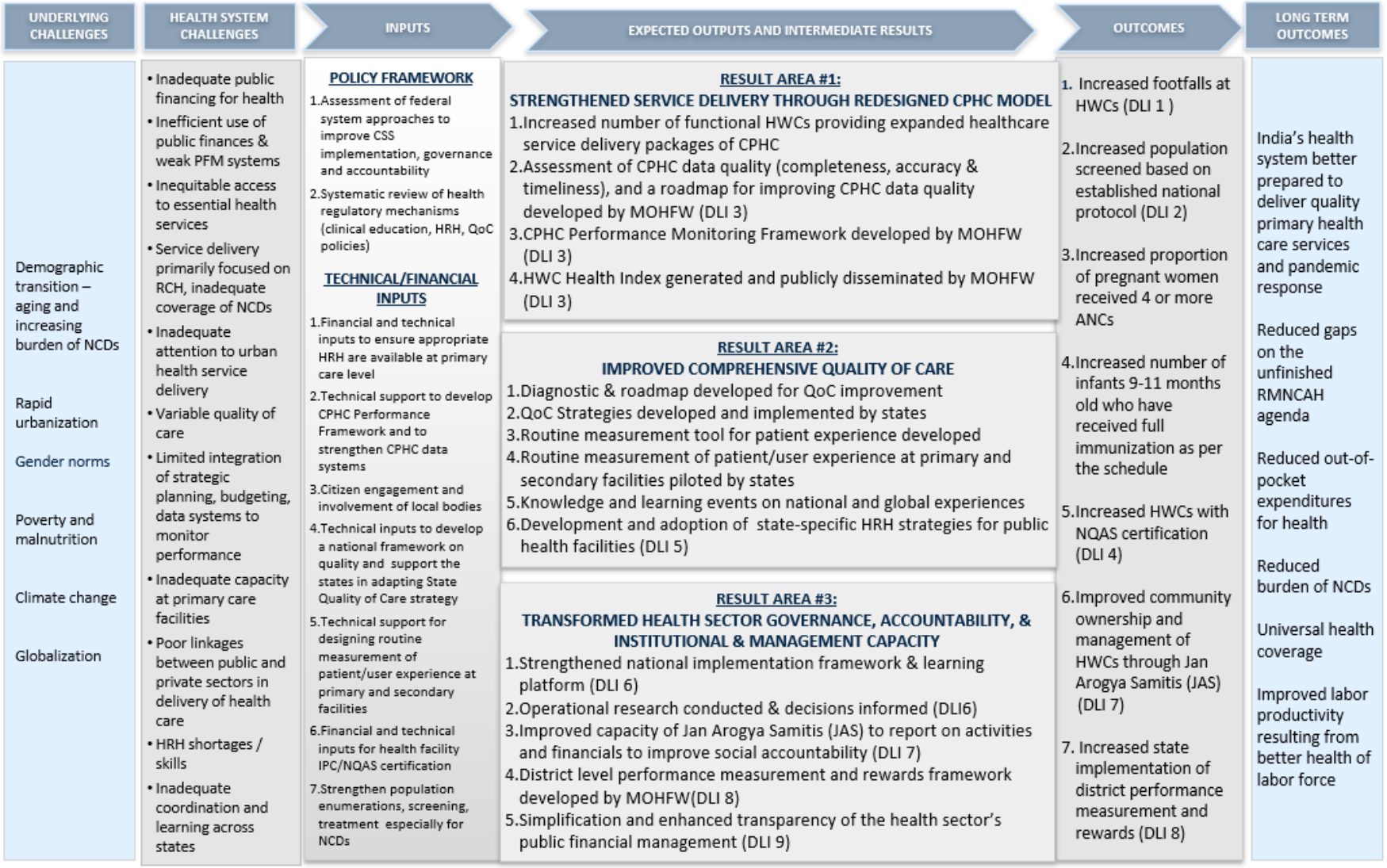
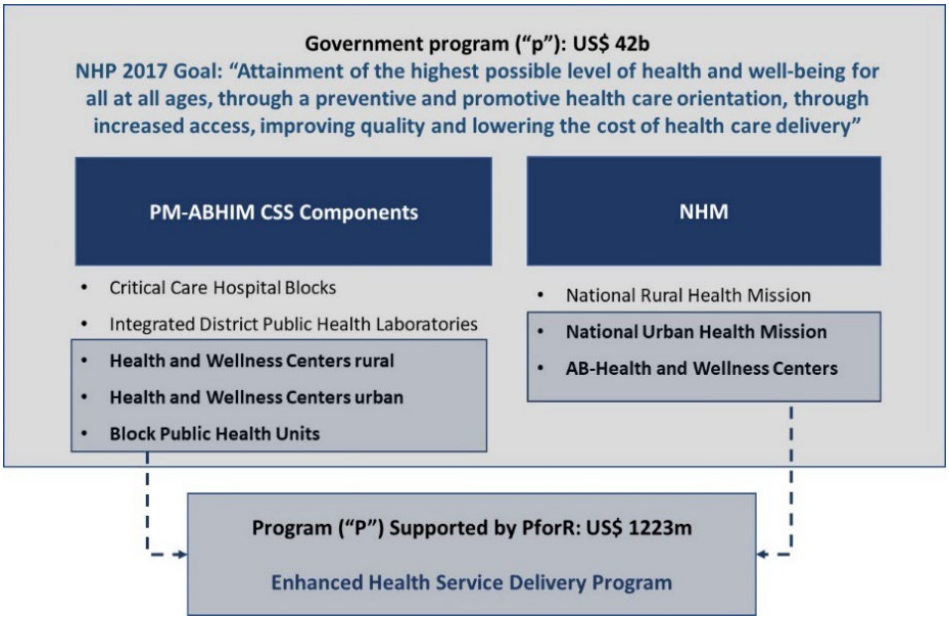


Figure 3. PforR Program Boundary



24. **The Program will support interventions across the four universal actions recommended by the 2018 Lancet Global Health Commission on High Quality Health Systems in the Sustainable Development Goal Era (HQSS):[24] redesigning service delivery, governing for quality, transforming the health workforce, and igniting demand for quality among citizens.** The Program specifically includes interventions and results that support redesigning service delivery to strengthen CPHC (for example: strengthening HWCs, population-based screening, strengthening CPHC data systems, and improving referral linkages for improved continuum of care). In addition, results that improve governing for quality include developing a comprehensive QOC framework, simplification and transparency of PFM and an implementation and learning platform. State-specific HRH strategies will be developed by priority states to transform the health workforce. Finally, igniting demand for quality among citizens will be fostered through better implementation of Jan Arogya Samitis[25] (JAS) and design and implementation of a district performance framework with public reporting of data.

RA#1: Strengthened service delivery through redesigned CPHC model

25. **Based on global best practice, RA#1 will support the implementation of an effective CPHC system in India.** This will include (i) household access to a primary health care (PHC) facility as its first port of call; (ii) stronger linkages between each household and its primary care facility through regular household visits by ASHAs (or equivalent); (iii) risk assessment of NCDs and tuberculosis, health promotion, and follow-up for treatment adherence during household visits; (iv) activities to increase utilization of services by providing complete package of services and to ensuring quality of services; (v) effective referrals between PHC and higher-level health facilities; and (vi) systems to closely monitor and incentivize performance of facilities on PHC service delivery. RA#1 will provide support to strengthen last-

[25] Jan Arogya Samiti (JAS) – 'people's health committee' – has the objective of institutionalizing people's participation in facility management to ensure quality service delivery to all members, planning and addressing social determinants of health, and resolving their grievances in seeking health care. JAS is considered a mechanism for democratizing health and promoting active public participation in healthcare.

mile monitoring systems to also reach women-headed households and improve provision of CPHC services for women and girls. RA#1 will also support interventions to strengthen CPHC data systems, including gender-disaggregation in data collection and usage, and better tracking of CPHC performance at the HWCs.

26. **This approach towards CPHC is transformational, effectively involving a redesigning of India's health care system**. All individuals will have access to a PHC facility, which will offer an expanded range of high-quality services organized in 12 service delivery packages.[26] All will undergo risk-assessment at the household level and will be encouraged to go to the PHC in their catchment area if they are at high risk for NCDs or other diseases. If needed, they will then be referred by their PHC provider to higher-level health facilities with regular follow-up occurring at the level of the PHC. This is a holistic and people-centred model that emphasizes prevention and lifestyle changes, and continuity of care from the household level and upwards. Furthermore, interventions in RA#1 will assist the most economically vulnerable populations.

27. **RA #1 will provide support to achieve the following results:**

i. **Increased footfalls at HWCs (DLI 1).**[27] This is a composite indicator that measures the utilization of the full range of services provided at the HWC and captures every time a service is utilized by an individual at the HWC. This is a disbursement-linked indicator (DLI). It is expected to show steady progress if the Program is implemented as designed—as the functionality of the HWCs improves to deliver services, the provision of the expanded package of services increases and there is positive patient experience with utilization of services. Additionally, service provision at HWCs will include targeted information delivery for pregnant women for antenatal care (ANC), information related to NCD screening for women-headed households and reproductive health for adolescent girls.

ii. **Operationalization of HWCs.** The Program will work with the GoI on reviewing the existing HWC operationalization indicators, reporting, and processes. It will support the GoI's efforts to increase the number of fully operational HWCs across the country, and to expand the number of service packages offered, over time. The HWCs are designed to provide 12 service delivery packages; over time the number of services being delivered is expected to gradually increase. The Program will track and support operationalization of HWCs in urban areas as well.

iii. **Increased population screened based on established national protocol (DLI 2).** Appropriate population-based activities are an essential element of an effective CPHC service delivery model. These will include population-based screening through a Community Based Assessment Checklist (CBAC) for eligible persons in all households, with additional facility-level screening encouraged for those found to be of high risk. The data from the screening, disaggregated by gender, would be maintained at the relevant HWC as part of family records for each household. State-led innovations, including HRH pilots, temporary stay facilities for pregnant women (third trimester) especially for remote areas, mobile medical units, and transport facilities to improve institutional deliveries and

[26] The 12 packages are: (1) care in pregnancy and child-birth, (2) neonatal and infant health care services, (3) childhood and adolescent health care services, (4) family planning, contraceptive services and other reproductive health services, (5) management of Communicable diseases, (6) management of communicable diseases and outpatient care for acute simple illnesses and minor ailments, (7) screening, prevention, control and management of NCDs, (8) care for common ophthalmic and ENT problems, (9) basic oral health care, (10) elderly and palliative health care services, (11) emergency medical services, (12) screening and basic management of mental health ailments

[27] A footfall is defined as a visit by an individual to a HWC for any service.

post-natal check-up rates in aspirational districts will be reinforced and scaled-up under the Program. These are critical activities that will help increase utilization of CPHC services.

iv. **Strengthened CPHC data systems for improved performance tracking and performance incentives (DLI 3).** The CPHC data systems are evolving, and there is need to further strengthen the data system for cohesive monitoring of CPHC performance. The Program will work on further improving the CPHC Performance Monitoring Framework, including prioritized indicators, pooling existing data from various data sources, and assessing data quality (for timeliness, completeness, and accuracy) for CPHC information systems to identify the gaps and develop a roadmap for improving the data quality, including independent verification system. A composite CPHC Index will be developed at the HWC and district levels and will be disseminated to the public to foster accountability. A performance incentive system for HWCs based on the CPHC Performance Monitoring Framework will be strengthened, as needed, to enhance HWC performance. The Program will closely track three key indicators as proxy indicators to track increased service utilization and are part of the Program's Results Framework: (i) proportion of pregnant women with at least four ANC visits; (ii) number of infants 9–11 months old who have received full immunization as per the schedule; and (iii) proportion of infants 9-11 months old who have received first dose of pentavalent vaccine.

RA#2: Improved comprehensive quality of care

28. **RA#2 will emphasize the importance of quality of care in building a resilient and high-quality health system.** To improve QOC, there needs to be a paradigm shift from narrowly focusing on structural (input) quality to a more holistic approach encompassing competent care processes and patient experience. The Program will support the following core areas: (i) improve quality of CPHC service delivery by supporting National Quality Assurance Standards (NQAS) certification of HWCs; (ii) leverage the knowledge sharing platform to create an enabling environment for comprehensive QOC improvement extending beyond NQAS certification; (iii) refine and further develop contextualized measurement tools for quality of care, including patient experience; and (iv) strengthen the health workforce through adopting a comprehensive state-specific HRH strategy for public health care facilities.

29. **Improved quality of CPHC service delivery.** India has adopted the NQAS, as a national framework to certify public health care facilities at primary and secondary levels, including the HWCs. NQAS certification – a micro-level intervention – is an important initial step towards improving structural quality, and accountability by strengthening the feedback loops within health facilities and between facilities and the Department of Health and Family Welfare (DOHFW) in states. It provides a strong foundation to subsequently expand the reform agenda for QOC to focus on meso- and macro-level interventions. The Program will support the progress of NQAS certification of the HWCs (DLI 4).

30. **Create an enabling environment for comprehensive QOC improvement at the national and state levels.** Given that the current progress made towards QOC improvement is variable across states, an expansion of the reform agenda for QOC would benefit from knowledge sharing, both among states and from global experiences. This would facilitate an enabling environment for introducing a more comprehensive approach to improving QOC over time – including a stronger emphasis on competent care processes and patient experience. During the Program, MoHFW will conduct a diagnostic analysis to identify key issues based on which a framework for supporting states to develop implementation strategies on quality of care will be developed. This will enable each state to create a roadmap for comprehensive quality improvement. Additionally, the Program will support the creation of a national

platform for documentation and learning exchange among states that will draw from global and states experiences.

31. **Develop contextualized measurement tools for patient experience.** Initiatives such as NQAS certification and *Mera Aspataal* have been focused on measuring patient satisfaction.[28] While patient satisfaction is important it is based primarily on patient expectations patient experience is a more objective way of capturing what happened in patient-provider interaction and to what extent it was clinically sound and patient-centered. The Program will support the MoHFW to develop, in consultation with states, a template for a patient experience measurement tool in Year 1 of the Program for states to subsequently adapt and pilot it. It is envisaged that this will help to improve demand for quality in the population and strengthen the feedback loops between the people and health facilities.

32. **Strengthen the health workforce.** The Program will support the GoI's efforts to strengthen its health workforce, focusing on increasing availability of qualified HRH and enhancing their performance to deliver quality services. One of the key interventions will be for MoHFW to develop, in consultation with states, a template for an HRH-strategy for public health facilities in Year 1 of the Program and for priority states to adapt in Year 2. In Years 3 to 5, the states will develop strategies that focus on increasing the number health care workers, introducing reforms in contractual arrangements and recruitment, and filling vacancies. The HRH strategy will also include capacity building of existing health care workers, continuous professional development, functional human resources information system (HRIS), task sharing/shifting, creation of a public health cadre, and performance measurement, among others. The approach to handle state-specific challenges would require developing a strategy that identifies these contextual challenges and aims to create a roadmap based on each state's needs, fiscal space, and institutional capacity (DLI 5).

