Program Safeguard Systems Assessment (Draft)

December 2014

IND: Supporting National Urban Health Mission

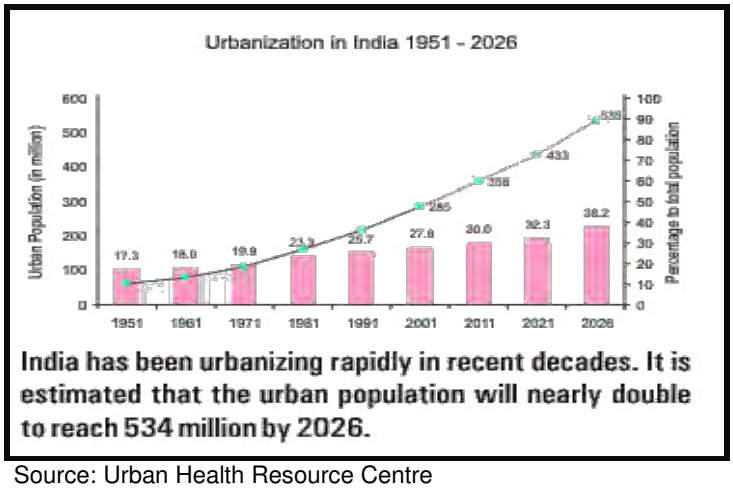
Additional Information – Environment Safeguard Assessment and Social Safeguard Assessment (Diagnostic Assessment Report)

ADDITIONAL INFORMATION TO PROGRAM SAFEGUARD SYSTEMS ASSESSMENT ENVIRONMENT SAFEGUARD ASSESSMENT – DIAGNOSTIC ASSESSMENT REPORT

I. INTRODUCTION

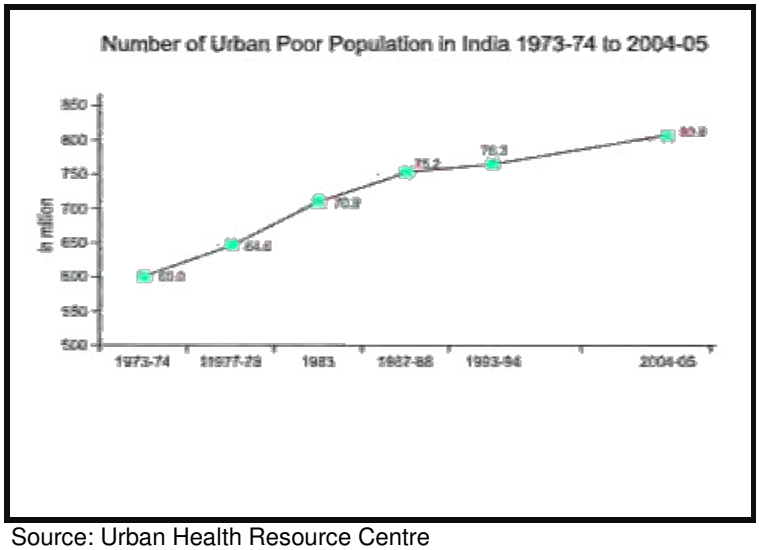
A. Context

1. India has the world's second largest urban population (after PRC). By 2011, India's urban population was 37.7 crores (in millions pl). It is projected that current urban population in India will be doubled by 2026.



Source: Urban Health Resource Centre

2. India also has the world's largest urban poor population living in slums. India also has large differentials in health indicators, e.g. the under-five mortality rate for the poorest quartile in Uttar Pradesh is four times that of the rest of the urban populations in Maharashtra and Madhya Pradesh. In Madhya Pradesh, the under-five mortality rate among its poorest quartile is more than three times that of the rest of its urban population. As urban populations, especially urban poor populations, continue to grow, the need for better urban health facilities is gaining more importance.



Source: Urban Health Resource Centre

B. National Urban Health Mission (NUHM)

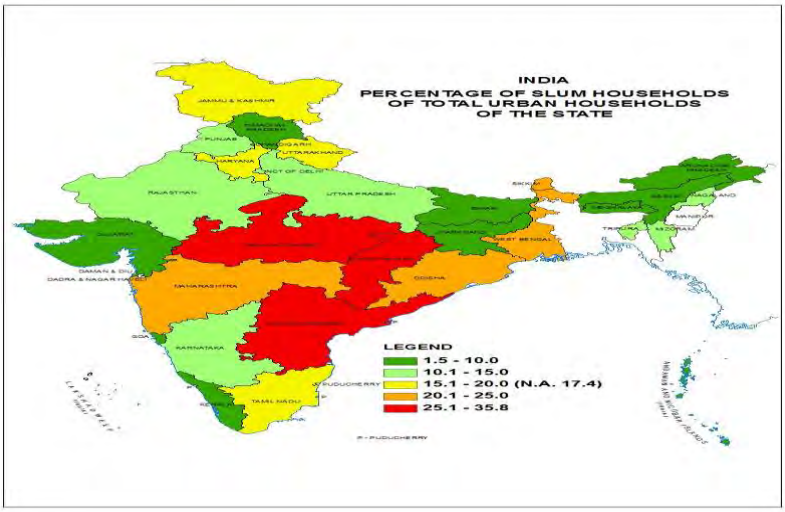
3. In order to provide a better health services specifically focused on urban poor, the Government of India (GoI) proposes to launch a National Urban Health Mission (NUHM). The NUHM is a component of the National Health Mission (NHM). The NHM's other component is the National Rural Health Mission (NRHM). The NUHM will cover all each of 779 cities which has more than 50,000 persons and all district and state headquarters (regardless of their population size).

4. The objective of the NUHM is to address the health concerns of the urban population. The high priority areas for the NUHM are:

(i) Urban poor population in listed and unlisted slums
(ii) All vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers and other temporary migrants.
(iii) Public health thrust on sanitation, clean drinking water, vector control, etc.
(iv) Strengthening public health capacity of urban local bodies.

Indicator	Number of households in (100,000)	
	Total	%
Slum	137	17.4
Non Slum	652	82.6
Total (Urban)	789	100

Source: Census of India, 2011



Source: Census of India, 2011

5. The objectives of the NUHM are to be achieved by making the existing health care service delivery system strong, targeting the people living in urban slums, and converging with various other schemes relating to drinking water and sanitation.

6. The NUHM's strategy comprises of four key activities:

(i) Developing a need based city specific urban health care system

(ii) Institutional mechanism and management systems to meet the health related challenges of a rapidly growing urban population.
(iii) Partnership with community and local bodies for a more proactive involvement in planning, implementation and monitoring of health activities.
(iv) Partnerships with NGOs, for profit and not for profit health service providers and other stakeholders

C. Results−based Lending Program for NUHM

7. The GOI has requested the Asian Development Bank (ADB) to assist to roll-out and scale-up the NUHM[1]. With ADB's assistance, the NUHM plans to address the difficulties of the urban poor in seeking health services, and the health system's incapacity to meet their needs through: (i) a system of urban primary health centers (UPHCs) with applicable norms and structures, that include community outreach services and referral linkages; (ii) incentivizing states and ULBs to improve the poor's access to potable water, adequate sanitation, and vector control by providing untied funds for innovations and convergent actions for improved public health; and (iii) empowering communities to demand for health services and to address the wider environmental and social dimensions of health.