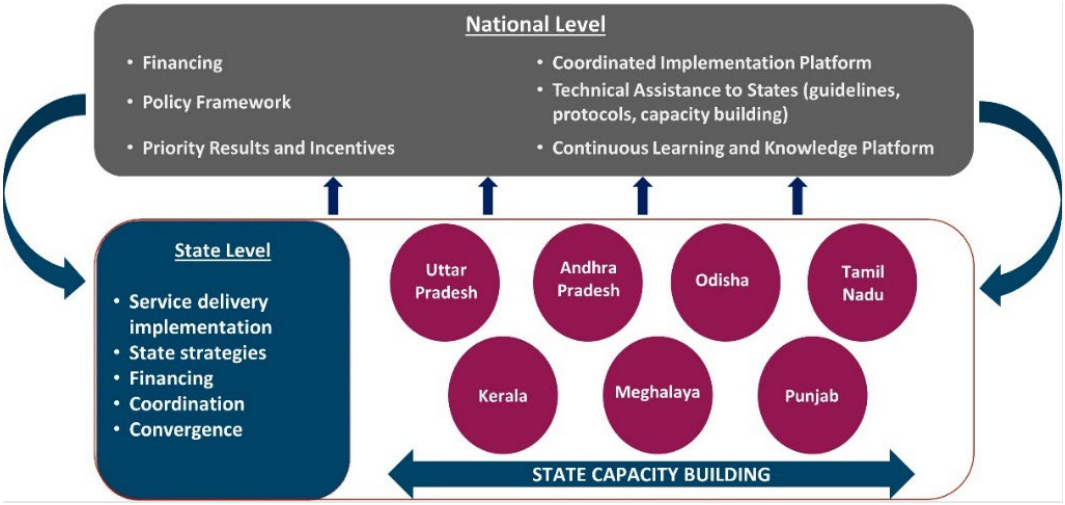
RA#3: Transformed health sector governance, accountability, and institutional and management capacity

33. **RA#3 focuses on the critical foundations of a high-performing health system and to improve governance, institutions, and accountability.** It aims to support actions that will help strengthen accountability along four dimensions: (i) between tiers of government; (ii) between the state and health care providers; (iii) between the state and people; and (iv) between health care providers and people.

34. **Strengthening the national implementation framework and learning platform (DLI 6) to foster better utilization and quality of service provision.** The Program will support the strengthening of an implementation framework and learning platform that leverages the comparative advantages of the center and the states, whereby the national level will identify priority results and provide incentives while allowing states to innovate and achieve results adapted to their own context (Figure 4). Such a platform will enable operational research to capture key factors critical to realizing results, knowledge exchange, and cross-state experience sharing in the areas of service delivery, quality assurance, and accountability.

[28] *Mera Aspataal* is an initiative of GoI in which patients can share their experience through mobile app/web.

Figure 4. Implementation Framework and Learning Platform



35. **Improving community ownership and management of HWCs through Jan Arogya Samitis (JAS) (DLI 7).** The PforR Program will strengthen relationships between providers and people by empowering citizens to participate in the management of HWCs and improve the delivery of CPHC services. This will support institutionalization of a platform for community participation and management of HWCs through JAS based on existing NHM guidelines. Furthermore, the Program will encourage states to improve representation of women grassroot leaders in JAS and strengthen links with *Mahila Arogya Samitis* (MAS) (women's health groups) for improved uptake of reproductive healthcare services, preventive care, and screening for NCDs such as cervical cancer and breast cancer. Additionally, women's health groups (MAS) will be involved in planning and monitoring of health programs in urban areas, including slums.

36. **Increasing state implementation of district performance measurement and rewards framework in Priority States (DLI 8).** This will be incentivized through a DLI aiming at introducing a Performance Measurement Framework at the district level, guided by the CPHC Performance Measurement Framework. The MoHFW in consultation with states will develop and agree on a district measurement framework in the first two years of the Program. States will then publish the annual district health index report for a proportion of districts and establish a rewards framework (which could be monetary (e.g., enhanced budget bonus) or non-monetary (e.g., peer recognition) in Years 3, 4, and 5 of the Program. By elevating district performance as a critical ingredient of scheme success, this DLI aims to empower districts to sustain momentum in delivering CPHC.

37. **Simplifying and enhancing transparency of health sector's public financial management (DLI 9).** The PforR Program contains a DLI to strengthen relationships between states and people by empowering citizens and other stakeholders to have access to better information for monitoring resource allocation and expenditure that affect PHC service delivery. At present, it is difficult to track resource allocation by the center, fund releases to states, and expenditures at the state level. This DLI will establish a mechanism whereby the MoHFW would report key financial data for which it is responsible—allocations and fund releases for PM-ABHIM—while also creating the space for states to report expenditures. In addition, this DLI will build upon a prior result in Year 1 aimed at simplifying PFM data by reducing the number of budget lines and resources pools under the NHM. This measure can both reduce the administrative burden on states and encourage better budget execution by making transfers across pools more flexibly achieved.

Table 2. Comparison of Government program and PforR Program

	GoI program ("p")	PforR Program ("P")	Reasons for Non-alignment
Objective	To attain the highest possible level of health and well-being for all, through a preventive and promotive health care orientation, through increased access, improving quality and lowering the cost of health care delivery.	To increase utilization of comprehensive primary health care services, improve quality of care, and strengthen governance of the health sector in India.	The PforR Program will support a subset of the GoI program's objectives.
Duration	2017–ongoing	2022–2027	Supporting the latter phase
Geographic coverage	National	National with a focus on 7 priority states	Priority engagement for the WB and maximum impact of available financing.
Results areas	• PM-ABHIM CSS Components (including XV-FC grants) • NHM	• PM-ABHIM HWCs, • PM-ABHIM BPHUs, • NHM (HWCs)	The Program will support a subset of the GoI program's focus areas and activities.
Overall Financing	US$42 billion	US$1,223 million (of which US$500 from IBRD financing)	The Program will support a subset of the GoI's program objectives.

Table 3. Program Financing

Source	Amount (US$, millions)	Percent of Total
Counterpart Funding	723.00	59.00
International Bank for Reconstruction and Development (IBRD)	500.00	41.00
Total Program Financing	**1,223.00**	**100.00**

D. Program Development Objective(s) (PDO) and PDO-Level Results Indicators

38. The PDO is to increase utilization of comprehensive primary health care services, improve quality of care, and strengthen governance of the health sector in India.

39. Achievement of the PDO will be assessed with progress on a select set of **strategic indicators:**

Table 4. Mapping of Elements of the PDO to Indicators to Measure Progress

PDO Indicator	Increased utilization of CPHC services	Improved quality of care	Strengthened governance
Increased pregnant women who received 4 or more ANC visits (disaggregated by urban/ rural) (percentage)	X		
Increased infants 9-11 months old who received full immunization as per the schedule (disaggregated by urban/rural and gender) (number)	X		
Increased footfalls at HWCs* (disaggregated by urban/rural and gender) (number) (DLI 1)	X		X
Increased HWCs with NQAS certification (disaggregated by type of facility) (number) (DLI 4)		X	X
Improved community ownership and management of HWCs through Jan Arogya Samitis (JAS) (percentage) (DLI 7)		X	X
Increased state implementation of district performance measurement and rewards framework (number) (DLI 8)			X

*The footfalls indicator will capture all health services delivered at HWCs, including NCDs

E. Disbursement Linked Indicators and Verification Protocols

40. **The DLIs for the Program listed in Table 5.** Each DLI reflects a critical area that the GoI must address to push health sector performance to the next level. Selected DLIs indicate the combined effect of specific technical interventions and institutional strengthening interventions. Annex 2 details each DLI and corresponding verification protocol, and identifies which ones are timebound and scalable. An independent verification agency (IVA) will verify achievement of the DLIs based on the agreed protocol.

Table 5. DLIs with prior results and annual allocations

DISBURSEMENT LINKED INDICATORS	PDO	IR	ALLOCATIONS (US$) (M)					
			PRIOR RESULTS	YEAR 1*	YEAR 2	YEAR 3	YEAR 4	YEAR 5
DLI 1: Increased footfalls at Health and Wellness Centers (HWCs) **US$50M**	X		N/A	6.25	6.25	15.63	15.62	6.25
DLI 2: Increased population screened based on established national protocol **US$87M**		X	N/A	17.5	20.0	20.0	20.0	9.5
DLI 3: Strengthened CPHC data systems for improved performance tracking and performance incentives **US$53M**		X	N/A	10.0	8.0	16.0	8.0	11.0
DLI 4: Increased HWCs with NQAS certification **US$60M**	X		3.76	1.54	8.14	18.7	23.59	4.26
DLI 5: Development and adoption of state-		X	N/A	10.0	10.0	16.0	16.0	8.0

specific Human Resources for Health (HRH) strategies for public health facilities in Priority States **US$60M**								
DLI 6: Strengthened national implementation framework and learning platform **US$37.75M**		X	6.0	4.25	10.0	6.5	6.0	5.0
DLI 7: Improved community ownership and management of HWCs through Jan Arogya Samitis (JAS) **US$50M**	X		7.0	0.0	10.75	10.75	10.75	10.75
DLI 8: Increased state implementation of district performance measurement and rewards framework in Priority States **US$56M**	X		N/A	0.0	11.0	18.0	27.0	0.0
DLI 9: Simplification and enhanced transparency of the health sector's public financial management **US$45M**		X	8.0	0.0	4.0	16.50	16.5	0.0
TOTAL			**24.76**	**49.54**	**88.14**	**138.08**	**143.47**	**54.76**

** Excludes amounts for prior results*

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

41. **The implementing agency for the Program is MohFW.** Within the MoHFW, the Joint Secretary (JS) (Policy), with support of the Director of NHM, will be responsible for the Program, provide implementation oversight, and be the WB's counterpart. The JS will work under the overall supervision and guidance of the Secretary, Health and Family Welfare (MoHFW) and Additional Secretary and Mission Director, NHM (AS&MD). The JS is supported by NHM's Director and other Directors in MoHFW, who will assist with day-to-day coordination, and a team of directors managing technical, fiduciary, and safeguards activities. The JS will coordinate with relevant Directors in the MoHFW for implementation of the Program. The National Health System Resource Center (NHSRC), the apex technical body under NHM, will be responsible for providing technical inputs for the implementation of the Program and be responsible for developing guidelines, tools, capacity building efforts, and technical assistance to states.

42. **The Program will be guided by the National Steering Committee constituted for PM AB-HIM, which will also have the mandate for the EHSDP at the national level.** The National Steering Committee – chaired by Secretary, Health and Family Welfare, MoHFW and with the AS/MD as the member – will be responsible for providing policy direction and reviewing overall Program performance. In addition to the established structures, the Program will also support strengthening of a national implementation framework and learning platform that will foster active engagement of states and help drive key priorities, support cross-learning among states, and support the operational research agenda. The MoHFW will issue an Office Memorandum (OM) detailing the Program to concerned officials in MoHFW, NHSRC, and seven priority states. The OM will cover aspects such as description of the Program objective and scope, Results Framework including DLIs, DLI allocations, roles, and responsibilities for achievement of results, fund

flows, and reporting of fund utilization, monitoring and reporting, Program Action Plan (PAP), anti-corruption protocol, and exclusion of high-value contracts (HVCs).

43. **The MoHFW will be responsible for the Program's national-level results while the seven priority states will be responsible for state-level results.** Table 6 provides a summary of entities primarily responsible for achieving the DLIs. The MoHFW is the implementing agency at the national level, responsible for policy development, technical oversight and assistance, setting results, monitoring and evaluation, providing financing, and ensuring a coordinated implementation platform that enables continuous learning and cross-state learning. Within the MoHFW, existing implementation mechanisms and platforms of NHM will be utilized. The experiences of the seven priority states will provide learning opportunities for the remaining states.

44. **Central Government-State relationship.** The NHM is a centrally driven program, and structures in terms of administration, powers, financing, are largely the same as the PM-ABHIM**.** The Program is to follow the same central-state relationship. The agreed instrument for Program planning, the PIP, will continue to be the means for planning and approval of resources for the HWC component within the NHM and PM-ABHIM.

45. **The State Health Society (SHS) for NHM, in coordination with relevant DOHFW officials, will bear the overall responsibility for implementation of relevant interventions at state level in the priority states.** The MoHFW and each state have an existing memorandum of understanding (MoU) for implementation of NHM and a similar MoU will also be signed for the centrally sponsored component of PM-ABHIM. Each state's Mission Director, NHM and existing State Program Management Unit (SPMU) will monitor and track implementation of the interventions under the Program. At the district level, the District Health Society, headed by the District Collector, will play a crucial role in planning, implementation and monitoring of the Program as per the existing arrangements. The SPMU is supported by the District Program Management Units (DPMUs) at the district level and Block Program Management Units (BPMUs) at the block level for implementation and monitoring of interventions at districts, blocks, and facility levels.

46. **Each of the seven priority states have different governance structures and varied implementation capacity.** Throughout implementation, the Program will assess capacities of different states and provide implementation support to support the achievement of desired results. The Program will also explore options for incentivizing states on achievement of pre-defined results.

Table 6. Roles and Responsibilities with Respect to DLIs

DLI		Responsibility for Achieving Results	National and State Roles to Achieve Results	
			National	State
DLI #1	Increased footfalls at Health and Wellness Centers (HWCs)	State	• **Oversight:** JS Policy	• **Implementation:** NHM State Health Society (SHS) in collaboration with relevant State DOHFW officials • **Oversight:** State MD NHM
DLI #2	Increased population screened based on established national protocol	State	• **Oversight:** JS Policy	• **Implementation:** NHM SHS in collaboration with relevant State DOHFW officials • **Oversight:** State MD NHM

DLI		Responsibility for Achieving Results	National and State Roles to Achieve Results	
			National	State
DLI #3	Strengthened CPHC data systems for improved performance tracking and performance incentives	National	• **Implementation:** HMIS Division; relevant technical and program divisions; NHSRC • **Oversight:** JS Policy	• **Implementation:** HMIS Division; relevant technical and program divisions
DLI #4	Increased HWCs with NQAS certification	State	• **Oversight:** JS Policy	• **Implementation:** NHM SHS in collaboration with relevant State DOHFW officials • **Oversight:** State MD NHM
DLI #5	Development and adoption of state-specific Human Resources for Health (HRH) strategies for public health facilities in Priority States	National + State	• **Implementation:** NHM Director; NHSRC • **Oversight:** JS Policy	• **Implementation:** MD NHM • **Oversight:** State Health Society, State Health Directorate and FW Directorate
DLI #6	Strengthened national implementation framework and learning platform	National + State	• **Implementation:** JS Policy; NHM; NHSRC; relevant technical and program divisions; operational research stakeholders • **Oversight:** AS MD NHM	• **Implementation:** NHM; relevant technical and program divisions; operational research stakeholders
DLI #7	Improved community ownership and management of HWCs through Jan Arogya Samitis (JAS)	State	• **Oversight:** JS Policy	• **Implementation:** NHM SHS in collaboration with relevant State DOHFW officials • **Oversight:** State MD NHM
DLI #8	Increased state implementation of district performance measurement and rewards framework in Priority States	National + State	• **Implementation:** JS Policy; relevant technical and program divisions; NHSRC • **Oversight:** AS MD NHM	• **Implementation:** MD NHM; relevant DOHFW technical and program officials
DLI #9	Simplification and enhanced transparency of the health sector's public financial management	National + State	• **Oversight:** JS Policy	• **Implementation:** NHM SHS in collaboration with relevant State DOHFW officials • **Oversight:** State MD NHM

B. Results Monitoring and Evaluation

47. The MoHFW will hold semi-annual review meetings with concerned MoHFW officials, NHSRC and seven priority states to track programmatic and financial progress and submit two semi-annual Program reports (covering implementation of activities, expenditures, bottlenecks, and progress toward results as

outlined in the Program Results Framework). The MoHFW will also report on DLI achievements with supporting evidence, which will then be verified by the IVA using the agreed verification protocols. In addition, the MoHFW will commission necessary surveys and assessments for the relevant DLIs, PDO indicators, and intermediate results indicators.