8. The NUHM will establish a link between UPHCs and beneficiaries, and a core vehicle for effective outreach. The proposed Program will therefore support the NUHM as a whole. This is in line with the ADB's India Country Partnership Strategy (2013–2017) which promotes urban health as part of human capital development. This is also in line with the mid-term review of Strategy 2020 which emphasizes support for inclusive growth, and an increased health sector lending from the current 2% to 3%–5%.

9. ADB through its lending instrument – Results Based lending (RBL) - will add value to the NUHM by: (i) strengthening incentives and accountability for results by linking disbursement to results that are essential to meet the NUHM outcome., It will also help strengthening the monitoring and evaluation (M&E) at all levels; (ii) supporting urban health system capacity development at all levels; (iii) assisting in risk mitigation and management; and (iv) financing part of the Program.

D. Program Outputs

10. The impact of the NUHM will be the improved health of the urban population, particularly of the poor. The outcome will be an equitable and quality urban health system targeted on the poor established. Outputs and potential disbursement-linked indicators (DLI):

(i) **Output 1: Urban primary healthcare delivery system created.** A network of 4,500 UPHCs will be created and each will serve about 50,000 persons. The UPHCs will deliver essential health service packages under the defined norms of services. To improve quality of services, standard treatment protocols will be developed and will be applied regularly to UPHCs. The UPHCs will be linked with community outreach services. About 39,000 accredited social health activists and 25,000 auxiliary nurses and midwives will provide essential links among the urban poor, the UPHC, and effective community outreach services. The UPHCs will also be linked with referral hospitals services for secondary and tertiary health care. About 350 referral points will be created under the NUHM.

[1] The government has requested for a loan of $500 million to support NUHM on 29 November 2013.

The Program will further support innovative solutions such as public-private partnership to reach out special target groups. The use of information and communication technologies for disease surveillance and monitoring will also be supported. Potential DLIs are: (a) the number of patients treated at UPHCs, ; (b) the increase in utilizing community outreach services by the poor; and (c) the number of states and cities developed and applied credible models of public-private partnership, and (d) innovative information and communication technologies.

(ii) **Output 2: ULB's capacity to manage and coordinate public health improved.** City level urban health committees will be formed and identify innovative health promotion actions such as convergent actions across sectors for public health, such as establishing and maintaining community toilets, or sanitation promotion activities led by community groups. Agreed innovative actions will be financed under an incentive pool funds for innovations. These actions will have strong community participation. About 155,000 community-based groups (Mahila Arogya Samiti) will organize communities to demand for better health services and will participate in formulating and implementing innovative health promotion actions. Strong contacts will be established with the Jawaharlal Nehru National Urban Renewal Mission and Basic Services to the Urban Poor to optimize the use of urban infrastructure. Furthermore, inter-connectivity with ADB-assisted urban development projects will be sought. A potential DLI are (i) the number of innovative public health promotion actions operational under defined norms to meet critical targets of public health. This will be evidenced by improved municipal services for public health, and reduced incidence of communicable diseases in the communities.

(iii) **Output 3: Urban health institutional capacity improved.** Capacity development in urban health system will be designed for each program output, as well as for improvement in M&E, fiduciary and safeguard systems. Actions will include: (i) strengthening existing health systems technical support agencies so that they expand their expertise to support urban health services; (ii) establishing experts' pool to support states and cities capacity development plans, staff development, and international twinning arrangements for schools of public health. Potential DLIs are (i) the number of NUHM capacity development plans approved and rolled-out at center, states, cities, and community levels.

E. Implementation Arrangements

11. The Ministry of Health and Family Welfare, GOI, is the executing agency while the state governments and the ULBs are the implementing agencies. State-level and ULB-level program management units are established to implement the approved PIPs.

II. ASSESSMENT METHODOLOGY

A. Desk Research and Review

12. A desk review of policy documents, baseline reports, assessments, and monitoring and evaluation reports of the NUHM Program and bio medical waste generation was carried out. The key documents reviewed were: Framework for Implementation NUHM, 2012-2017, Infection Management and Environment Plan, Policy Framework March 2007, Guidelines for Healthcare Workers for Waste Management and Infection Control in PHCs and CHCs under IMEP, World

Bank studies; Mainstreaming Environmental Management in the Health Care Sector, Environmental, Health and Safety Guidelines. Documents on the NUHM Program, its expectations and deliverables were also studied, CRM reports, TRG Recommendations, Infection Control and Waste Management Plan for National AIDS Control Support Project (NACSP), 2012-17, Operational Guidelines for Quality Assurance, 2012, 2013, The web sites of NUHM, MOHFW and NHSRC and other information provided by them were studied.

B. Consultations

13. Consultations with the MOHFW specifically with the NUHM personnel were held to explore whether the NUHM Program has any guidelines for identifying and mitigating the environmental issues associated with Program activities. Discussions were held at various levels at the Ministry. Meetings were also held with State Mission offices and State Pollution Control Boards West Bengal, Tamil Nadu, and Madhya Pradesh.

14. It was observed that the Program does not have its own environmental framework. It uses the National Policy document formulated by MOHFW and the Framework for implementation of an Infection Management and Environment Plan (IMEP). The policy document was commissioned under the Reproductive and Child Health Program Phase II, with technical and financial support from DFID and the World Bank.

15. The IMEP Framework comprises a Policy Framework document and a set of Operational Guidelines. Although these policy and operational instruments were prepared for the National Rural Health Mission (NRHM) to help internalize best management practices in managing health and environmental risks at health care institutions.

16. Consultations with the regulatory bodies such as the State Pollution Control Boards (SPCBs) indicated that there are rules and regulation to address environmental impacts and risks of the health care sector and for the enforcement of compliance. For BMW management compliance, private operators have set up common BMW management facilities with the approval of SPCBs to collect, transport, treat and dispose BMW. Consultations were also held with the facility owners.

C. Field Visits

17. The PHCs in West Bengal, Tamil Nadu & Madhya Pradesh were visited. A checklist (Annex 1) was used to collect information from the PHCs visited. The key environmental issues examined during the visits are:

(i) BMW management: awareness, segregation, collection and transportation and disposal, disposal practices
(ii) Location of the PHCs: whether any site screening criteria had been considered; proximity to any environmentally sensitive features including reserved forests
(iii) Regulatory compliance; environmental consents to establish and operate under the Water & Air Acts
(iv) Best practices followed in case of infection control in the PHCs

18. There are no separate environmental safeguard guidelines or frameworks made for the sub-mission NUHM. As a result, awareness about the above mentioned policies, frameworks and guidelines is minimal among the staff.

19. It was observed that the BMW initiative is compliance driven. At several locations, approvals have been obtained to operate the BMW initiative. . Compliance status is satisfactory in Tamil Nadu compared to that of West Bengal and Madhya Pradesh. Awareness on BMW segregation and disposal was average amongst the health workers in the health facilities. Different colour coded bins are placed at health facilities; sharps were being burnt in the burners; needles were sterlized with appropriate solutions; and final waste is packed, weighed, and disposed approved BMW facility operators.

III. ENVIRONMENTAL MAINSTREAMING IN NUHM

20. The MOHFW has developed Operational Guidelines for Quality Assurance in PHCs, 2013 comprising a comprehensive system of quality assurances. This system includes standards and measures, roadmaps, monitoring and reviewing and guidelines and frameworks for quality management. There is an Assessor's Guidebook for Quality Assurance at District Hospitals, (Volumes I & II) which provides tools for internal and external assessment of district hospitals and other health facilities.

21. The main pillars of the Quality Measurement Systems (QMS) are Quality Standards. There are seventy standards, defined under the QMS. The standards are grouped into 8 units. Each standard has specific measurable elements. These standards and measurable elements are checked at each department of PHC through department specific checkpoints. All checkpoints of a department are collated, and together they form the assessment tool called "Checklist". Scored/filled-in Checklists would generate scoreboards.

22. Infection control is one of the areas of concern – standard 'F' in QMS Guidelines. The first principle of health care is "to do no harm". As public hospitals usually have high occupancy, the infection control practices, hand hygiene, antisepsis, personal protection, processing of equipment, environment control and BMW management are on high alert. Annex 2 shows the Standard F in Areas of Concern regarding infection control and its measurable elements.

23. The MOHFW has a National Policy to address the issues relating to infection control and waste management, and a framework for implementation of an Infection Management and Environment Plan (IMEP) in health care facilities; IMEP Policy Framework and a set of Operational Guidelines for Healthcare Workers for Waste Management and Infection Control in Primary Health Centres. Annex 3 shows the main points of the Guidelines.

24. The IMEP is a framework to guide managing – avoiding, reducing and controlling – health and environmental risks arising from healthcare facilities. Health and environmental risks arise out of poor infection control practices and unsound environment management systems such as (i) inappropriate disinfection, (ii) poor sterilization techniques, (iii) inadequate use of protective gears, (iv) poor bio-medical waste handling, treatment and disposal practices, (v) unhygienic and unsanitary conditions, and (vi) inadequate potable water at health care facilities. Through a structured and systematic approach, IMEP aims to bring in state-of-the-art best practices in managing these health and environmental risks.

25. These above guidelines and frameworks are applicable for the NUHM Program too. The main Program activities under the NUHM which will have environmental impacts are new construction, refurbishing, and siting/locating a new PHC.

26. At the State level, the State Department of Health & Family Welfare (DoHFW) is the implementing agency and also holds the responsibility for IMEP implementation. Principal

Secretary (DoHFW), Secretaries/Commissioners (H and/or FW) will have the overall responsibility. An officer will be assigned to monitor the application of IMEP.

27. At the district level, the District Health Officer will be responsible for the application of IMEP. At health facilities, this responsibility will lie with the Hospital Superintendent or Medical Officer. IMEP nodal officers will coordinate IMEP related activities and act as focal points to ensure its effective, successful application. . BMW has been recognised as the generator of significant environmental impacts. There is an exclusive Rule on BMW issued by the MoEF, and strict compliance with it is expected from all BMW generating entities. The latest amended BMW Rule, 2011 says that "irrespective of the quantum of the BMW generation every occupier of an institution includes a hospital, nursing home, clinic, dispensary, veterinary institution, animal house, pathological laboratory, blood bank generating, collecting, storing, transporting, disposing and or handling shall apply for grant of authorisation". The BMW Rule is given in Annex 3.

28. The review of Bio-medical waste management in JRM, 2011 says that bio-medical waste management and segregation of waste at the point of generation is not taking place in the prescribed manner at health care facilities. Sometimes bags are not collected as per agreed frequency. The Review recommends that Bio-medical waste management wherever it has been outsourced to private agency needs to be managed better through e.g. clear specifications for services to be delivered. Also there should be closer co-ordination with State Environment Pollution Prevention Board, which is responsible for adherence to standards for bio medical waste disposal as per the Act.

IV. APPLICABLE LEGAL AND REGULATORY FRAMEWORK

29. The following Acts, Rules and Guidelines are application to the NUHM.

Table 1: Applicable Legal and Regulatory Framework

Name of Act, Rule, Guideline	Brief Contents	Relevance to Program
National		
Environmental Protection Act, 1986	i. Serves as an "umbrella" legislation designed to provide a framework for central government coordination for the activities of various established central and state authorities. ii. As this is an "umbrella" and all-encompassing legislation, this is relevant to the health sector activities as well. iii. There are rules / notifications that have been brought out under this Act, which are directly relevant to the health sector.	Provides for regulation on environment related activities undertaken in the NUHM. All environmental Rules come under this Act.
Water (Prevention and Control of Pollution) Act, 1974	i. Establishes standards for water quality and effluents ii. Also establishes an institutional structure for preventing and reducing water pollution. Consent to Establish & Consent to Operate from SPCBs is required when there is impact on water quality	NUHM places special emphasis on water sanitation, and the Water (Prevention and Control of Pollution) Act guides on how to prevent and control water pollution which might happen due to different activities of the mission
Air (Prevention &	i. Sets standards for Prevention, control &	PHCs would need a diesel

Name of Act, Rule, Guideline	Brief Contents	Relevance to Program
Control of Pollution) Act, 1981	abatement of air pollution by controlling emission of air pollution as per the prescribed standards. ii. Consent to Establish (CTE) & Consent to Operate (CTO) from SPCBs is needed when there is impact on air quality	generating set to generate power back up. All DG sets need CTE and CTO under Air Act.
EIA Notification, Sept 2006	i. Under sub-rule (3) of Rule 5 of the Environment (Protection) Rules, 1986 for imposing certain restrictions and prohibitions on new projects or activities, or on the expansion or modernization of existing projects or activities based on their potential environmental impacts as indicated in the Schedule to the Notification. ii. Falling under Building and construction projects, threshold limits of >_20000 sq. mtrs and <1,50,000 sq mtrs of built-up area (built up area for covered construction; in the case of facilities open to the sky, it will be the activity area). http://envfor.nic.in/legis/eia/so1533.pdf	Though this notification may not have a direct implication on the PHCs. But it applies to sub-centres when investments on r new facilities or on refurbishing are considered. If the size of the new PHC is more than the size limits as stated, then an EIA study would be required along with an environmental clearance.
CPCB Manual on Hospital Waste Management	i. In 2000, CPCB brought out technical guidance in the areas of bio-medical waste segregation, storage, transport and treatment. ii. The CPCB manual gave special emphasis to incineration, covering incinerator emissions, maintenance requirements, operational problems & solutions, and pollution control systems.	The CPCB Manual will help the team of NUHM to manage the bio-medical waste in a better way.
Guidelines for Universal Immunisation Programme (UIP)	i. UIP in India is one of the largest health programmes in the world for giving vaccinations to children and women. The vaccination practice of the UIP so far involved the use of either glass or disposable syringes. ii. There are other regulation including, Guidelines on AD Syringes, Guidelines on Mercury-Contaminated Wastes, CPCB Guidelines on Central Waste Treatment Facilities and others.	All medical facilities will generate waste like syringes, used cotton and bandages etc. These Guidelines will provide appropriate advice on the handling, managing and disposing off of the waste.
National Health Policy	i. MOHFW laid down a National Health Policy, with the objective of achieving an acceptable standard of good health amongst the general population, with more equitable access across the social and geographical expanse of the country. ii. This policy recognizes linkages with the environment sector and envisages that the environment-related policies & programmes be smoothly interfaced with the health policies and programmes	National Health Policy helps the NUHM to link with environment sector while talking about equitable access to good health services.
Hospital Waste Management Guidelines	i. In 2002, MOHFW laid down national Guidelines on Hospital Waste Management. In addition to covering the important aspects of the Bio-Medical Waste Management Rules, these Guidelines include good practices, training requirements, management & administration requirements and co-ordination between	The NUHM talks about capacity building and co-ordination between different agencies. The Hospital Waste Management Guidelines covers these areas.