48. While there have been significant improvements in data and information systems in the health sector, it has been noted that data are scattered across different monitoring systems, making effective use of data for decision-making a key challenge. Under the Program, efforts will be undertaken to improve data generation, analysis and use for decision-making. National and international expertise to strengthen capacity to analyze and utilize data based on best practices will be employed.

C. Disbursement Arrangements

49. **Disbursements will be made based on achievement of results under each DLI.** The GoI will prefinance expenditures for the Program using its own budgetary resources through the identified budget lines of the PEF. The implementing agencies will prepare technical reports to document the achievement of DLIs that will be verified by the designated IVA. Upon verification of DLIs by the IVA, the MoHFW will communicate the achievement of DLIs and corresponding DLI values to the WB along with the supporting documents. For timebound DLIs, achievement of the DLIs must happen in the year outlined in the DLI matrix. For non-timebound DLIs, if the DLI targets are not achieved in the anticipated year, disbursement will be rolled over for the future years till such time the DLI is achieved. For non-scalable DLIs, the WB will disburse the DLI value only upon full achievement of the DLI target. For scalable DLIs, the WB will disburse the DLI value against achievement of the agreed thresholds and targets as set out in the DLI matrix. The WB will issue an official letter to the implementing agency endorsing the achievement of the DLI targets and value of disbursement.

50. **Advance and prior results.** There will be an advance equivalent to up to 25 percent of the loan amount, totaling US$125 million. DLIs 4, 6, 7, and 9 have prior results associated with them, which are expected to be achieved before the EHSDP legal agreement is signed. Combined with prior results achievement estimated at US$24.76 million, the total disbursement upon effectiveness is expected to be US$149.76 million (29.9 percent of the loan amount), which is within the PforR allowed threshold. When DLIs are achieved, the amount of advance will be deducted (recovered) from the amount due to be disbursed under the DLI.

D. Capacity Building

51. **Capacity-building support will be critical for achieving the transformational results envisaged under the EHSDP**. The Program will establish a coordinated implementation framework and learning platform (DLI 6) at the national level with active engagement of states to identify key implementation challenges, support operational research, and scale up priority interventions. Extensive implementation support will be provided for effective absorption of financing from PM-ABHIM and NHM's HWC component, including need-based,just-in-time analytical and diagnostic support. At the national level, it is also envisaged that the NHSRC will support program monitoring and developing guidelines and strategies.

IV. ASSESSMENT SUMMARY

A. Technical (including Program economic evaluation)

52. **The COVID-19 outbreak has re-emphasized the urgency for significant reforms to improve India's health sector performance.** As India is steadily working towards the target of operationalizing 150,000 HWCs by December 2022, the proposed Program will support efforts for redesigning CPHC, including increasing the number of and utilization at functional HWCs, improving annual population enumeration for CPHC at the HWCs, and developing a CPHC Performance Monitoring Framework.

53. **India has made substantial progress in improving access and the focus is now on improving the quality of care.** The Program will emphasize the importance of quality of care in building a resilient and high-quality health system. First, it will support the implementation of the recently updated NQAS. The Program will build on this to create an enabling environment both nationally and at state level for a comprehensive approach to improving quality of care. Second, the Program will support the development of a Quality of Care Strategy (QOCS) tailored to each selected state. Third, it will facilitate the shift focus from patient satisfaction to patient experience. Finally, it will support the development and adoption of state-specific HRH strategies for public health facilities. The interventions are aligned with best global practices, and the focus on competent care processes and patient experience rather than structural interventions to improve quality is supported by global evidence.

54. **India has embarked on an ambitious reform agenda to transform the delivery and quality of essential health services as well as underlying accountability mechanisms needed to enable such reforms.** Aligned with the World Development Report 2004 Framework for service delivery, the Program will support actions that will strengthen accountability along four dimensions and also strengthen implementation framework and learning platform to enhance state implementation capacity and foster innovation to achieve results. Through the establishment and institutionalization of the platform for community participation and management of HWCs through JAS, the Program aims to achieve vertical integration of accountability (provider-people dimension). Through better access to information, the Program will also empower citizens and other stakeholders to monitor resource allocation and expenditure that affect PHC service delivery (state-people dimension). Additionally, to strengthen state accountability, the Program will support a focus on outputs and outcomes rather than inputs and a one-size-fits-all approach by introducing performance measurement and rewards at the district level.

55. **Program Expenditure Framework (PEF).** The PEF is premised on the following: (a) Health and Wellness Centers (HWCs) and Urban Primary Health Centers (UPHCs)/Urban Community Health Centres (UCHCs) are part of the NHM program, and (b) the PM-ABHIM. While the HWCs/UPHCs/UCHCs are funded by both national and state governments based on an agree ratio, the PM-ABHIM has both central sector schemes components (100 percent financing by the GoI) and CSS components. The overall expenditure framework of the Government program ("p") for FY22/23 to FY26/27 is estimated at US$42 billion. The proposed PforR-supported Program ("P") is a subset of the Government program ('p'). (Table 7).

56. **The PEF for the proposed Program has been ascertained using the following estimates:**

- PM-ABHIM allocations in the seven priority states, restricted to the recurring costs for HWCs and BPHU: this has been calculated using the annual physical targets for HWC and BPHUs in the seven priority states and the standard unit costs indicated in the operational guidelines.
- Recurring expenditures of HWCs and UPHCs/UCHCs under NHM in the seven priority states: this is based on previous years' expenditure trends (adjusted by 25 percent to reflect the expected expenditures during FY20–21 and FY21–22, as the pandemic years recorded low levels of expenditure due to a steep decline in out-patient department consultations), with an annual projected growth (10 percent), and inflation adjustment (5 percent).

Table 7. Summary of Program Expenditure Framework (in INR millions)

Scheme	Y1	Y2	Y3	Y4	Y5	Total	Assumption
PM-ABHIM	-	59	193	644	1,473	2,369	Only Urban HWC and BPHU recurring costs for 7 states
NHM-HWCs	1,010	1,161	1335	1,536	1,766	6,808	Only HWC recurring cost for 7 states + UPHCs and UCHCs HR cost for 7 states
Total INR millions	1,010	1,220	1,528	2,180	3,239	9,177	
Total US$ millions						**1,223**	

Proposed Program (P) as a % of government program (p)	**3%**
IBRD financing US$ millions	500
IBRD financing as a % of total Program	**41%**

57. **The nature of expenditures under the proposed Program includes revenue expenditures under both schemes**. The economic classification for the HWCs budget under NHM is analyzed based on past trends; for the 5-year approved PM-ABHIM allocations, the detail of the indicative costs for HWCs and BPHUs (as provided in the guidelines[29]) has been used for the purpose of this analysis (Table 8).

Table 8. Program Budget Composition by economic classification

	PM-ABHIM		NHM-HWC/UPHC/UCHC		Total	
Economic classification	**Amount**	**Percent**	**Amount**	**Percent**	**Amount**	**Percent**
Source:	*GoI's PM-ABHIM scheme documents*		*Past budget trends analyzed*			
Human Resources	886.46	37	4,763.95	70	5,650.41	62
Information Education and Communication	20.58	1	119.93	2	140.52	2
Minor civil works	686.25	29	-	0	686.25	7
Operating expenditures	327.28	14	532.94	8	860.22	9
Supplies and Materials	420.75	18	990.79	14	1,411.54	15
Training/ Capacity Building	27.45	1	400.42	6	427.87	5
TOTAL (INR millions)	**2,368.78**	**100**	**6,808.05**	**100**	**9,176.84**	
TOTAL (US$ millions)	**315.84**		**907.74**		**1,223.58**	

58. **Economic justification.** The Program will improve equitable access to health care and offer an efficient approach to improve health outcomes while striving for financial sustainability. First, the Program

[29] *Technical and Operational Guidelines – Implementation of XV FC – health grants through local governments.*

targets public PHC facilities whose primary beneficiaries are poor, making it "pro-poor." Fostering NCD prevention is also critical to decrease out-of-pocket expenses among the poor and address their unmet need for diagnosis and treatment of diabetes or hypertension. Second, according to the World Health Organization, investing US$1 per person per year in a package of NCD interventions can yield an economic return of US$7 to which the EHSD Program will make a meaningful contribution.[30] Third, most interventions included in RA#1 have a cost per disability-adjusted life year (DALY) saved below US$200, an acceptable international threshold. Fourth, the Program has a favorable cost-benefit ratio in that it would only need to achieve 181,319 additional healthy life-years for the beneficiary population over a 5 year-span to break-even, which is far surpassed by the annual footfall of 228 million in public PHC facilities across the seven states (Table 9).

Table 9. Cost-benefit ratio of the EHSD Program and PforR Program boundaries

	EHSD Program	WB PforR Program boundaries
Value in US$ (millions)	500	1,223
GDP*	1,927	1,927
Value of a statistical life year**	6,745	6,745
Break-even level of health life years gained***	74,134	181,319
Annual footfall in the 7 states (includes NCD screenings) ****	228,768,989	228,768,989
Annual NCD screening in the 5 states	114,024,941	114,024,941

Source: * *https://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=IN*; ** based on methodology in Robinson et al. 2019; *** estimated by dividing the value of the Program by the value of a statistical life year. ****HWC Portal. Footfall data were downloaded in February 2022 from the HWC portal and reflect accumulated OPD footfall data since July 2021, hence we divided the accumulated footfall by 1.5 to translate them into annual basis.

B. Fiduciary

59. **As part of preparation, the WB carried out an Integrated Fiduciary System Assessment (IFSA) of implementing entities responsible for the Program (at the GoI and states) to determine whether their fiduciary systems provide reasonable assurance that funds will be used for the intended purposes.** The conclusion of the IFSA is that the Program's fiduciary systems, subject to timely implementation of proposed mitigation measures, will provide reasonable assurance that financing proceeds will be used for intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. Based on the IFSA, the residual fiduciary risk of the Program is assessed as Substantial. Based on the assessment of Procurement Profile of the Program, there are no high value contracts (HVCs) in the Program.

60. **The IFSA identified key fiduciary risks that may affect the Program's development outcomes, and recommended systems improvement and capacity-strengthening /risk mitigation measures that will be implemented during the life of the Program.** The key fiduciary risks identified and mitigating measures are detailed in Annex 4.

61. **Annual audits will be conducted by private Chartered Accountants for the state level expenditures incurred under the Program.** The ToR for such audits will be mutually agreed between the MoHFW and the WB and will be broadly within the NHM framework. Audit reports will be submitted to the WB within nine months from the close of the financial year.

[30] WHO (World Health Organization). 2021. *Saving Lives, Spending Less: The Case for Investing in Noncommunicable Diseases*. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.

62. **Compliance of Fiduciary Requirements:** MoHFW will issue an Office Memorandum requiring Program Implementing Agencies to comply with Program Actions, KPI Reporting, Anti-Corruption Guidelines (ACG) Protocol, and exclusion of HVCs.

63. **To operationalize the ACG, a Protocol has been developed.** The Protocol covers key compliance issues related to reporting, investigations, and mechanisms to ensure ineligibility of debarred firms/ individuals.

C. Environmental and Social

64. **An Environmental and Social Systems Assessment (ESSA) was carried out for the identified Program.** The ESSA covers an assessment of the MoHFW, the DoHFW in each of the seven priority states, and associated departments most relevant for environment and social management of health services, and recommends several measures to further strengthen environmental and social systems and mitigate the identified risks. These can be found in Annex 6.

65. **The ESSA concluded that the environmental and social risk ratings for the Program is Moderate.** The ESSA confirmed that the current system for managing the environmental aspects of the Program is well covered by the country regulatory framework and institutional arrangements, but enforcement and implementation capacity could be further strengthened. The MoHFW and a few of the states (Tamil Nadu and Andhra Pradesh) have demonstrated experience and institutional capacity on environment and social aspects, having undertaken several national-level health engagements with the WB, to manage expected risks. The results area identified under the Program and the corresponding DLIs include recurring expenditures under PM-ABHIM health centers which do not cover activities and/or actions that will have significant adverse impacts on the environment.

66. **The assessment reviewed the social policies and procedures for the government program and found them to be adequate.** The assessment finds an enabling policy, regulatory and legal framework at the national and state-levels that will promote decentralized planning, implementation and monitoring, active redressal of grievances through JAS, and effective participation and safeguarding of the interests of vulnerable sections. However, residual social risks related to exclusion of vulnerable groups particularly in aspirational districts and Integrated Tribal Development Agency Blocks (ITDA blocks) in Schedule V and VI areas remain.[31] The anticipated social risks are manageable and can be mitigated through localized implementation strategies, better local oversight, and enhanced capacities of JAS and MAS. The Program is likely to have overall positive social impacts in geographical areas where investments are planned.

67. **The key environmental concern of the Program centers on the biomedical waste (BMW) generated at the health care facilities and its improper handling which could result in risks to communities and healthcare workers.** Apart from BMW, e-waste, hazardous waste, plastic waste, and wastewater streams from health care facilities are likely to increase with increased footfall and require attention for proper handling and disposal. Other risks and impacts include: (i) worker occupational health and safety and public safety while HWCs are being refurbished; (ii) building, fire, and electric safety; and (iii) infection control and worker health. There will be no additional health facilities created, all interventions will be carried out within the existing facilities such as refurbishment and minor modifications. The impacts arising through the upgrading of HWCs (like dust and noise) would be temporary and easily mitigated using country systems for pollution management and community and worker safety.

[31] ITDA blocks are identified by the Integrated Tribal Development Agency (ITDA) for delivery of public goods and services to Scheduled Tribes.

68. **The EHSDP does not include large-scale infrastructure and, thus, risks of land acquisition and involuntary resettlement are not applicable under the Program.** Additionally, existing grievance redressal systems under PM-ABHIM at the national, state and community levels are functional. Across states, the ESSA noted variations in implementation of the 2013 Prevention of Sexual Harassment at the Workplace (POSH) Act, access to information about the POSH Act, and redress mechanisms for contracted workers and frontline workers, including ASHA workers and field heath supervisors. The PIP will include activities to strengthen implementation, and outreach.