Name of Act, Rule, Guideline	Brief Contents	Relevance to Program
	hospital and outside agencies.	
Infection Management and Environment Plan (IMEP):	ii. Policy Framework and Operational Guidelines to address the issues relating to infection control and waste management (IC-WM). iii. IMEP Guidelines are a framework providing a broad overview and generic guidance to central and state level institutions on the type of systems and processes to be established for infection control and BMW. iv. Then there are a set of operational guidelines which consist of operation manuals for health care workers at primary level health care facilities. There are steps needed to manage infectious waste in a hygienic, safe and environmentally sound manner. v. The Plan is an approach for managing – avoiding, reducing and controlling health and environmental risks arising from the health care facilities. Through a structured and systematic approach, the IMEP aims to bring in state-of-the-art, best practices in managing these health and environmental risks effectively. vi. The Guidelines target all the stakeholders including the health workers, doctors, nurses, management and other chain of stakeholders in the healthcare system. IMEP is intended to be a synthesis of many instruments and other best practices with an aim to establish and maintain high quality standards for infection control and environmental management. vii. The IMEP Guidelines are quite comprehensive and include all the policies, legislation and regulation pertaining to the health sector from the MoEF, MOHFW and CPCB. All the regulation discussed above is included in the IMEP Guidelines.	When the NUHM is underway health and environmental risks can arise out of poor infection control practices and unsound environment management systems such as (i) inappropriate disinfection, (ii) poor sterilization techniques, (iii) inadequate use of protective gears (iv) poor bio-medical waste handling, treatment and disposal practices (v) unhygienic and unsanitary conditions and inadequate potable water within the healthcare facilities. The IMEP gives guidance on controlling the above issues.
Indian Public Health Standards (IPHS) Guidelines for Primary Health Centres, Revised 2012,Directorate General of Health Services	i. This standard provides the overlap between health and environment. These standards would also help monitor and improve the functioning of the UPHCs. ii. A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 6 indoor/observation beds. iii. It acts as a referral unit for 6 Sub-Centres and refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level. iv. As the population density in the country is not uniform, the number of UPHCs would depend upon the case load should become a 24 hour facility with nursing facilities. v. Select UPHCs, especially in large blocks where the CHC/FRU is over one hour of journey time	These guidelines will help in improving the day to day operations of Primary Health Centres.

Name of Act, Rule, Guideline	Brief Contents	Relevance to Program
	away, may be upgraded to provide 24 hour emergency hospital care for a number of conditions by increasing number of Medical Officers, preferably such PHCs should have the same IPHS norms as for a CHC.	
Bio-Medical Waste (Management and Handling) Rules, 1998.	i. "Bio-medical waste" means any waste, which is generated during the diagnosis, treatment or immunisation of human beings or animals or in research activities pertaining thereto or in the production or testing of biologicals ii. Rules apply to all persons who generate, collect, receive, store, transport, treat, dispose, or handle bio medical waste in any form.	All medical facilities are likely to have these wastes requiring appropriate disposal and need to be factored into the facilities proposed
ADB's Safeguard Policy Statement, 2009	i. Environmental Safeguards: The Safeguard Policy Statement (SPS) focuses on ensuring the environmental soundness and sustainability of projects. There are several principles which are used by the policy. These principles are discussed below. A screening process is used for every project to determine the appropriate environmental assessment. Conducting of an environment assessment is necessary to identify potential impacts. Examine different alternatives to the project's location, design, technology etc. and their potential environmental and social impacts. Also consider no project alternative. Avoid and where avoidance is not possible minimize and mitigate adverse impacts. Prepare an Environmental Management Plan (EMP) which will include the mitigation measures, monitoring and reporting requirements etc. Carry out consultation with affected people (including women) to address issues related to environmental assessment. Establish a grievance Redressal mechanism to receive and facilitate resolution of affected people's concerns regarding project's environmental performance. Disclose draft and final environmental assessment to affected people and stakeholders. ii. Implement the EMP, monitor its effectiveness and document monitoring results and disclose monitoring reports. Do not implement project activities in areas of critical habitats unless there are no measurable adverse impacts on it. Apply pollution prevention and control technologies and practises consistent with international good practices. Establish preventive and emergency preparedness and response measures to avoid (or minimize where avoidance is not possible) adverse impacts and risks to the Health & Safety to the local communities. Conserve physical cultural	The policy will help the NUHM to understand the importance of screening process and environment assessment. Guidance is available on how to prepare an EMP. Consultation with affected parties as advised by the SPS will help make NUHM work better to safeguard environmental concerns of people. Also, the SPS helps in understanding the importance of preventing pollution.

Name of Act, Rule, Guideline	Brief Contents	Relevance to Program
	resources and avoid destroying and damaging them.	
Implementation Framework of NUHM	Defines the goals, objectives, strategies and Outcomes of NUHM, besides the institutional arrangements, financial resources and planning and appraisal process	Indicates the approach to be taken i.e. of renovation /refurbishment of existing facilities and construction of new facilities.
NUHM: Guidelines for Preparation of State PIP during 2013-14	Provides structure for state PIPs, the planning process including the need to prioritize cities, broad contents, time frame for activities.	Indicates details on the proposed physical infrastructure of UPHCs and UCHCs
Other Regulations	There are other regulations that do not directly refer to healthcare facilities but are indirectly applicable. For instance, mercury waste generated from medical equipment, such as thermometers and dental amalgam, have to be disposed as per the Hazardous Waste (Management & Handling) Rules. Municipal Solid Waste Management Rule, 2000 deals with the municipal waste, non bio medical waste coming out of the health facility.	Different regulations will provide guidance on miscellaneous issues as and when they arise.

V. STATE LEVEL ASSESSMENTS

30. Based on the site visits assess the existing health sector scenario and the NUHM implementation roll out, involving institutions, and assessments of sites in cities – Kolkata in West Bengal, Chennai in Tamil Nadu Bhopal and Indore in Madhya Pradesh following observations were made:

A. West Bengal

31. In Kolkatta, West Bengal, discussions were held with the State NUHM Directorate, Dept of Health, PHCs at New Barrackpore, and the Principle Secretary & NHSRC. Summary of observations:

(i) There is no action plan for either identification or assessment of the environmental impacts that would be created during the implementation of the Program.
(ii) Partial compliance with rules regarding bio medical waste (BMW) collection and disposal
(iii) Segregation of BMW was erratic, as there was low level of awareness on the significance of segregation.
(iv) BMW is not appropriated disposed of. A private operator collects, treat and disposed of BMW at a treatment facility.

Picture 1: BMW disposed off and burnt in the open

32. There are no guidelines or a framework for environmental assessment for the implementation of the NUHM Programme.

B. Tamil Nadu

(i) Satisfactory level of awareness on environmental impacts is noted at the Health Directorate, Mission Directorate and Department of Public Health on bio medical waste

(ii) Apart from compliance with Bio Medical Waste and Public Health Act, 1939, there are training programmes on segregation and disposal of BMW that are conducted by the Department of Public Health for the health workers, doctors and others.

(iii) There is a system of accountability for BMW. Medical officers and health inspectors check on environmental conditions in the city/town along with the local bodies such as the Municipal Corporation. Health Inspectors report to the Medical Officer and the Municipal Commissioner. Medical Officer reports to District Health Officer who reports to the Deputy Director of Health Services

(iv) Public health Norms include environmental pollution reduction and no hazards to human health

(v) BMW is being collected and transported by 10 approved BMW private operators. These operators are inspected and managed by the Pollution Control Board

(vi) Department of Public Health (DPH) is aware of the IMEP Guidelines on environment of NRHM and refers to it in the NUHM Programme. They do regular monitoring of drinking water. They have 6 water quality testing laboratories.

(vii) Prescribed protocols on infection control are also followed by the Department of Health.

(viii) There is a system in place for bio medical waste management including segregation at source, handling and disposal.

(ix) Hospitals have colour coded bins to dispose waste and portable incinerators to cauterize needles.

Picture 2: Colour-coded bins

(x) There was awareness at all levels on the significance of bio medical waste handling and disposal. Training is being provided on regular basis to the staff and doctors.

(xi) It was observed that there was a big unattended open drain next to the public health facility which was stinking and highly contaminated. This facility has now been converted into a health post under the NUHM programme. This implies that a screening process for the site selection for the PHC was not done when it was started and it has also not been done when converted into NUHM health post.

Picture 3: Open Drain near PHC

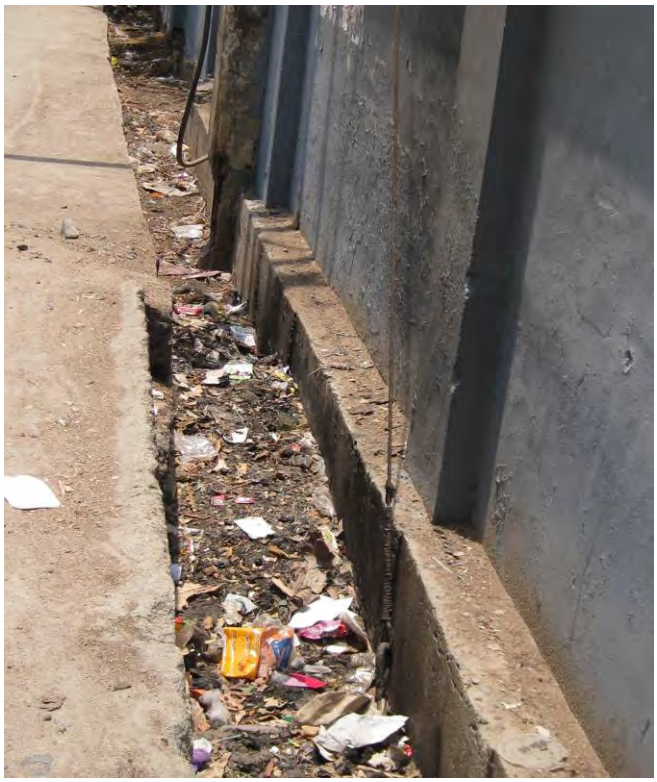
(xii) Municipal Corporation is responsible BMW management at its PHCs. It also managing the drinking water quality in Chennai City. It regularly tests the quality of water for chlorine content and other parameters.

(xiii) A system is in place for bio medical waste management including segregation at source, handling and disposal.

(xiv) There were colour-coded bins at hospital and portable incinerators to cauterize needles.

(xv) A low-level of awareness at all levels on the significance of bio medical waste handling and disposal is noted. At one PHC, the waste is thrown into the municipal garbage stream.

Picture 4: Waste in the open



(xvi) Private operators collect and dispose BMW. PHCs segregate the waste in colour coded bins and keep a record of the waste by weight when giving it to the operator. The TN State Pollution Control Board has appointed BMW operators in Chennai.

C. Madhya Pradesh, Bhopal

(i) A satisfactory level of awareness on environmental impacts of setting up PHCs and refurbishing, especially about bio medical waste management was found among the Health Mission Directorate and Department of Public Health staff.

(ii) Apart from following rules and regulations on bio medical waste, the staff is also familiar with the Nursing Home Act or the Clinical Establishment Act which is directly relevant to setting up of PHCs. This Act includes pre-screening criteria for site selection.

(iii) The PHCs are responsible for segregating and disposing BMW. In the city of Bhopal, Bhopal Incinerator Ltd (BIL) collect and dispose of BMW. All PHCs pay a fee to BIL for its services. The Pollution Control Board inspects BIL and grants the licence to operate.

(iv) As the PHCs have no earnings of their own, they pay for BMW services from the Rogi Kalyan and Kaya Kalp funds.

D. Madhya Pradesh, Indore

(i) In Indore all health care facilities are under the purview of the Department of Health. There is one BMW operator who collects -BMW from private and government health care facilities. In case of PHCs, the state pays the BMW fee to this operator.

Picture 5: Primary Health Centre in Indore

(ii) The private operator has a tripartite agreement with the MC and Nursing Home Association. The role of MC is to ensure that the operator collects BMW from the entire city.

(iii) There is a treatment cum disposal facility handling 3.0 TPD of BMW a day. Indore City generates 3.5 TPD of BMW a day.

(iv) All PHCs have to obtain NOCs to establish and operate from the Pollution Control Board. They also have to get an authorization from the PCB to become a member of the Common BMW treatment and disposal facility.

(v) The Common treatment and disposal facility has to get an environment clearance from the Ministry of Environment and Forests as it falls under Category A.

(vi) All PHCs are required to have effluent treatment plant, but most of them do not have.

33. A list of the people met during the various site visits is given in Annex 4.

VI. ENVIRONMENTAL IMPACTS

34. Environmental impacts will be generated during construction/ refurbishing of the PHCs. From the location of PHC to disposal of BMW, the environmental impacts need to be tracked step by step.

(i) While planning a new UPHC the first task is site selection. Siting should not be in the vicinity of any environmentally sensitive areas; wetland, or protected area. There should not be any environmental impacts like loss of forests, drainage logging, inadequate water supply and others. An environmental screening format (SPS Policy of ADB), Annex 5, of site selection criteria/ checklist should be used

during site selection phase. Screening is also a part of the EIA and also of IMEP Guidelines.

a. **Construction Phase.** Environmental impacts would be generated mainly during the construction of new UPHCs and refurbishing/upgrading of old UPHCs. These impacts are site specific. Under the NUHM Program, there will be a range of new constructions, such as sub centres, operation theatres, labour rooms, maternity wards, testing laboratories and blood banks. Many diesel generators would be installed during the construction phase. Impacts during the construction phase will be typical of all medium-scale construction activities and limited to the project sites. Environmental impacts and risks arising from the construction activities would be noise, dust, occupational hazards risks in handling electrical equipment, the lack of drainage management, water pollution and air pollution, construction debris which stressed sanitary conditions, and inadequate and non-functional washing and toilet facilities. The short-term construction-related impacts and risks, and safeguard risks outlined above, can be prevented or mitigated by adopting standard operational procedures and good construction management practices.

(ii) **Operation Phase.** There are several environmental impacts generated during the operations of health care facilities. These include generation of hazardous and infectious bio medical waste, disposal of sharps, generation of plastic waste, generation of waste water, air pollution and generation of infections, contaminated water and degraded sanitation. Generation of BMW is the most significant environmental impacts generated in UPHC operations. BMW consists of infectious wastes such as sharps (infected needles and syringes, surgical equipment, IV sets) infected blood, test kits used in laboratories, blood bags, human organs and parts, laboratory samples and pharmaceutical wastes. These wastes if not managed and disposed of well would generate significant environmental and public health risks

(iii) Components of the BMW management system at health facilities

a. Segregation of waste at source; infectious waste, sharps, infectious plastics and general waste
b. Sharp management; needles, cutting devices sterilisation and destruction to minimize infection including HIV
c. Collection and interim storage of waste; storage in colour coded bins in a designated area
d. Occupational safety and infection control; patient safety and infection control, use of personal protection equipments like masks, hand gloves

(iv) Disinfection and liquid waste; waste water treatment for the liquid disinfectant waste Disposal of BMW is another major impact. The Bio-Med Rules allow construction of deep burial pits in health care facilities which are not connected to the central waste management facilities. However, these pits create air pollution by burning the waste in these pits and ground pollution too. Then there is no solution to fill up pits. The use

of CBWTF for the management and final disposal of the BMW is a part of compliance to the Bio-Med Rule. All the health facilities have to obtain an authorization from the Pollution Control Board to dispose-off their BMW via the CBWTF. The optimal number of CBWTFs in the states is decided by the state pollution control boards in consultation with the state health departments, municipalities or the urban local bodies. Contractual rates for collection, transportation and disposal are also set in consultation.