69. **The key social risks of the Program are directly associated with exclusion, particularly for Scheduled Tribes[32] and vulnerable groups in underserved areas, that is aspirational districts and ITDA blocks.** Four of the seven participating states have designated Schedule V and Schedule VI areas.[33] Additionally, across seven states, the Program covers 15 aspirational districts. The ESSA found that despite state-led efforts to strengthen health service delivery in aspirational districts and ITDA blocks, gaps in access, uptake, and issues of fragmented programming in aspirational districts/ITDA blocks remain. Therefore, social risks relate to of exclusion in aspirational districts and ITDA blocks and functionality of community-level platforms (JAS, MAS) in aspirational districts and ITDA blocks (see details in Annex 6).

70. **Stakeholder engagement and consultations.** The ESSA was developed with inputs from the federal and state levels with relevant stakeholders from MoHFW, state health societies, biomedical waste management (BMWM), and infection control and quality control officers. A checklist to capture key issues and gaps in government systems was circulated to the states before the consultation. A consultation was conducted on April 4, 2022 based on the draft ESSA to share the findings and recommended actions for the PAP. The ESSA was subsequently updated to reflect stakeholder comments, and the final ESSA was disclosed by the government on May 23, 2022, on the MoHFW's website.[34] Additionally, in the first quarter after Program effectiveness, MoHFW plans to hold a multi-stakeholder consultation workshop with participating states to seek feedback on state-level programming for tribal communities, women and other vulnerable communities.

71. **Citizen engagement.** The Program will invest in strengthening community-led platforms and community-driven processes through existing community-level platforms. These efforts will include adoption of standard operating procedures and operational guidelines to support convergence between JAS, MAS (in urban areas) and bridging information asymmetries particularly in aspirational districts and ITDA blocks related to roles and responsibilities of JAS, structures of the committees, avenues to seek information and improve utilization of untied grants. Across Priority states, the Program will improve the capacity of JAS and MAS through training on financial, procurement and civil works related procedures; orientation on NCDs screening and preventive care; periodic patient satisfaction and experience surveys

[32] Scheduled Tribes (STs) are officially designated groups of people and among the most disadvantaged socio-economic groups in India and recognized in the Constitution of India.

[33] In Scheduled Areas declared so under the Fifth Schedule, the governor of the state has special responsibilities with respect to tribal populations in the area including issuing directives to the state government and limiting the effect of acts of the central or state legislature on the Scheduled Area. On the other hand, in Scheduled Areas declared so under the Sixth Schedule, the emphasis is on self-rule; tribal communities are granted considerable autonomy, including powers to tribal communities to make laws and receive central government funds for social and infrastructure development. To enable local control, the role of the Governor and the State are subject to significant limitations in Sixth Schedule areas.

[34] The ESSA was disclosed by the MoHFW at *https://main.mohfw.gov.in/sites/default/files/Environment%20And%20Social%20Systems%20Assessment_0.pdf*. The ESSA was also publicly disclosed by the WB on external website on May 14, 2022.

and social audits; training of JAS in Schedule V and Schedule VI areas to undertake social audits; and development and adoption of an inclusion template to monitor functionality of JAS in ITDA blocks.

72. **Gender.** The EHSDP supports gender equity by operationalizing two key governing principles: (i) investments that help women and girls' access to health services in an equal manner; and (ii) transformative results that measure the impact on women and girls, specifically in aspirational districts. Government PHCs and HSCs cater to the poorest beneficiaries, and the disaggregation of the CPHC indicators is aimed to measure and then improve the uptake of health services among female beneficiaries, particularly in underserved areas. The following DLIs are designed to have a direct impact on the poorest quintile of female beneficiaries and are disaggregated by gender: (i) footfalls at HWCs (DLI 1), and (ii) population-based screening (DLI 2). Further, the Results Framework includes PDO indicators measuring pregnant women's access to ANC and immunizations disaggregated by gender.

73. **Climate co-benefits.** Given that India has very high exposure to flooding, tropical cyclones and their associated hazards, and drought, the Program aims to include climate considerations. Improving access to quality health services will help increase the adaptive capacity of vulnerable populations to deal with climate-related shocks and diseases. Through RA#1, the redesigning of CPHC will integrate climate and disaster resilience of the building and equip health facilities with resource-efficient equipment, including sustainable cooling measures for storing specimens and temperature-sensitive medical supplies. Through RA#2, the Program will support HRH strategy development which will include guidance on trainings, including on the impact of climate change on health care. Through RA#3, the Program may explore development of a climate change module for the implementation and knowledge platform. It will also reach out to communities and vulnerable populations through various platforms to help increase their resilience to deal with climate-related shocks and diseases.

V. GRIEVANCE REDRESS SERVICES

74. Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. 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/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit http://www.inspectionpanel.org.

VI. RISK

75. **The overall risk rating of the Program is considered Moderate.** Except for the **"**institutional capacity for implementation and sustainability" and "fiduciary" risks – both assessed as Substantial—all other risks are considered Moderate.

76. **Institutional capacity for implementation and sustainability.** The Program supports an ambitious reform agenda that is expansive and complex. While sector strategies and policies are sound, institutional

capacity to implement them has generally been more of a challenge. In addition, the Program involves both the national and state levels within the context of a federal system where health is a state subject. Mitigation measures have been developed and will be in place during implementation, including building on existing implementation arrangements of NHM (which has been operating for 17 years) rather than establishing parallel systems, strengthening a learning platform and operations research, providing substantial TA especially at state level, and collaboration with other development partners to support the MoHFW.

77. **Fiduciary risks.** Considering the size of the PEF, complexity and procurement profile of the Program, federal nature of the health system, and varied capacities of participating states, the fiduciary risk is assessed as Substantial. Mitigation measures have been built into the Program on reporting, fund flows and audit mechanisms. These measures are reflected in the Program Action Plan (PAP) detailed in Annex 6.

ANNEX 1. RESULTS FRAMEWORK MATRIX

Results Framework
COUNTRY: India
India's Enhanced Health Service Delivery Program

Program Development Objective(s)

To increase utilization of comprehensive primary health care services, improve quality of care, and strengthen governance of the health sector in India.

Program Development Objective Indicators by Objectives/Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Increase Utilization of Comprehensive Primary Healthcare Services							
Increased pregnant women who received 4 or more ANC visits (Text)		84 percent is the average of the 7 states where PW receive 4 or more ANC checks among those registered for ANC.	86 percent	87 percent	88 percent	89 percent	90 percent
Increased infants 9-11 months old who received full immunization as per the schedule (Text)		Urban Male: 810,151 Urban Female: 753,402 Rural Male: 3,492,945 Rural Female: 3,177,710	Urban Male: 818,253 Urban Female: 760,936 Rural Male: 3,527,874 Rural Female: 3,209,487	Urban Male: 826,435 Urban Female: 768,545 Rural Male: 3,563,153 Rural Female: 3,241,582	Urban Male: 834,699 Urban Female: 776,231 Rural Male: 3,598,785 Rural Female: 3,273,998	Urban Male: 843,046 Urban Female: 783,993 Rural Male: 3,634,773 Rural Female: 3,306,738	Urban Male: 851,477 Urban Female: 791,833 Rural Male: 3,671,120 Rural Female: 3,339,805
Increased footfalls at Health and Wellness Centers (CRI)	DLI 1	212,006,578 in rural areas; 47,924,765 in	5 percent for rural; 5 percent for urban; 5	10 percent for rural; 10 percent for urban; 10	22.5 percent for rural; 22.5 percent for urban;	35 percent for rural; 35 percent for urban; 35	40 percent for rural; 40 percent for urban; 40

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
(Text)		urban areas; 259,931,343 in aggregate	percent in aggregate (increase over baseline, as percent of baseline)	percent in aggregate (increase over baseline, as percent of baseline)	22.5 percent in aggregate (increase over baseline, as percent of baseline)	percent in aggregate (increase over baseline, as percent of baseline)	percent in aggregate (increase over baseline, as percent of baseline)
Increased footfalls at Health and Wellness Centers by women (Text)		116,397,996 in rural areas; 27,135,351 in urban areas; 143,533,347 in aggregate	5 percent for women in rural areas; 5 percent for women in urban areas ; 5 percent for women in aggregate (increase over baseline, as percent of baseline)	10 percent for women in rural areas; 10 percent for women in urban areas ; 10 percent for women in aggregate (increase over baseline, as percent of baseline)	22.5 percent for women in rural areas; 22.5 percent for women in urban areas ; 22.5 percent for women in aggregate (increase over baseline, as percent of baseline)	35 percent for women in rural areas; 35 percent for women in urban areas ; 35 percent for women in aggregate (increase over baseline, as percent of baseline)	40 percent for women in rural areas; 40 percent for women in urban areas; 40 percent for women in aggregate (increase over baseline, as percent of baseline)
Improve Quality of Care							
Increased HWCs with NQAS certification (Text)	DLI 4	HWC-SC:0; HWC-PHC:501; HWC-UPHC:59	Prior result:127; HWC-SC:22: HWC-PHC: 25: HWC-UPHC:5	Prior result:127; HWC-SC:147: HWC-PHC: 145: HWC-UPHC:35	Prior result:127; HWC-SC:462: HWC-PHC: 413: HWC-UPHC:84	Prior result:127; HWC-SC:884: HWC-PHC: 719: HWC-UPHC:153	Prior result:127; HWC-SC:961: HWC-PHC: 774: HWC-UPHC:165
Strengthen governance of the health sector in India							
Improved community ownership and management of HWCs through Jan Arogya Samitis (JAS) (Text)	DLI 7	None	0.00	10 percent of HWCs with functional JAS	20 percent of HWCs with functional JAS	30 percent of HWCs with functional JAS	40 percent of HWCs with functional JAS
Increased state implementation of district performance measurement and rewards framework (Number)	DLI 8	0.00	0.00	0.00	5.00	5.00	5.00

Intermediate Results Indicator by Results Areas

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Strengthened service delivery through redesigned CPHC model							
Functional HWCs providing expanded healthcare service delivery packages of CPHC (including urban HWCs) (Text)		37,653 for rural areas; 1,831 for urban areas	47,855 rural HWCs and 1,559 urban HWCs functional with 7 service delivery packages as defined by CPHC guidelines of GoI	47,855 rural HWCs and 1,559 urban HWCs functional with 7 service delivery packages as defined by CPHC guidelines of GoI	47,855 rural HWCs and 1,559 urban HWCs functional with 8 service delivery packages as defined by CPHC guidelines of GoI	47,855 rural HWCs and 1,559 urban HWCs functional with 8 service delivery packages as defined by CPHC guidelines of GoI	47,855 rural HWCs and 1,559 urban HWCs functional with 9 service delivery packages as defined by CPHC guidelines of GoI
Strengthened CPHC data systems for improved performance tracking and performance incentives (Text)	DLI 3	TBC	Develop a CPHC Performance Monitoring Framework	Assessment of CPHC data quality (completeness, accuracy and timeliness) and development of a road map for improving CPHC data quality	(i) Develop protocols to verify and analyze data for CPHC Performance Monitoring Framework, based on the CPHC data quality assessment (ii) Roll-out protocols for CPHC Performance Monitoring Framework	Develop mechanism for providing incentives to HWCs based on the CPHC Performance Monitoring Framework	(i) Generate HWC Health Index and publicly disseminate it (ii) Implement incentives to HWCs based on HWC Health Index scores
Increased population screened based on established national protocol (Text)	DLI 2	35,072,471 in rural areas; 11,750,531 in urban areas; 46,823,002 in aggregate.	17.5 percent for rural; 17.5 percent for urban; 17.5 percent in aggregate (increase over baseline, as percent of baseline)	37.5 percent for rural; 37.5 percent for urban; 37.5 percent in aggregate (increase over baseline, as percent of baseline)	57.5 percent for rural; 57.5 percent for urban; 57.5 percent in aggregate (increase over baseline, as percent of baseline)	77.5 percent for rural; 77.5 percent for urban; 77.5 percent in aggregate (increase over baseline, as percent of baseline)	87 percent for rural; 87 percent for urban; 87 percent in aggregate (increase over baseline, as percent of baseline)
Infants 9-11 months who have received the first dose of Pentavalent vaccine (Percentage)		88.00	88.00	88.00	88.00	88.00	88.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Improved comprehensive quality of care							
Development and adoption of state-specific Human Resources for Health (HRH) strategies for public health facilities (Number)	DLI 5	0.00	0.00	0.00	2.00	4.00	5.00
A diagnostic analysis for quality of care improvement conducted to develop a template for a comprehensive state-specific Quality of Care Strategy (QOCS) (Yes/No)		No	Yes	Yes	Yes	Yes	Yes
Development of state QOCS (Number)		1.00	1.00	2.00	3.00	4.00	5.00
Conducting a learning exchange event for fostering an enabling environment for comprehensive quality of care improvement (Number)		0.00	1.00	2.00	3.00	4.00	5.00
Piloting of routine measurement of patient/user experience at primary and secondary facilities (Text)		No	A template for designing routine measurement of patient/user experience at primary and secondary facilities developed at the National level and shared with states for adaptation: Y	Routine measurement of patient/user experience at primary and secondary facilities piloted in at least 1 district in ONE priority state: Y	Routine measurement of patient/user experience at primary and secondary facilities piloted in at least 1 district in TWO priority states: Y	Routine measurement of patient/user experience at primary and secondary facilities piloted in at least 1 district in THREE priority states: Y	Routine measurement of patient/user experience at primary and secondary facilities piloted in at least 1 district in FOUR priority states: Y
Transformed health sector governance, accountability, and institutional and management capacity							
States conducting operational	DLI	0.00	0.00	2.00	3.00	4.00	5.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
research (Number)	6.3, 6.4, 6.5, 6.6						
National knowledge exchange events held (Number)	DLI 6.1, 6.2, 6.7	0.00	0.00	1.00	2.00	3.00	4.00
Development of Jan Arogya Samitis (JAS) template for annual report and financial audit (Text)		No	Template for Jan Arogya Samitis (JAS) annual report and financial audit developed by MoHFW	At least 10 percent of HWCs with functional JAS; At least 40 percent of JAS utilizing at least 50 percent of their annual resources	At least 20 percent of HWCs with functional JAS; At least 50 percent of JAS utilizing at least 50 percent of their annual resources	At least 30 percent of HWCs with functional JAS; At least 60 percent of JAS utilizing at least 50 percent of their annual resources	At least 40 percent of HWCs with functional JAS; At least 70 percent of JAS utilizing at least 50 percent of their annual resources
Increased state implementation of district performance measurement and rewards framework (Text)		No	District level performance measurement developed by MoHFW	Annual district level performance-based measurement implemented by 2 Priority States	Annual district level performance-based measurement implemented by 5 Priority States	Annual district level performance-based measurement implemented by 5 Priority States	Annual district level performance-based measurement implemented by 5 Priority States
Simplification and enhanced transparency of the health sector's public financial management (Text)	DLI 9	No	New guidelines on streamlining the PIP process planning, appraisal, implementation and monitoring developed by MoHFW and transmitted to states	Reporting mechanism for publishing approvals and releases for PM-ABHIM developed by MoHFW	Annual reporting of all approvals and releases under PM-ABHIM by MoHFW Annual reporting of PM-ABHIM expenditures by 7 Priority States	Annual reporting of all approvals and releases under PM-ABHIM by MoHFW Annual reporting of PM-ABHIM expenditures by 7 Priority States	Annual reporting of all approvals and releases under PM-ABHIM by MoHFW Annual reporting of PM-ABHIM expenditures by 7 Priority States