(v) All the CBWTFs require environmental clearances and their operations and compliance are monitored by the SPCBs and CPCB. These facilities need support in procuring land, technology and sufficient volumes of waste to operate to make their operations sustainable.

(vi) Proper handling, treatment and disposal of BMW are also legal requirements as per GoI's Bio Medical Waste Management Rules (1998 and as mended in 2000). The Rule can become more stringent in the states. The overall context for healthcare waste management in India is covered in Waste (Management and Handling) Rules.

(vii) Health care workers are at great risk because most of the blood borne infections occurring through injuries from sharps contaminated with blood through accidents or unsafe practices. Improper disposal of BMW including dumping, uncontrolled burning creates risk of infections and exposure to toxic emissions from combustion. Hepatitis B and C, tuberculosis and water-borne diseases, are few of the diseases are created by the improper handling of BMW. Many human pathogens can be found in health-care waste items, (e.g., Staphylococcus sp., HIV, Hepatitis B and Hepatitis C in blood, Salmonella, Shigella sp in faeces and vomit, and Streptococcus in mucus) though the transmission routes are still uncertain.

(viii) Building related specifications; proper ventilation and natural lighting should be available to the workers, doctors and patients. Good indoor air quality, good flooring, fire resistant building materials are other requirements.

(ix) Waste water and sanitation; sanitary standards for waste treatment storage and disposal are to be ensured for avoiding health risks, provision of toilets separate for males and females is a must. Waste water generated from the UPHCs would have to be treated and an effluent treatment plant would have to be installed to comply with the Water Act.

(x) Adequate and good quality water supply along with good waste management and infection control practices are essential for maintaining good hygiene and sanitation.

(xi) UPHCs would require diesel generating sets and these generate air emissions. No objection certificate to operate under the Air Act (EPA Act, 1986) would have to be obtained from State Pollution Control Board.

VII. SAFEGUARDS SYSTEM ASSESSMENT

35. As per Constitution of India, Health is a concurrent subject with both Centre and States. In case of the NUHM, the MOHFW Centre is responsible to provide Policy and related guidelines, and the state has the responsibility apply them in operations. The MOHFW provides an overall framework for implementation of NUHM by states. It also provides Guidelines for the preparation of PIPs and also for approval of annual PIPs and sanctioning funds for implementation. The states have the responsibility of providing the necessary physical infrastructure and manpower to rollout the program which includes the task of identification and selection of sites – building and land sites, manpower and also managing associated risks from resulting impacts.

36. As mentioned earlier, the NUHM is a sub-Mission of the NHM. Under this umbrella programme there are other programmes such as NRHM and RCH. All the policies made by the MOHFW for these Missions and Programmes are also applicable to the NUHM. Assessment of the Congruence between NHM System and ADB's Environmental Safeguard Policy.

Table 2: Assessment of Infection Management & Environment Plan (IMEP) Guidelines of the NHM with the Environmental Safeguard Policy Principles of ADB

	Gap Analysis	
ADB Policy Principle	**Congruence Between NHM with IMEP Guidelines and SPS Environmental Safeguard Requirements**	**Assessment of Implementation Capacity**
1.Use a screening process for each proposed project, as early as possible, to determine the appropriate extent and type of environmental assessment	IMEP Guidelines include site selection criteria for a new UPHC and compliance requirements to other regulation by MoEF including the EIA Notification. As per the EIA Notification 2006, , any construction project falling under Building and Construction projects, threshold limits of >_20000 sq.mtrs and <1,50,000 sq mtrs of built-up area# (built up area for covered construction; in the case of facilities open to the sky, it will be the activity area) will need an Environmental Impact Assessment (EIA study). Any UPHC to be built or rebuilt would have to comply with the requirements of this Rule and would have to go through the screening process. This is applicable to all categories of the projects; A and B. As A part of the EIA study a site assessment/screening has to be conducted. In case of SPS, for construction of new and refurbishment of old ones, Rapid Environmental Assessment (REA) Checklist focuses on environmental issues and concerns. As in case of SPS screening criteria, EIA screening guidelines use the type, scale and magnitude of the proposed project as well as its location in determining the category-prescribed or non-prescribed. Thus SPS environmental safeguard policy principle is congruent with the IMEP Guidelines set for	The MOHFW applies these rules to any building either to be constructed or to be refurbished.

ADB Policy Principle	Gap Analysis	
	Congruence Between NHM with IMEP Guidelines and SPS Environmental Safeguard Requirements	**Assessment of Implementation Capacity**
	the UPHCs	
2.Conduct an environmental assessment for each proposed project to identify potential direct, indirect, cumulative, and induced impacts and risks to physical, biological, socioeconomic and physical cultural resources in the context of the project's area of influence	IMEP Guidelines clearly refer to the compliance of environmental regulation of MoEF including the Environmental Protection Act, 1986 and EIA Notification, 2006. It clearly states that all UPHCs under the programme have to be in full compliance with the applicable rules. The regulatory system applicable to the projects in the programme are congruent with the SPS Policy requirements	Environmental assessments would have to be conducted based on the guidelines as per the environmental regulatory framework which would be sufficient to meet ADB environmental safeguard requirements.
3.Examine alternatives to the project's location, design, technology, and components and their potential environmental and social impacts and document the rationale for selecting the particular alternative proposed. Also consider the no project alternative	For new locations of UPHCs, a screening criteria checklist is included in the IMEP Guidelines. Not applicable to the Program's UPHCs refurbishment activities as it will have all construction works at current sites. This is in congruence with the SPS Policy. There is a project screening checklist in the SPS Policy and the criteria mentioned in this checklist are similar to that in the IMEP Guidelines	The screening checklist would have to be administered before a new site is selected for upcoming UPHC.
4. Avoid, and where avoidance is not possible, minimize, mitigate, and/or offset adverse impacts and enhance positive impacts by means of environmental planning and management. Prepare an EMP that includes the proposed mitigation measures, environmental monitoring and reporting requirements, related institutional or organizational arrangements, capacity development and training measures, implementation schedule, cost estimates, and	IMEP Guidelines require compliance with the EIA Notification Rule of MoEF. An EIA or IEE along with an EMP will be required depending on the size of the new UPHC. If the size of the UPHC is within the regulated limits, then a No Objection Consents have to be obtained from the SPCBs for the operations of DG sets and waste water treatment plant installed in the UPHC. The Consents give action plans for mitigation, monitoring and reporting. All UPHCs irrespective of the size are required to take authorizations from the SPCBs for the BMW disposal. This is in congruence with the SPS Policy of ADB	Most of the UPHCs are small and below the EIA Notification size limits, therefore no EIAs or environmental assessments had been conducted and and there are no EMPs. Most of them had not obtained consents from the SPCBs.