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Increased pregnant women who received 4 or more ANC visits	Proportion of pregnant women received 4 or more ANCs against total number of women registered for ANC during a specific year Numerator: Number of pregnant women who received 4 or more ANCs in a specific year Denominator : Total number of women registered for ANC during the specific year	Annual	HMIS	Routine data system	MoHFW
Increased infants 9-11 months old who received full immunization as per the schedule	Number of infants 9-11 months old who have received BCG, 3 doses of DPT, 3 doses of OPV and one dose of measles.	Annual	HMIS	Routine data system	MoHFW
Increased footfalls at Health and Wellness Centers (CRI)	Number of footfalls at HWCs	Annual	HWC Portal	Routine data system	MoHFW
Increased footfalls at Health and Wellness Centers by women	Number of footfalls at HWCs by women beneficiaries	Annual	HWC Portal	Routine data system	MoHFW
Increased HWCs with NQAS certification	This indicator will include No. of HWCs / UHWCs NQAS certified	Annual	MoHFW	NQAS certification	MoHFW
Improved community ownership and management of HWCs through Jan Arogya	The indicator measures functionality of JAS defined	Annual	Program reports	HWC administrative data	MoHFW

Samitis (JAS)	as HWCs preparing annual report and audit. Numerator: No. of HWCs with a functional JAS Denominator: No. of functional HWCs				
Increased state implementation of district performance measurement and rewards framework	A district performance measurement system implemented in the state (e.g. budgetary or non-budgetary incentive to high-performing districts based of the performance measurement system)	Annual	Program reports	Administrative data	MoHFW

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Functional HWCs providing expanded healthcare service delivery packages of CPHC (including urban HWCs)	Number of operational / functional HWCs - functionality defined based on CPHC / HWC guidelines for providing increased service delivery packages	Annual	HWC Portal	Facility reporting	MoHFW
Strengthened CPHC data systems for improved performance tracking and performance incentives	(i) Develop CPHC Performance Framework; (ii) Establish verification structures and introduce other interventions to ensure timely and accurate data reported through CPHC routine data systems, based on data quality assessment; (iii) Develop and disseminate HWC Performance Index; (iv) Provide incentives to HWCs based on selected CPHC indicators.	Annual	MoHFW	MoHFW report	MoHFW
Increased population screened based on established national protocol	Cumulative number of individuals that have had population-based screening across (7 Priority states), as per the protocol.	Annual	HWC Portal	Routine data system	MoHFW
Infants 9-11 months who have received the first dose of Pentavalent vaccine	Number of infants 9-11 months old who have	Annual	HMIS	Routine data collection	MoHFW

	received first dose of Pentavalent vaccine				
Development and adoption of state-specific Human Resources for Health (HRH) strategies for public health facilities	Number of states where a state-specific HRH strategy for public health facilities is developed and adopted.	Annual	MoHFW and DoHFW of priority states	State reports on HRH Strategies	MoHFW and DoHFW of priority states
A diagnostic analysis for quality of care improvement conducted to develop a template for a comprehensive state-specific Quality of Care Strategy (QOCS)	A diagnostic analysis to identify quality of care improvement at the meso- and macro-level is conducted by MoHFW to develop a template for a comprehensive state-specific QOCS including micro-, meso- and macro-level interventions.	One-time	MoHFW and DoHFW of priority states	Report on diagnostic analysis for quality of care improvement	MoHFW and DoHFW of priority states
Development of state QOCS	Development of State QOCS in priority states, including micro, meso- and macro-level interventions	Annual	DoHFW	State reports on QOCS	DoHFW
Conducting a learning exchange event for fostering an enabling environment for comprehensive quality of care improvement	A learning exchange event on national and global experiences on High Quality Health Systems, including micro, meso- and macro-level interventions, is convened by MoHFW for the priority states to share their progress on comprehensive quality improvement.	Annual	MoHFW and DoHFW of priority states	Report on learning exchange events	MoHFW and DoHFW of priority states

Piloting of routine measurement of patient/user experience at primary and secondary facilities	This indicator would include development and piloting of an evidence-based and contextualized patient/user experience routine measurement tool at primary and secondary facilities.	Annual	MoHFW and DoHFW of priority states	State reports on development and pilot of state-specific measurement tool for patient experience	MoHFW and DoHFW of priority states
States conducting operational research	Facilitated by the national implementation and learning platform, states will issue an annual call for proposals for operational research on CPHC, urban health, and high quality health systems to capture key factors critical to realizing results, knowledge exchange, and cross-state experience sharing.	Annual	MoHFW and DoHFW of priority states	Report on operational research conducted by states	MoHFW and DoHFW of priority states
National knowledge exchange events held	National knowledge exchange event sponsored by India to enhance state implementation capacity and foster innovation to achieve results. Topics to capture key factors such as CPHC, urban health, and high quality health systems.	Annual	MoHFW and DoHFW of priority states	Report on knowledge exchange events	MoHFW and DoHFW of priority states
Development of Jan Arogya Samitis (JAS) template for annual report and financial	JAS annual report and audit template is necessary to	Once	District	Central note presenting JAS annual report and	MoHFW

audit	measure the functionality of JAS.			financial audit templates	
Increased state implementation of district performance measurement and rewards framework	Development of a district level performance measurement system that includes CPHC performance and other relevant indicators.	Once	District	State reports on development of district level performance measurement system (year 2)	DoHFW of priority states
Simplification and enhanced transparency of the health sector's public financial management	This indicator measures the implementation of guidelines developed by MoHFW to improve transparency of public financial information of PM-ABHIM at central level.	Annual	MoHFW	Central note stating new guidelines on simplification of the Program Implementation Plan (PIP) have been transmitted to States (year 1) Central report documenting GoI developed template for GoI approvals and releases under PM-ABHIM (year 2) Central report documenting GoI published GoI approvals and releases under PM-ABHIM (from year 3 onwards) State reports on PM-ABHIM expenditures (from year 3 onwards)	MoHFW

ANNEX 2. DISBURSEMENT LINKED INDICATORS, DISBURSEMENT ARRANGEMENTS AND VERIFICATION PROTOCOLS

Disbursement Linked Indicators Matrix				
DLI 1	Increased footfalls at Health and Wellness Centers			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	50.00	10.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	259,931,343			
Prior Results	-		0.00	-
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	-		0.00	-
Results to be achieved in FY25/26 (Year 4)	-		0.00	-
Results to be achieved in FY26/27 (Year 5)	40 percent increase in number of footfalls at HWCs		50.00	1. US$1.25m per percent annual increase in number of footfalls at HWCs over baseline, up to a total

				amount of US$50m

DLI 2	Increased population screened based on established national protocol			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	87.00	17.40
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	46,823,002			
Prior Results	-		0.00	-
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	-		0.00	-
Results to be achieved in FY25/26 (Year 4)	-		0.00	-
Results to be achieved in FY26/27 (Year 5)	87 percent increase in number of individuals screened with community-based assessment checklist (CBAC) in accordance with established national protocol.		87.00	2. US$1.0m per percent annual increase in number of individuals screened with CBAC over baseline, up to a total amount of US$87m

DLI 3	Strengthened CPHC data systems for improved performance tracking and performance incentives			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	No	Text	53.00	10.60
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	-			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	3.1 CPHC performance monitoring framework developed by MoHFW		10.00	3.1 One time payment of maximum US$10m on achievement of DLR
Results to be achieved in FY23/24 (Year 2)	3.2 Assessment of CPHC data quality (completeness, accuracy and timeliness), and a road map for improving CPHC data quality developed by MoHFW		8.00	3.2 One time payment of maximum US$8m on achievement of DLR
Results to be achieved in FY24/25 (Year 3)	3.3 Protocols to verify and analyze data for CPHC performance monitoring framework, based on the CPHC data quality assessment developed by MoHFW; 3.4 Protocols for CPHC performance monitoring framework rolled-out by MoHFW.		16.00	3.3 One time payment maximum of US$8m; 3.4 One time payment of maximum US$8m
Results to be achieved in FY25/26 (Year 4)	3.5 Mechanism for providing incentives to HWCs based on the CPHC performance monitoring framework developed by MoHFW		8.00	3.5 One time payment of maximum US$8m on achievement of DLR
Results to be achieved in FY26/27 (Year 5)	3.6 HWC health index generated and publicly disseminated by MoHFW; 3.7 Incentives to HWCs based on HWC health index scores implemented		11.00	One time payment of maximum US$11m; DLR 3.6 maximum of US$5m and maximum US$6m for

			3.7

DLI 4	Increased HWCs with NQAS certification			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	60.00	12.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	560.00			
Prior Results	127.00		3.76	US$29,600 for every HWC NQAS certified
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	-		0.00	-
Results to be achieved in FY25/26 (Year 4)	-		0.00	-
Results to be achieved in FY26/27 (Year 5)	2,027.00		56.24	4. US$29,600 for every HWC NQAS certified up to a total amount of US$60 million

DLI 5	Development and adoption of state-specific Human Resources for Health (HRH) strategies for public health facilities in Priority States			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	60.00	12.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	5.1 Template for HRH strategy for public health facilities developed by MoHFW, in consultation with Priority States.		10.00	5.1 One time payment of maximum US$10m on achievement of DLR
Results to be achieved in FY23/24 (Year 2)	5.2 A comprehensive capacity building plan for Priority States to develop their HRH strategy was developed, approved and requisite support provided by MoHFW.		10.00	5.2 One time payment of maximum US$10m on achievement of DLR
Results to be achieved in FY24/25 (Year 3)	5.3 HRH strategy for public health facilities, based on the template developed by MoHFW, adopted by 5 Priority States		16.00	5.3 US$8m per Priority State (min of 2 Priority States) up to a total amount of US$40m for years 3-5
Results to be achieved in FY25/26 (Year 4)	5.3 HRH strategy for public health facilities, based on the template developed by MoHFW, adopted by 5 Priority States		16.00	5.3 US$8m per Priority State (min of 2 Priority States) up to a total amount of US$40m for years 3-5
Results to be achieved in FY26/27 (Year 5)	5.3 HRH strategy for public health facilities, based on the template developed by MoHFW, adopted by 5 Priority States		8.00	5.3 US$8m per Priority State (min of 2 Priority States) up to a total amount of US$40m for years 3-5

DLI 6	Strengthened national implementation framework and learning platform			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	No	Text	37.75	7.50
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	None			
Prior Results	6.1 Office Memorandum issued by MoHFW 6.2 Guidelines on knowledge and learning developed by MoHFW		6.00	6.1 One time payment on issuance of Office Memorandum, maximum of US$6m
Results to be achieved in FY22/23 (Year 1)	6.2 Guidelines on knowledge and learning developed by MoHFW		4.25	6.2 One time payment on achievement of DLR, maximum of US$4.25m
Results to be achieved in FY23/24 (Year 2)	6.3 Operational research on Program's topics initiated in at least 2 Priority States and approved by MoHFW 6.7 At least one annual knowledge exchange event developed and implemented by MoHFW		10.00	6.3 US$3.5m/ Priority State up to a max of US$7m; 6.7 US$3m per year up to a total amount of US$12m for year 2-5
Results to be achieved in FY24/25 (Year 3)	6.4 Operational research on Program's topics initiated in at least 3 Priority States and approved by MoHFW 6.7 At least one annual knowledge exchange event developed and implemented by MoHFW		6.50	6.4 US$3.5m/ Priority State up to a max of US$3.5m; 6.7 US$3m per year up to a total amount of US$12m for year 2-5
Results to be achieved in FY25/26 (Year 4)	6.5 Operational research on Program's topics initiated in at least 4 Priority States and approved by MoHFW 6.7 At least one annual knowledge		6.00	6.5 US$3.0m/ state up to a max of US$3m; 6.7 US$3m per year up to a total amount of US$12m for year 2-

	exchange event developed and implemented by MoHFW		5
Results to be achieved in FY26/27 (Year 5)	6.6 Operational research on Program's topics initiated in at least 5 Priority States and approved by MoHFW 6.7 At least one annual knowledge exchange event developed and implemented by MoHFW	5.00	6.6 US$2.0m/ state up to a max of US$5m; 6.7 US$3m per year up to a total amount of US$12m for year 2-5

DLI 6.1	Office Memorandum issued by MoHFW			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	6.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	NA			
Prior Results	Office memorandum issued by MoHFW on implementing arrangements at national level and Priority States for achievement of Program results		6.00	One time payment on issuance of a Office Memorandum
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	-		0.00	-

Results to be achieved in FY25/26 (Year 4)	-	0.00	-
Results to be achieved in FY26/27 (Year 5)	-	0.00	-

DLI 6.2	Guidelines on knowledge and learning developed by MoHFW			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	4.25	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	NA			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	Guidelines on knowledge and learning developed by MoHFW		4.25	One time payment on achievement of DLR
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	-		0.00	-
Results to be achieved in FY25/26 (Year 4)	-		0.00	-
Results to be achieved in FY26/27 (Year 5)	-		0.00	-

DLI 6.3	Operational research on Program's topics initiated in at least 2 Priority States and approved by MoHFW			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	7.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	NA			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 2 Priority States.		7.00	US$3.5m per Priority State up to a maximum of US$7m
Results to be achieved in FY24/25 (Year 3)	-		0.00	-
Results to be achieved in FY25/26 (Year 4)	-		0.00	-
Results to be achieved in FY26/27 (Year 5)	-		0.00	-

DLI 6.4	Operational research on Program's topics initiated in at least 3 Priority States and approved by MoHFW			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	3.50	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	NA			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 3 Priority States.		3.50	US$3.5m per Priority State
Results to be achieved in FY25/26 (Year 4)	-		0.00	-
Results to be achieved in FY26/27 (Year 5)	-		0.00	-

DLI 6.5	Operational research on Program's topics initiated in at least 4 Priority States and approved by MoHFW			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	3.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	NA			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	-		0.00	-
Results to be achieved in FY25/26 (Year 4)	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 4 Priority States.		3.00	US$3m per Priority State
Results to be achieved in FY26/27 (Year 5)	-		0.00	-