ADB Policy Principle	Gap Analysis	
	Congruence Between NHM with IMEP Guidelines and SPS Environmental Safeguard Requirements	**Assessment of Implementation Capacity**
performance indicators		
5. Carry out meaningful consultation with affected people and all other stakeholders. Continue consultations during project implementation	With reference to the EIA Notification, 2006 and EIA Rule, IMEP Guidelines provides for stakeholder consultation with health workers, community and other stakeholders. However, in Category B projects stakeholder consultations and public hearing process are not required. This is in congruence with the ADB SPS Policy	This would be required only if the EIA Rule is applicable and there is risk of impacts on the community and other stakeholders.
6. Disclose a draft environmental assessment (including the EMP) in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected people and other stakeholders. Disclose the final environmental assessment, and its updates if any, to affected people and other stakeholders	EMPs are a part of the EIA Report as per the EIA Rule. However, EIA Report is not required in this category of projects. This is in congruence with the ADB SPS Policy.	Environmental assessments are not required.
7. Implement the EMP and monitor its effectiveness. Document monitoring results, including the development and implementation of corrective actions, and disclose monitoring reports	Cross reference to the EIA Rule, EMPs would be made and monitored internally through audits and externally by third party audits and inspections by the State Dept of Environments and SPCBs. The SPS Policy elaborates these requirements and provides guidance on this aspect.	Apart from the Rule, the Guidelines provide guidance on Action Plans but mainly on BMW management and infection control.
8. Do not implement project activities in areas of critical habitats. If a project is located within a legally protected area, implement additional programs to promote and enhance the conservation aims of	The regulatory framework provides for the protection of critical habitats and environmentally sensitive areas to which IMEP Guidelines refer to. In congruence with the SPS Policy	This is being considered under the regulation

ADB Policy Principle	Gap Analysis	
	Congruence Between NHM with IMEP Guidelines and SPS Environmental Safeguard Requirements	**Assessment of Implementation Capacity**
the protected area. Use a precautionary approach to the use, development, and management of renewable natural resources		
9.Apply pollution prevention and control technologies and practices consistent with international good practices as reflected in internationally recognized standards such as the World Bank Group's Environmental, Health and Safety Guidelines. Adopt cleaner production processes and good energy efficiency practices. Avoid pollution, or, when avoidance is not possible, minimize or control the intensity or load of pollutant emissions and discharges, including direct and indirect greenhouse gases emissions, waste generation, and release of hazardous materials from their production, transportation, handling, and storage. Avoid the use of hazardous materials. Purchase, use, and manage pesticides based on integrated pest management approaches and reduce reliance on synthetic chemical pesticides	The IMEP Guidelines are quite comprehensive and cover environment management system components on waste management and infection control; goals, organizational structure, environmental impacts, mitigation and management plans, reviewing and monitoring and awareness and training The SPS Policy elaborates them further.	The implementation of the Guidelines is weak at the state level. As there is poor level of awareness about the pollution Guidelines, especially at the state level.
10. Conserve physical cultural resources and avoid destroying or	The environmental regulatory framework provides for the conservation of physical cultural resources and to protect such	As a part of the environmental clearance process of the Category A

ADB Policy Principle	Gap Analysis	
	Congruence Between NHM with IMEP Guidelines and SPS Environmental Safeguard Requirements	**Assessment of Implementation Capacity**
damaging them by using field-based surveys that employ qualified and experienced experts during environmental assessment. Provide for the use of "chance find" procedures that include a pre-approved management and conservation approach for materials that may be discovered during project implementation	resources which mentioned in the Guidelines. EIA Notification covers the essence of this principle when an EIA/EA study is done. In congruence with the SPS Principle	and B1 projects the components of this Principle are implemented.
11. Provide workers with safe and healthy working conditions and prevent accidents, injuries and disease. Establish preventive and emergency preparedness and response measures	The IMEP Guidelines have 3 separate operational guidelines for 3 types of PHCs consisting of pictorial instructions for health care workers on procedures and plans for infection control and BMW management. This is partially covered in the manuals.	As there is low awareness on the existence of these Guidelines at the state levels.

37. Although the Indian safeguard systems are robust the weakness lies in the enforcement and implementation. The MoEF has allocated the responsibility of the enforcement of the regulation to the CPCB and to SPCBs, but there is widespread non-compliance at the project proponent levels.

38. Various assessments have been done to compare the Indian environmental assessment system with that of other agencies. Table 3 provides a comparison with the World Bank's Environmental, Health, and Safety Guidelines, ADB and Indian regulation. Reference has been taken from IFC's Environmental, Health, and Safety Guidelines, Health Care Facilities and Environmental Compliance and Enforcement in India: Rapid Assessment by OECD Programme of Environmental Co-operation with Asia. This study was a rapid assessment of India's environmental compliance and enforcement programmes conducted by the Secretariat of the Asian Environmental Compliance and Enforcement Network (AECEN) – with funding from the U.S. Agency for International Development (USAID) – and the Organisation for Economic Co-operation and Development (OECD). It was carried out in close collaboration with India's Ministry of Environment and Forests (MOEF) under the guidance of the Central Pollution Control Board (CPCB) in 2006. Another diagnostic study Environmental and Social Safeguards Framework (ESSF) conducted by India Infrastructure Financing Company Limited (IIFCL) has been referred to for the comparison done in Table 3.

Table 3: Comparison of World Bank's and ADB's Safeguards Policy Statement, 2009 on Environment Safeguards with GOI EIA/EC System

Sl No	World Bank Environment Guidelines	ADB's Safeguard Policy Statement	GOI EIA/EC System	Gaps/Similarities
1	Evaluate potential environmental risks and impacts in a projects' area of influence, project alternatives, ways of improving project selection, siting, planning, design, and implementation by preventing, minimizing, or compensating of adverse environmental impacts and enhancing positive impacts	To analyze, manage, and plan to address environmental impacts of development policies, strategies, programs, and projects	The objective of EIA is to foresee and address potential environmental problems/concerns at an early stage of project planning and design. • EIA/EMP should assist planners and government authorities in the decision making process by identifying the key impacts/issues and formulating mitigation measures	All three policy/systems talk about identifying potential environmental impacts and risks and about possible mitigation of the same
2	Covers topics like natural environment, human health and safety, social aspects, trans-boundary, and global environmental aspects	Covers topics like physical and biological environment, and social, health, and economic conditions	Covers topics like physical and biological environment and social, health and economic conditions • The impacts that should be assessed include air, noise, land, water, biological and socioeconomic.	While ADB and GOI systems talk about economic conditions along with other conditions the World Bank policy does not talk about economic aspects
3	Any project with potential to cause significant adverse impacts that are sensitive, diverse or unprecedented, affect broad areas and cannot easily be predicted, prevented, or mitigated require EIA	Any project with potential cause of significant adverse environmental impacts require EA	The projects requiring are well defined in EIA Notification (2006) as Schedule – I. Criteria such as Project type, size and location are considered in stipulating EIA requirements	The GOI system is quite detailed when specifying the type of projects that require EIA specifying project type, size and location etc.
4	For legal requirements and standards applied must comply with national and WB standards and take account of national and international obligations and commitments	For legal requirements and standards, national and/or WB standards (whichever are the most stringent) must be met. Alternative standards must be fully justified.	For legal requirements and standards, standards at National level are issued by Central Pollution Control Board (CPCB). These standards are generally at par (and in cases even stricter) than the international	THE ADB and GOI policy/system focus on the most stringent law to be followed while World Bank asks to comply with both national and World Bank standards irrespective of stringency.