DLI 6.6	Operational research on Program's topics initiated in at least 5 Priority States and approved by MoHFW			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Text	2.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	NA			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	-		0.00	-
Results to be achieved in FY24/25 (Year 3)	-		0.00	-
Results to be achieved in FY25/26 (Year 4)	-		0.00	-
Results to be achieved in FY26/27 (Year 5)	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 5 Priority States.		2.00	US$2m per Priority State

DLI 6.7	At least one annual knowledge exchange event developed and implemented by MoHFW			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Output	No	Number	12.00	
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Prior Results			0.00	
Results to be achieved in FY22/23 (Year 1)	0.00		0.00	-
Results to be achieved in FY23/24 (Year 2)	1.00		3.00	US$3m per year up to a total amount of US$12m
Results to be achieved in FY24/25 (Year 3)	2.00		3.00	US$3m per year up to a total amount of US$12m
Results to be achieved in FY25/26 (Year 4)	3.00		3.00	US$3m per year up to a total amount of US$12m
Results to be achieved in FY26/27 (Year 5)	4.00		3.00	US$3m per year up to a total amount of US$12m

DLI 7	Improved community ownership and management of HWCs through Jan Arogya Samitis (JAS)			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	No	Text	50.00	10.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**

Baseline	None		
Prior Results	7.1 Template for Jan Arogya Samitis (JAS) annual report and financial audit developed by MoHFW	7.00	7.1 One time payment on achievement of DLR
Results to be achieved in FY22/23 (Year 1)	-	0.00	-
Results to be achieved in FY23/24 (Year 2)	7.2 At least 10 percent of HWCs with functional JAS; 7.3 At least 40 percent of JAS utilizing at least 50 percent of their annual resources	10.75	7.2 US$6.25m for every 10 percent increase up to US$6.25m; 7.3 US$4.5m for every 10 percent increase up to US$4.5m
Results to be achieved in FY24/25 (Year 3)	7.4 At least 20 percent of HWCs with functional JAS; 7.5 At least 50 percent of JAS utilizing at least 50 percent of their annual resources	10.75	7.4 US$6.25m for every 10 percent increase up to US$6.25m; 7.5 $4.5m for every 10 percent increase up to maximum of US$4.5m
Results to be achieved in FY25/26 (Year 4)	7.6 At least 30 percent of HWCs with functional JAS; 7.7 At least 60 percent of JAS utilizing at least 50 percent of their annual resources annually	10.75	7.6 US$6.25m for every 10 percent increase up to US$6.25m; 7.7 US$4.5m for every 10 percent increase up to maximum of US$4.5m
Results to be achieved in FY26/27 (Year 5)	7.8 At least 40 percent of HWCs with functional JAS 7.9 At least 70 percent of JAS utilizing at least 50 percent of their annual resources	10.75	7.8 US$6.25m for every 10 percent increase up to US$6.25m; 7.9 US$4.5m for every 10 percent increase up to US$4.5m

DLI 8	Increased implementation of district performance measurement and rewards framework in Prirority States			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Outcome	Yes	Text	56.00	11.20
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	0.00			
Prior Results	-		0.00	-
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	8.1 District level performance measurement and rewards framework developed by MoHFW		11.00	8.1 One time payment on achievement of DLR of maximum US$11m
Results to be achieved in FY24/25 (Year 3)	8.2 Annual district level performance-based measurement implemented by 5 Priority States		18.00	8.2 US$9m per Priority State up to a total amount of US$18 million
Results to be achieved in FY25/26 (Year 4)	8.2 Annual district level performance-based measurement implemented by 5 Priority States		27.00	8.2 US$9m per Priority State up to a total amount of US$27 million
Results to be achieved in FY26/27 (Year 5)	-		0.00	-

DLI 9	Simplification and enhanced transparency of the health sector's public financial management			
Type of DLI	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Intermediate Outcome	Yes	Text	45.00	9.00
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	No			
Prior Results	9.1 New guidelines on streamlining the PIP (Program Implementation Plan) process planning, appraisal, implementation and monitoring developed by MoHFW and transmitted to states		8.00	9.1 One time payment of maximum amount of US$8m
Results to be achieved in FY22/23 (Year 1)	-		0.00	-
Results to be achieved in FY23/24 (Year 2)	9.2 Reporting mechanism for publishing approvals and releases for PM-ABHIM developed by MoHFW		4.00	9.2 One time payment of maximum amount of US$4m
Results to be achieved in FY24/25 (Year 3)	9.3 Annual reporting of all approvals and releases under PM-ABHIM by MoHFW 9.4 Annual reporting of PM-ABHIM expenditures by 7 Priority States		16.50	9.3 US$6m/ year up to a total of US$12m for years 3-4; 9.4: US$1.5m/state/year up to total of US$21m for years 3-4 (max. 7 states)
Results to be achieved in FY25/26 (Year 4)	9.3 Annual reporting of all approvals and releases under PM-ABHIM by MoHFW 9.4 Annual reporting of PM-ABHIM expenditures by 7 Priority States		16.50	9.3 US$6m/ year up to a total of US$12m for years 3-4; 9.4: US$1.5m/state/year up to total of US$21m for years 3-4 (max. 7 states)

Results to be achieved in FY26/27 (Year 5)	-	0.00	-

Verification Protocol Table: Disbursement Linked Indicators	
DLI 1	Increased footfalls at Health and Wellness Centers
Description	A footfall is defined as a visit to a HWC by an individual for any service provided by the HWCs in a given year, including: (i) all SC-level as well as PHC-level HWCs in rural areas, and (ii) urban HWCs. This includes visits for any of the service packages offered by the HWCs notably for RMNCAH, communicable diseases, NCDs and consultations for minor ailments (covered by the 7 service packages currently mandated, as well as other additional packages to be included over time). The percentage increase in each year T will be calculated as (FT - FMax)/FB where: (i) FT is the number of footfalls in year T; (ii) FMAX is the highest annual number of footfalls recorded in previous years starting from (and including) the baseline year; and (iii) FB is the number of footfalls in the baseline year 2021/22 (259,931,343 footfalls). If FT is less than FMax, the percentage increase in year T will be taken as zero. As long as the number of footfalls keeps on increasing every year, FMax will be the number of footfalls in the previous year (T-1). Disbursement for each year T will be based on the percentage increase in that year.
Data source/ Agency	HWC Portal
Verification Entity	IVA
Procedure	The achievement report provided by MoHFW should provide a breakdown of the total number of footfalls in each period – by HWC. This data would be from the HWC (or other similar) portal. The IVA should cross-check these figures against the HWC or other portal, in consultation with MoHFW. The IVA will also apply a stratified random sampling method to verify 5 percent of all HWCs listed in each report, via field visits – to ensure the figure reported in the HWC portal for the selected HWC and selected period corresponds to what is seen from the HWC records (and the IVA should cross-check the various HWC records to ensure accurate reporting). The strata will be: (i) state; (ii) whether in urban or rural; (iii) whether SC-level or PHC-level (for rural areas). The results of this field-level sample-based verification will be provided to MoHFW, but will not affect disbursements. For Years 4 and 5, this indicator will count towards disbursements only in states where the data sources for this indicator are subject to verification in accordance with the findings of the data quality assessment (see DLI 3). (The sample-based verification of 5 percent of HWCs by the IVA will be done throughout.)
DLI 2	Increased population screened based on established national protocol
Description	This is the number of eligible people that have undergone population-based screening as per the nationally established protocol which currently includes: (i) initial enumeration of the population by ASHAs or equivalent; (ii) annual administration of the Community-Based Checklist (CBAC) including identification of the risk level of each household; (iii)

	maintaining of basic household records at the HWC including from the CBAC tool. The percentage increase in each year T will be calculated as (PT - PMax)/PB where: (i) PT is the number of persons screened in year T; (ii) PMAX is the highest annual number of persons screened recorded in previous years starting from (and including) the baseline year; and (iii) PB is the number of persons screened in the baseline year 2021/22 (46,823,002). If PT is less than PMax, the percentage increase in year T will be taken as zero. As long as the number of persons screened keeps on increasing every year, PMax will be the number of persons screened in the previous year (T-1). Disbursement for each year T will be based on the percentage increase in that year.
Data source/ Agency	HWC portal
Verification Entity	IVA
Procedure	The verification protocol here is similar to that for DLI 1. The achievement report provided by MoHFW should provide a breakdown of the total numbers screened in each period – by HWC. This data would be from the HWC portal. The IVA should cross-check these figures against the HWC portal in consultation with MoHFW. The IVA will also apply a stratified random sampling method to verify 5 percent of all HWCs listed in each report, via field visits – to ensure accuracy and adherence to the full protocol for the population-based screening including maintaining complete family records at the HWC. The strata will be: (i) state; (ii) whether in urban or rural district; (iii) whether SC-level or PHC-level (for rural areas). (The same HWCs can be visited to verify footfalls as well as population-based screening, for the HWCs that are reporting both. Additional sampling will be needed for the HWCs reporting just one of these two DLIs, notably the PHC-level HWCs in rural areas which would report for DLI 1 but not DLI 2) The verification will be done by looking at the HWC records and family records maintained. The results of this field-level sample-based verification will be provided to MoHFW, but will not affect disbursements. For Years 4 and 5, this indicator will count towards disbursements only in states where the HWC portal data are subject to verification in accordance with the findings of the data quality assessment (see DLI 3). (The sample-based verification of 5 percent of HWCs by the IVA will be done throughout.)
DLI 3	Strengthened CPHC data systems for improved performance tracking and performance incentives
Description	(i) Develop CPHC Performance Framework; (ii) Establish verification structures and introduce other interventions to ensure timely and accurate data reported through CPHC routine data systems, based on data quality assessment; (iii) Develop and disseminate HWC Performance Index by drawing on appropriate indicators from the framework and assigning weights based on relative importance of the indicators to generate Composite HWC Index Scores on periodic basis (annually at a minimum); (iv) Provide incentives to HWCs based on selected CPHC indicators.

Data source/ Agency	MoHFW/ NHSRC
Verification Entity	IVA
Procedure	MoHFW will provide a report on how each of the below DLRs was achieved, at the time of request for disbursement for that DLR, with adequate details of each DLR to facilitate verification. **Year 1**: The IVA will confirm the establishment and functionality of a CPHC Performance Framework which will track key CPHC indicators at the level of HWCs and districts. This Framework will **pool data on** the key indicators from existing CPHC data sources (HWC portal, HMIS, etc.). The IVA will assess the accuracy of a sample of indicator reported via this Framework, by comparing against the data sources from which it was derived (HWC portal, HMIS etc.), in consultation with the Government. **This will be DLR 3.1**. **Year 2**: The IVA will confirm the completion of an assessment of the quality of data (timeliness, completeness and accuracy) from CPHC data systems, particularly those feeding into the CPHC Monitoring Framework. Alongside this, the IVA will confirm the development of a road map for improving the CPHC data quality, including an independent verification structure for the data. **This will be DLR 3.2.** **Year 3**: The IVA will confirm the development of protocols to verify and analyze data in support of the CPHC Performance Monitoring Framework (based on the data quality assessment). This system will include IT aspects as needed and will include integration of data verification protocols. **This will be DLR 3.3.** The IVA will confirm the rollout of the abovementioned protocols for CPHC Performance Monitoring including integration of data verification protocols. **This will be DLR 3.4.** **Year 4**: The IVA will confirm the development of a mechanism for providing incentives to HWCs based on the CPHC Performance Monitoring Framework. **This will be DLR 3.5.** **Year 5**: (i) The IVA will confirm the generation of a HWC Health Index which will be a composite score of key CPHC indicators drawn from the CPHC Performance Monitoring system, tracked for each HWC. The IVA will also confirm dissemination to the public of the values of this index (for each HWC and also district averages) at least annually. **This will be DLR 3.6.** (ii) The IVA will confirm the implementation of incentives to HWCs based on these HWC Health Index scores. These incentives will be provided subject to appropriate verification protocols in place as per the system for CPHC Performance Monitoring. **This will be DLR 3.7.**

DLI 4	Increased HWCs with NQAS certification
Description	Number of HWCs/UHWCs NQAS certified
Data source/ Agency	MoHFW/ NHSRC
Verification Entity	IVA
Procedure	The IVA will confirm NQAS certificates achieved by HWCs including UHWCs.
DLI 5	Development and adoption of state-specific Human Resources for Health (HRH) strategies for public health facilities in Priority States
Description	Number of states where a state-specific HRH strategy for public health facilities is developed and adopted
Data source/ Agency	MoHFW/NHSRC and DoHFW of the 5 states
Verification Entity	IVA
Procedure	**Year 1:** (i) The IVA will confirm a template for a state-specific HRH strategy is developed by MoHFW, in consultation with Priority States, including the following domains of reforms and interventions: production, recruitment and deployment, filling vacancies, capacity building, continuous professional development, functional HRIS, task sharing/shifting including creation of a public health cadre, retention, performance measurement, among others; (ii) The IVA will confirm the template with above mentioned domains is shared with the Priority States through Office Memorandum/ appropriate official Government communication. This will be DLR 5.1. **Year 2:**The IVA will verify the capacity building plans, for each priority state to adopt their HRH strategy, developed and initiated by MoHFW based on a checklist designed in consultation with MoHFW and the World Bank. The comprehensive capacity building plans, developed and executed by a working group constituted within MoHFW (if not already present), will entail context-specific consultative workshops, guidance notes and other analytical support. This will be DLR 5.2. **Year 3 to 5:** The IVA will confirm the adoption of a state-specific HRH strategy, developed based on the above mentioned template, through a Government Order/ appropriate official Government communication. The targets for this DLR are adoption by at least 2 states by Year 3, 4 states by Year 4, and 5 states by Year 5. This will be DLR 5.3.

DLI 6	Strengthened national implementation framework and learning platform
Description	Year 1: 6.1 Office Memorandum issued by MoHFW on implementing arrangements at national level and Priority states for achievement of Program results (Prior result) 6.2 Guidelines on knowledge and learning developed by MoHFW Year 2 to 5: 6.3 to 6.6: Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 5 Priority States. 6.7 At least one annual knowledge exchange event developed and implemented by MoHFW
Data source/ Agency	Yr 1: 6.1 MoHFW, 6.2 MoHFW/NHSRC Yr 2 to 5: DoHFW of 5 Priority States for operational research and MoHFW/NHSRC for knowledge exchange events
Verification Entity	IVA
Procedure	**Year 1:** 6.1 The verification agency will confirm that MoHFW issued the Office Memorandum to concerned officials in MoHFW, NHSRC and 7 Priority states that covered aspects such as description of the Program objective and scope, results framework including DLIs, DLI allocation, roles and responsibilities - national and state level for achievement of results, fund flow and reporting of fund utilization, monitoring and reporting (including KPI reporting), Program Actions and compliance, Anti-corruption protocol, and exclusion of High Value Contracts (HVCs). 6.2: The verification agency will confirm that final guidelines with clear definition of knowledge and learning and roles and responsibilities are available. **Year 2 to 5:** 6.3 to 6.6 Proof of MoHFW approvals for operational research. **Year 2 to 5:** 6.7 Proof of national knowledge exchange events taking place with participation of states.
DLI 6.1	Office Memorandum issued by MoHFW
Description	Office memorandum issued by MoHFW on implementing arrangements at national level and Priority states for achievement of Program results
Data source/ Agency	MoHFW
Verification Entity	IVA
Procedure	The verification agency will confirm that MoHFW issued the Office Memorandum to concerned officials in MoHFW, NHSRC and 7 Priority States that covered aspects such as description of the Program objective and scope, results framework including DLIs, DLI allocation, roles and responsibilities - national and state level for achievement of results, fund flow and reporting of fund utilization, monitoring and reporting (including KPI reporting), Program Actions and compliance, Anti-corruption protocol, and exclusion of high-value contracts.

DLI 6.2	Guidelines on knowledge and learning developed by MoHFW
Description	Guidelines on knowledge and learning developed by MoHFW
Data source/ Agency	MoHFW
Verification Entity	IVA
Procedure	Proof of guidelines developed by MoHFW
DLI 6.3	Operational research on Program's topics initiated in at least 2 Priority States and approved by MoHFW
Description	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 2 Priority States.
Data source/ Agency	DoHFW of the 2 Priority States
Verification Entity	IVA
Procedure	Proof of MoHFW approvals for operational research.
DLI 6.4	Operational research on Program's topics initiated in at least 3 Priority States and approved by MoHFW
Description	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 3 Priority States.
Data source/ Agency	DoHFW of 3 Priority States
Verification Entity	IVA
Procedure	Proof of MoHFW approvals for operational research.
DLI 6.5	Operational research on Program's topics initiated in at least 4 Priority States and approved by MoHFW
Description	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 4 Priority States.
Data source/ Agency	MoHFW

Verification Entity	IVA
Procedure	Proof of MoHFW approvals for operational research.
DLI 6.6	Operational research on Program's topics initiated in at least 5 Priority States and approved by MoHFW
Description	Operational research on Program's topics (e.g., CPHC, urban health, quality, governance) initiated in at least 5 Priority States.
Data source/ Agency	DoHFW of 5 Priority States
Verification Entity	IVA
Procedure	Proof of MoHFW approvals for operational research.
DLI 6.7	At least one annual knowledge exchange event developed and implemented by MoHFW
Description	At least one annual knowledge exchange event developed and implemented by MoHFW
Data source/ Agency	MoHFW
Verification Entity	IVA
Procedure	Proof of knowledge exchange events held
DLI 7	Improved community ownership and management of HWCs through Jan Arogya Samitis (JAS)
Description	Year 1: 7.1 7.1 Template for Jan Arogya Samitis (JAS) annual report and financial audit developed by MoHFW Year 2-5: 7.2, 7.4, 7.6, 7.8 Percentage point increase in HWCs with functional JAS (from 10 percent in year 2 to 40 percent in year 5); 7.3, 7.5, 7.7, 7.9 Percentage point increase (from 40 percent in year 2 to 70 percent in year 5) in JAS utilizing at least 50 percent of their resources annually.
Data source/ Agency	Yr 1: MoHFW/NHSRC Yr 2-5 to 5: DoHFW of the 7 states
Verification Entity	IVA
Procedure	**Year 1:** 7.1 Availability of annual reporting and financial audit format for *JAS* at state level. **Year 2-5:** 7.2, 7.4, 7.6, 7.8 The verification agency will confirm a percentage increase (10 percent in year 2, 20 percent in

	year 3, 30 percent in year 4 and 40 percent in year 5) of HWCs with functional *JAS* through availability of *JAS* annual report and audit report. **Year 2-5:** 7.3, 7.5, 7.7, 7.9 The verification agency will confirm a percentage increase (40 percent in year 2, 50 percent in year 3, 60 percent in year 4 and 70 percent in year 5) of JAS have used 50 percent of their resources annually *through yearly JAS* financial statement.
DLI 8	Increased implementation of district performance measurement and rewards framework in Prirority States
Description	Year 1-2: 8.1 District level performance measurement developed by India Year 3-5: 8.2 Annual district level performance-based measurement (e.g., budgetary or non-budgetary incentive to high-performing districts based on performance management system) implemented by at least one Priority State (up to a maximum of 7 Priority States)
Data source/ Agency	Yr 1-2:8.1 MoHFW/NHRSC Yr 3-5: 8.2 DoHFW at Priority State level
Verification Entity	IVA
Procedure	**Year 1- 2: 8.1** The verification agency will confirm a concept note explaining the performance measurement at district level is available and proof that it has been disseminated to the Priority States **Year 3-5: 8.2** The verification agency will confirm states implement performance measurement at district level through availability of budgetary and/ or non-budgetary rewards allocated to any districts in each state
DLI 9	Simplification and enhanced transparency of the health sector's public financial management
Description	Year 1: 9.1 New guidelines on streamlining the PIP process planning, appraisal, implementation and monitoring developed by MoHFW and transmitted to states Year 2: 9.2 Development of reporting template at central level to publish GoI approvals and releases for PM-ABHIM. Year 3 and 4: 9.3 GoI annually reporting all approvals and releases under PM-ABHIM. Year 3 and 4: 9.4 Number of states annually reporting PM-ABHIM expenditures
Data source/ Agency	Yr 1 and 2: MoHFW/NHSRC at central level and DoF at state level Yr 3 and 4: MoHFW/NHSRC at central level and DoF at state level
Verification Entity	IVA
Procedure	**Year 1:** 9.1 Availability of new guidelines on streamlining the PIP process planning, appraisal, implementation and monitoring and proof of reception by states. **Year 2:** 9.2 Availability of final reporting template on NHM website to report GoI approvals and releases for PM-ABHIM. **Years 3 and 4**: Proof of annual publication of (i) GoI approvals and releases under PM-ABHIM at central level and (ii) PM-

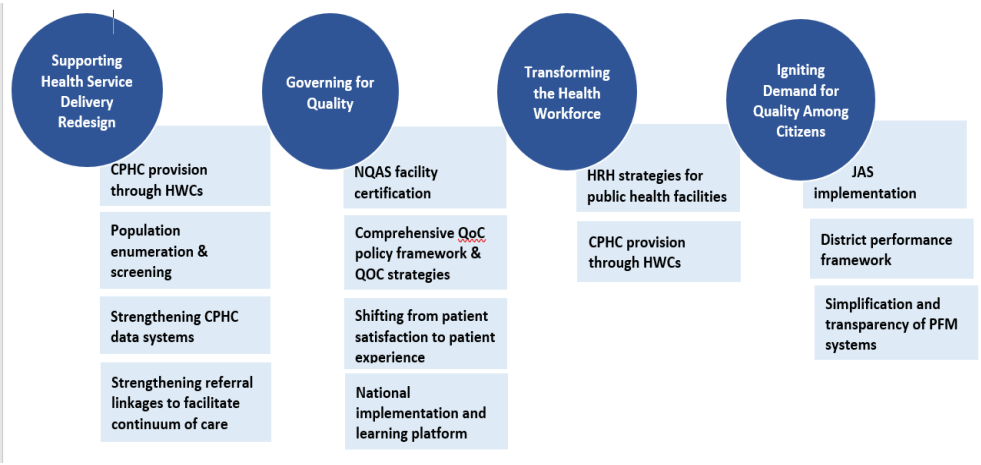
	ABHIM expenditures at state level.

ANNEX 3. TECHNICAL ASSESSMENT

1. **India's health system has made significant progress but continues to be challenged by some critical and systemic performance issues.** India's experience with COVID-19 has provided an opportunity to invest in a pivotal shift in the health sector reform agenda by changing focus from coverage to also concentrating on quality; redesigning service delivery to strengthen primary care; and transforming health sector governance, the nature of center-state accountability, and inter-fiscal transfers for health. The proposed EHSDP, in combination with Transforming India's Public Health Systems for Pandemic Preparedness Program (P175676) and other WB-supported health system strengthening programs will collectively contribute to the overall reform agenda to achieve India's 21st century vision of "Universal and Effective Health Coverage."

2. **The EHSDP focuses on strengthening CPHC services, prioritizing quality of care, and bringing about accountability reforms at multiple levels**, thereby contributing to 'universal and effective health coverage,' 'spending better,' and 'accountability for results' reforms. It will support interventions across the four universal actions as recommended by the 2018 Lancet Global Health Commission on HQSS. (Figure 3.1).

Figure 3.1. Program Areas Mapped to Lancet Commission's HQSS (2018) Universal Actions



3. **In the wake of the COVID-19 pandemic and given the growing burden of NCDs, mental health, and injuries, India has undertaken an essential step toward expanding and transforming its CPHC service delivery (RA#1).**The Program will support the transformation of PHCs and HSCs into functional HWCs by increasing the number of operational/functional HWCs providing expanded health care service delivery packages of CPHC, with an aim to increase the utilization of CPHC services by measuring the footfall at HWCs.[35] Additionally, the Program will support improvements in annual population enumeration for CPHC at the HWCs. Recognizing the importance of data and monitoring, the Program will develop a CPHC

[35] This includes: 12 core service delivery packages and 3 health promotion packages—thereby expanding service delivery at the primary care level beyond RMNCAH and communicable diseases, to also include NCDs; mental health; ear, nose, and throat; ophthalmology; palliative care; and trauma and emergency care.

Performance Monitoring Framework prioritizing a selection of CPHC data, the development of a CPHC dashboard, and strengthening data systems to track performance. The Program will strengthen data systems with a focus on pooling data from existing sources and improving data quality with respect to enhanced timeliness, completeness, and accuracy of data recording.

4. **India has made substantial progress in improving access and the focus is targeting improving quality of care (RA#2).** The Program will support the implementation of the recently updated NQAS and will build on this to create an enabling environment, including knowledge sharing, both nationally and at state level for a comprehensive approach to improving quality of care. The Program will support the development of a state-specific Quality of Care Strategy based on a template designed by the center. It will facilitate the shift in focus from patient satisfaction to patient experience. Finally, it will support the development and adoption, of state-specific HRH strategies, based on a consultative process with stakeholders from both the center and state levels, for public health facilities. The interventions are aligned with best global practices, and the focus on competent care processes and patient experience rather than structural interventions to improve quality is supported by global evidence.

5. **India has embarked on an ambitious reform agenda to transform the delivery and quality of essential health services as well as underlying accountability mechanisms needed to enable such reforms (RA#3).** Aligned with the World Development Report 2004 Framework for service delivery, the Program will support actions that will help strengthen accountability along four dimensions, particularly within a federal system context: (i) between tiers of government, (ii) between the state and providers, (iii) between the state and people, and (iv) between providers and people. The Program will support the establishment of an implementation and learning platform to enhance state implementation capacity and foster innovation to achieve results through operational research, knowledge exchange, and cross-state experience sharing (national-state tiers and provider-state).Through the establishment and institutionalization of the platform for community participation and management of HWCs through JAS, the Program aims to achieve vertical integration of accountability by providing a platform for citizens to engage in health policy (provider-people). The Program will aim to strengthen relationships between states and people by empowering citizens and other stakeholders to have access to better information to monitor resource allocation and expenditure that affect PHC service delivery (state-people). Additionally, for strengthening state-state accountability, the Program will support the focus on outputs and outcomes rather than inputs and a one-size-fits-all approach by introducing performance measurement and rewards at the district level.

6. **The overall expenditure framework of the government program (“p”) is US$42 billion while the proposed Program (“P”) is estimated at US$1,223 million.** The proposed Program was estimated using the following assumptions: (i) NHM allocation for AB-HWC and PM-ABHIM allocations for HWCs and BPHU in the 7 states only for recurring expenditures; (ii) AB-HWC allocations pertaining to HR costs of UPHCs and UCHCs; (iii) estimates for FY2022–23 to FY2026–27 were projected based on the average expenditure of FY2020–21 and FY2021–22, to which a 25 percent increase was applied to correct for limited outpatient related recurrent expenditures during the COVID-19 pandemic. Additionally, a projected growth of 10 percent and inflation of five percent were applied annually to estimates for FY2022-23 to FY2026-27.

7. **Economic justification**. According to the World Health Organization, investing US$1 per person per year in a package of NCD interventions can yield an economic return of US$7 to which the EHSDP will make a meaningful contribution. Additionally, investing in NCDs positively correlates with the accumulation of human capital. The Program incurs limited budget liability, accounting for 1 percent of

annual state health budgets, and its investments will have a return that will continue beyond its implementation.

8. **Finally, the estimated benefit-to-cost ratio of the WB PforR Program is highly favorable.** For India, based on standard approximations in the literature, the value of a statistical life year can be estimated as US$6,700, or about three to four times GDP per capita.[36] With a total IBRD contribution to the Program of US$500 million, this implies that if the Program activities can help achieve an increase of 75,000 additional healthy life-years for the beneficiary population over a five-year span, the investment will "break even." This is a very modest figure, considering the annual footfall in public sector PHC facilities across the seven states is 228 million per year while annual NCD screening is 114 million per year.[37] The benefit-to-cost ratio will remain favorable if we extrapolate the analysis to US$1,223 million, the total cost of the WB PforR Program's boundaries. In that scenario, the Program would need to achieve about 181,319 additional healthy life-years for five years to "break even," which is still highly achievable given the existing footfall at PHC level in those seven states. In brief, based on these estimates, the benefit-to-cost ratio of the Program is considered highly favorable.

[36] Lisa A Robinson 1, James K Hammitt 1 2, Lucy O'Keeffe 1 J Benefit Cost Anal 2019;10(Suppl 1):15-50. doi: 10.1017/bca.2018.26. Epub 2019 Jan 15.

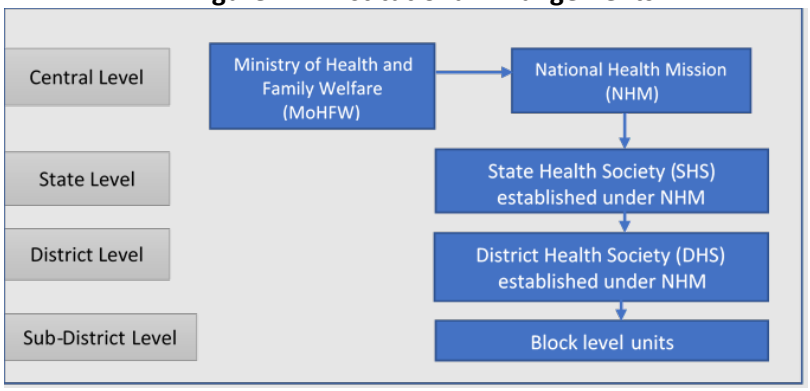
[37] Consolidated report March 16, 2022. Ayushman Bharat - Health and Wellness Centre. Downloaded on March 17, 2022, from: *https://ab-hwc.nhp.gov.in/home/Consolidated_Weekly_Report?state=0*

ANNEX 4. FIDUCIARY SYSTEMS ASSESSMENT

1. **The conclusion of the Integrated Fiduciary Systems Assessment (IFSA) is that the Program's fiduciary systems, subject to timely implementation of proposed mitigation measures, will provide reasonable assurance that financing proceeds shall be used for intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability.** The IFSA identified key fiduciary risks that may affect the Program's development outcomes, and recommended systems improvement and capacity-strengthening /risk mitigation measures that will be implemented during the life of the Program. Based on the IFSA, the residual fiduciary risk of the Program is assessed as **Substantial**. To strengthen the existing systems of the implementing agencies and to mitigate fiduciary risk, various action items are recommended as to be completed during Program implementation.

2. **The implementation arrangements for the Program are based on the NHM implementation platform.** The NHM is GoI's flagship scheme, housed within the MoHFW, which provides overall stewardship and ensures the GoI financing share is made available to the states for implementation. Implementation is done at the states and districts through autonomous health societies established by NHM.[38] At the sub-district level, most states have a block level office. The State Health Society (SHS) is established in most states with a reporting line to the State's DoHFW to facilitate implementation of state level schemes and the NHM. The SHS is governed through high level committees chaired by the Chief Secretary in most states. The SHS usually relies upon the State Medical Corporations to fulfil its procurement needs; and civil works is done through the State Public Works Department or an equivalent agency in the State. The proposed Program will be implemented through the NHM institutional arrangements mentioned above, with the last accounting center varying from state to state.

Figure 4.1. Institutional Arrangements



3. **The IFSA was conducted at the national level for central NHM (MoHFW) with inputs from states to understand its role in providing guidance to states from time to time, as well as the controls around the limited fiduciary functions pertaining to budgeting, fund flow, and financial reporting.** The Program boundary includes seven states—consultations were organized with all seven states over two days, and data were requested for performance assessment of the prescribed systems. A deep-dive assessment was done at such time for three states: Andhra Pradesh, Punjab and Tamil Nadu. The IFSA focused on three main procuring entities in the sample states— Andhra Pradesh Medical Service and Infrastructure Development Corporation (APMSIDC) in the state of Andhra Pradesh, Punjab Health System Corporation (PHSC) in state of Punjab, and Tamil Nadu Medical Service Corporation (TNMSC) in the state of Tamil Nadu. However, the performance of the

[38] Legal entities registered under the Societies Registration Act of 1860 (national legislation), or the respective states' equivalent legislation, as applicable

systems varies from state to state. For this purpose, the FSA team has proposed a list of key performance indicators (KPIs) to be monitored through the Program duration for all seven states to assess the continued adequacy of the fiduciary systems in effect.

4. **The FM and procurement systems, regulatory aspects, and operational practices at the SHS and the procurement entities in the states have been discussed in the detailed IFSA report.** An understanding of the performance of the systems was derived from review of budget and financial data, audit reports and sample review of procurement undertaken, and contracts awarded in the last three years.

5. **Program Expenditure Framework definition does not include any Capital Expenditure.** It is estimated with high likelihood that procurable expenditure would be less than 50 percent of total Program expenditure. Overall procurement profile of the Program would cover four main procurement categories as listed below

   i. Health Sector Goods: Drugs, Consumables, Equipment (excluding Capital Equipment)

   ii. Minor Works: Minor civil upgradation/renovation works, repair (civil, electrical, mechanical) works. Major works are excluded from Program Expenditure Framework.

   iii. Information Technology: Equipment (Tablets) and Services (Internet, Maintenance of Telemedicine Hub)

   iv. Non-Consulting services: Information Education and Communication (IEC), Printing, Training etc.

6. **The key fiduciary risks identified during the assessment and the mitigating measures are mentioned below:**

   i. **Opportunities for inter-state knowledge sharing.** Lack of formal training/knowledge exchange programs for medical service corporations is identified as a substantial gap. Therefore, it is recommended to conduct annual knowledge exchange events among State Medical Service Corporations/Entities

   ii. **Fiduciary Reporting Mechanism.** Based on performance data analysis, there have been cases of low bidder participation, longer procurement cycle times, time overrun, cost overrun, delays in release of funds to the SHS, weak concurrent audits, along with the inherent design of proliferation of implementing agencies with varying capacities across the seven states. It is therefore recommended that a fiduciary KPI report shall be shared with WB on a semi-annual basis in prescribed format.

   iii. **Fiduciary oversight mechanism.** The Concurrent Audit function is not uniform across the States and there is scope to strengthen its implementation. Also, the scope of these audits appears to be mainly transactional in nature, involving review of accounting records and financial transactions, and internal control processes. The internal/concurrent audit function can be made more effective by strengthening the ToR of the audit (similar to the standardized ToR and detailed annual guidance for external audits issued by NHM-FMG to all states which helps in standardizing the quality of external audits), with a focus on risk-based audits, and specialized review in specific functional areas. Also, effective compliance and follow-up mechanism may be facilitated by the constitution of State Audit Committees (SAC) in all states.

   iv. **Reliability and timeliness in Program expenditure reporting.** All accounting centers are processing the transactions through Public Financial Management System (PFMS) and continued use of the same is expected for the Program. The accounts are maintained separately in a software and/or manual

records, as PFMS does not have an accounting functionality yet. The current financial reports are prepared on excel spreadsheets, relying on the above-mentioned records. It is proposed that this process of quarterly financial reports to the NHM is continued, and all transactions continue to be processed through PFMS for the Program.

v. **Audit assurance for the Program expenditure.** Annual audits will be conducted by private chartered accountants for the state -level expenditures incurred under the Program. The ToR for such audits will be agreed with the WB. The audit reports will be compiled at NHM-FMG, along with summaries of (i) eligible Program expenditure for the year, and (ii) auditor observations. The same will be submitted to the WB within nine months from the close of the financial year. The external audit scope would include these specific points: (i) review of contracts to ensure that contracts are not awarded to debarred/suspended firms/individuals; (ii) focus on internal control systems for assessing their effectiveness; (iii) verification on a sample basis to ensure that no HVC is present in Program Expenditure Framework without World Bank approval; and (iv) complaints received were satisfactorily addressed.

vi. **Financial transparency.** The state level audit reports will be disclosed on the NHM website for enhanced financial transparency of the Program.

7. **In addition to the above-mentioned risks, mitigated through DLIs/RF indicators/PAP, fiduciary performance will be monitored during implementation through the following KPIs for the Program** and reported (in agreed format) by MoHFW to the World Bank every six months during Program implementation:

i. Funds transferred to the SHS in a timely manner (measured in days)

ii. Six-monthly Program expenditure reporting against identified budget lines from FMR to keep track of financial progress of the Program

iii. Periodic State Audit Committee meetings

iv. Six monthly financial progress reports submitted by the Medical Corporations to the SHS only in cases where funds are physically transferred to the former

v. Number of bids received for tenders of value above INR 10 million

vi. Procurement Cycle Time for tenders of value above INR 10 million

vii. Details of Contracts with award value above INR 10 million experiencing time overrun

viii. Details of Contracts with award value above INR 10 million experiencing cost overrun

ix. Any critical staffing gaps in the fiduciary function hampering the pace of Program implementation

ANNEX 5. SUMMARY ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT

Introduction

1. An Environment and Social Systems Assessment (ESSA) was conducted by the WB. Following the requirements of the WB PforR Policy, the Program relies on country-level systems for the management of environmental and social effects.

2. The ESSA has been prepared to (i) identify the Program's environmental and social effects; (ii) assess the legal and policy framework for environmental and social management, including a review of relevant legislation, rules, procedures, and institutional responsibilities that are being used by the Program; (iii) assess the capacity to implement requirements under the system; and (iv) recommend specific actions to address gaps in the Program's system and implementation capacity. Through this process, the ESSA team assessed the extent to which the Program's environmental and social management systems are consistent with six core environmental and social principles (hereafter, Core Principles) contained in the PforR Policy and corresponding Key Planning Elements.

ESSA Methodology

3. This ESSA report provides an overview and analysis of the MoHFW and the seven state governments' policies, regulatory frameworks, and ongoing programs for the environmental and social aspects of the participating state health societies. The ESSA discusses relevant environmental and social national legislations for the health sector in India. Apart from the national legislations, there are several state-level environment regulations and social inclusion guidelines (for example, tribal health programming and community-level initiatives) which are also considered before implementing activities in any state.

4. The ESSA evaluates modalities at the national and state levels to help improve access and quality of health service delivery in tribal blocks of the states—specifically for vulnerable groups; scheduled caste and scheduled tribe (SC/ST) households; and women-headed households in Meghalaya, Tamil Nadu, Odisha, and Andhra Pradesh. The ESSA also focuses on land management aspects and labor and safety standards as well as inclusionary strategies adopted by states.

5. The methodology focused on the understanding of Program activities, benefits and risks associated with various activities, environmental and social conditions, the existing institutional mechanism at various levels for implementation, management, policies, and regulatory aspects. It also focused on understanding the gaps and recommending an action plan to not only address the gaps but also ensure sustainable environmental and social effects under the Program.

Potential Environmental and Social Effects of the Program

The key environmental effects of the Program include the following:

i. Increase in BMW. As health care centers are upgraded and offer more comprehensive services, increase in footfall will lead to increase in BMWs and other associated wastes—plastics, e-wastes, and solid wastes. Some HCWs, particularly in the rural areas which do not have access to centralized waste treatment facilities, would need to plan for final disposal facilities and sealed pits.

ii. Increase in quantity of liquid wastes (wastewater, blood, disinfectants, and reagents), which need to be appropriately treated and disposed.

iii. Risks to worker health and safety during the operations of the HCWs need to be abated through appropriate immunization and training programs for all workers (contracted and health care staff), ensuring good hygiene, infection control practices, and BMW handling.

iv. While the standards of HCWs encompass critical elements such as life and fire safety, building safety, and maintenance, there is a need to ensure all staff are trained on these aspects and systems and that there is also good collaboration with other disaster planning initiatives.

v. Generation of dust, noise, and debris while HCWs are being refurbished. Though these impacts are temporary and manageable, the health care facilities need to ensure that appropriate mitigation is followed so that solid wastes are disposed appropriately, and dust and noise do not cause adverse impacts to inpatients and visitors.

Social Effects

6. The activities supported by the Program are likely to provide considerable social benefits such as (i) increased community ownership and management of HWCs through VHSCs, JAS, and MAS; (ii) development of performance measurement and rewards at the district level including for aspirational districts; (iii increased number of operational/functional HWCs providing expanded health care service delivery packages of CPHC, including for tribal blocks in Schedule V areas of the state; and (iv) increased utilization of public health facilities by women-headed households and SC/ST households.

7. The key social risks of the Program are the risks of exclusion particularly for STs and vulnerable groups in unserved areas, that is, aspirational districts and ITDA blocks. Four of the seven participating states have designated Schedule V and Schedule VI areas. The social systems assessment filtered Odisha and Tamil Nadu as focus states to decipher key social risks and institutional capacities in improving health service delivery in tribal blocks. Additionally, across the seven states, the Program covers 15 aspirational districts. Therefore, social risks can be broadly divided into two pillars.

i. *Risks of exclusion in aspirational districts and ITDA blocks:* (a) uptake and utilization of health facilities by traditionally excluded vulnerable groups in unserved and underserved areas, including aspirational districts, tribal blocks, and Schedule V areas of Odisha, Andhra Pradesh, Meghalaya, and Tamil Nadu; (b) utilization of health facilities by women-led households and adolescent girls for reproductive health care, noncommunicable disease (NCD) screening, and preventive care; and (c) access to quality health care for the urban poor, including migrants and informal workers.

ii. *Functionality of community-level platforms (JAS, MAS) in aspirational districts and ITDA blocks:* low institutional capacities of JAS and MAS in tribal/unserved areas to manage health facilities, coordinate with VHSNCs, and act as grievance redressal platforms as per JAS Guidelines.[39]

[39] https://nhsrcindia.org/sites/default/files/2021-06/Guidelines%20for%20Jan%20Aarogya%20Samiti.pdf

Way Forward

8. The Program will ensure adequate resources are provided for timely and effective implementation of environmental and social measures and the key recommendations are made a part of the PAP. Annex 6 includes the detailed E&S PAP.

ANNEX 6. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Conduct an annual knowledge-exchange event for Medical Service Corporations (MSCs)	Fiduciary Systems		MoHFW	Recurrent	Yearly	Held annual knowledge exchange event among state medical service corporations/entities
Timely sharing of Program's fiduciary reports with the Bank	Fiduciary Systems		MoHFW supported by priority states	Recurrent	Semi-Annually	Sharing fiduciary report regarding KPIs and Anti-Corruption Guidelines protocol within two months from last date of each (six-month) reporting period.
Establish a complaints handling mechanism	Fiduciary Systems		MoHFW with SHS of priority states	Other	Within 6 months of the Effective Date	Sharing details of Complaint Handling Nodal Officer on the website of respective State Health Societies.
Program expenditure audit reports for Priority States shall be annually disclosed on the National Health Mission official website.	Fiduciary Systems		MoHFW	Recurrent	Yearly	Annual public disclosure of Program expenditure audit reports for states on the National Health Mission official website.
Quarterly financial reports, and PFMS shall be used for all transaction processing	Fiduciary Systems		MoHFW through SHS of priority states	Recurrent	Semi-Annually	Quarterly financial reports submitted by States to MoHFW, and continued use of PFMS for all transaction processing
Internal audit function shall be strengthened through: issuance of standardized TOR by NHM-FMG; carrying out quarterly concurrent audits at Priority States; and establishment	Fiduciary Systems		MoHFW through SHS of priority states	Other	Within one year of the effective date	Standardized ToR issued for Concurrent Audit by NHM-FMG Quarterly concurrent audit confirmation through 6 monthly KPI reporting State Audit Committee meetings confirmation through 6 monthly KPI reporting

of State Audit Committee at SHS in priority states with clear TORs.						
Designating environmental and social (E&S) specialists for the Program	Environmental and Social Systems		MoHFW	Other	Within three months of the effective date	Designation of qualified staff, with defined scope of work (including the preparation of E&S guidance, monitoring the implementation of E&S actions and reporting protocols).
Sharing of guidelines with the states as issued and updated by the MoEF&CC and CPCB on management of all health care related waste.	Environmental and Social Systems		MoHFW	Recurrent	Continuous	Updated guidelines issued to state-level bio-medical waste management advisory committee
Priority States shall conduct periodic occupational health and safety training to all outsourced agencies engaged in the cleanliness activities for HWCs	Environmental and Social Systems		Priority states	Recurrent	Yearly	Priority States to include action and costing in their annual work plans submitted to MoHFW
Development of an inclusion monitoring template to track roll-out of PM-ABHIM in aspirational districts and integrated tribal development blocks in Priority States.	Environmental and Social Systems		MoHFW	Other	Within the first year after the Effective Date	Submission of a template for Priority States to monitor: (i) fund utilization in integrated tribal development blocks; (ii) specific KPIs to track tribal health programming, utilization; and (iii) functionality of JAS in aspirational districts.
Produce a simple monitoring framework for priority states to monitor E&S actions.	Environmental and Social Systems		MoHFW	Recurrent	Semi-Annually	Regular reporting in implementation support missions