Sl No	World Bank Environment Guidelines	ADB's Safeguard Policy Statement	GOI EIA/EC System	Gaps/Similarities
			standards. • Standards can be made stricter by State Pollution Control Board based on location specific considerations	
5	Borrower is responsible for ensuring that all EA activities are carried out in accordance with national and WB requirements. Borrower is also responsible for ensuring that the EMP is fully implemented and reported • Bank will review and agree screening category with Borrower, review ToR of EIA studies, review EIA report and EMP and require borrower to submit monitoring reports to Bank showing compliance with national and WB standards. WB will also carry out review missions to ensure compliance with EMP.	Borrower is responsible for doing the EA in accordance with national and ADB's EA requirements. The borrower is also responsible for implementing the recommendations of the EA • The ADB will screen the project and is responsible for ensuring that the EA report meets the ADB's requirements and provides a sound basis for project processing and implementation. ADB will monitor implementation of agreed environmental mitigation measures by borrower	Responsibilities for preparing EIA are with the project proponent. MoEF and State Departments of Environment have responsibility finalizing TOR, review, and take a decision on EC	All three systems are similar in the matter of responsibility of conducting EA/EIA and also monitoring whether the EMP is implemented
6	EA should be initiated" as early as possible" in the project cycle. For some categories of projects like Category A, EA Reports must be received at least 60 days before Board approval is due (and in some cases 120 days before)	EA activities begin as soon as potential projects for ADB financing are identified. EA studies are carried out simultaneously with pre-feasibility and feasibility studies. EA activities should also continue throughout the project cycle – not a one-off report.	Timing of EIA is concurrent to project development	ADB is different than other two systems as it requires EA activities to go on throughout the project
7	Each proposed project is screened to determine appropriate extent and type of EA.	Each proposed project is scrutinized as to its type, location, the	Screening is done to see whether a project requires EC as per the statutory	Only ADB takes into consideration the availability of cost effective mitigation

Sl No	World Bank Environment Guidelines	ADB's Safeguard Policy Statement	GOI EIA/EC System	Gaps/Similarities
	Projects are classified into 1 to 4 categories depending on type, location, sensitivity and scale of project, and nature and magnitude of its environmental impacts. For dam and reservoir Projects, the borrower must engage independent expert/s whose qualifications and TOR are acceptable to the Bank, review the project BEFORE screening.	sensitivity, scale, nature and magnitude of potential environmental impacts and the availability of cost effective mitigation measures	notifications. Screening Criteria are based upon: 1. Scales of impact; 2. Severity of impact 3. Location of development	measures along with other factors like scale, location etc. of the project. Also GOI system screens the project only when EC is needed as per statutory requirement.
8	Categories of projects are as mentioned below: A: Likely to have significant adverse impacts that are sensitive, diverse, or unprecedented and may affect a broad area • B: Potential impacts are less adverse than for Category A, they are site specific, few if any are irreversible and in most cases, mitigatory measures can be designed more readily than for Category A projects. • C: Minimal or no adverse environmental impacts • FI: May result in adverse environmental impacts financed through a financial intermediary	Categories of projects are as mentioned below: A: Potential to have significant adverse environmental impacts. • B: Some environmental impact but less significant than Category A. • C: Unlikely to have adverse environmental impacts • FI: Involve investment through an FI. Financial intermediary must apply an environmental management system unless all subprojects will result in insignificant impacts Categorization can be changed if necessary	All projects and activities are broadly categorized in to two categories -Category A and Category B, based on the spatial extent of potential impacts and potential impacts on human health and natural and man made resources	All three policy/systems are similar in the approach that they identify different categories of projects and these categories are based on the potential impacts and their severity. The World Bank and ADB have identified more categories than GOI system has
9	Multiple component projects are categorized according to the component with potentially most	EA category is determined by the category of its most environmentally	Not addressed nor applicable in EC	While World Bank and ADB take into consideration the most sensitive/component

Sl No	World Bank Environment Guidelines	ADB's Safeguard Policy Statement	GOI EIA/EC System	Gaps/Similarities
	serious adverse effects. Dual categories are not used.	sensitive components including direct and indirect impacts.		with most serious adverse effects, the GOI system does not talk about the overriding criteria for categorization
10	Advice on pollution abatement measures, guidance on impact etc. are provided in World Bank Pollution Abatement Handbook and Environment Assessment Sourcebook (and updates).	Some guidance on the approach to completing EA studies is provided in the ADB's Environmental Assessment Guidelines. ADB follows standards and approach laid down in the World Bank's Pollution Abatement Handbook.	Scoping is a process of detailing the terms of reference of EIA. It refers to the process by which the EAC/SEAC determine detailed and comprehensive Terms Of Reference (TOR) addressing all relevant environmental concerns for the preparation of an EIA Report with respect to the project or activity for which prior EC is sought • The MoEF has published guidelines for different sectors, which outline the significant issues to be addressed in the EIA studies.	The most detailed advice regarding tools to use as reference. ADB provides only some guidance and depends on World Bank's Pollution Abatement Handbook
11	Emissions and environmental quality standards as per Pollution Abatement Handbook and/or national standards whichever are the most stringent • Alternative standards may be proposed but their application must be fully justified.	Emissions and environmental quality standards as per World Bank Pollution Abatement Handbook and/or national standards whichever are the most stringent. Alternative standards may be proposed but their application must be fully justified.	National standards as stipulated by CPCB. These standards can be tightened by SPCBs depending on the sensitivity of the location country. Where specific standards are not developed or are deemed inappropriate, other international standards (EU, Germany, World Bank) should be applied	All three policy/system place emphasis on using the best and most stringent quality standards
12	Preventative	No detail is given	For every project,	World Bank favors

Sl No	World Bank Environment Guidelines	ADB's Safeguard Policy Statement	GOI EIA/EC System	Gaps/Similarities
	measures are favored over mitigatory or compensation measures	on preferred mitigation hierarchy	possible alternatives should be identified and environmental attributes compared. Alternatives should cover both project location and process technologies. Alternatives should consider 'no project' option also. Alternatives should then be ranked for selection of the best environmental option for optimum economic benefits to the community at large.	preventative measures and GOI System focuses on possible alternatives so have a similar approach but ADB does not provide any detail on mitigation hierarchy.
13	Borrower must consult with project affected groups and local NGOs about the project's aspects and take their views into account for all Category A and B projects. For Category A projects, consultation must happen at least twice: (a) shortly after screening and before TOR for EA study reports is prepared. The borrower must also consult with these groups during project implementation. During EA review by the Bank, special attention is paid to the nature of consultations and the extent to which views of affected people and local NGOs have been taken into account.	Borrower must consult with project affected groups and local NGOs for all Category A and B projects. Must be carried out as early as possible in the project cycle so that views are taken into account in project design and mitigation measures Consultation should continue into project implementation to identify and help address environmental issues that arise. • Category A projects, consultation must occur at least twice: (a) during early stage of EIA field work (the TOR for the EIA study should be disclosed to and discussed with affected	Requires that the locally affected persons and other stakeholders must be informed and consulted on a proposed development with a view to taking into account all the material concerns in the project or activity design as appropriate. • Any one likely to be affected by the proposed project is entitled to have access to the Executive Summary of the EIA. • The affected persons may include: bonafide local residents; local associations; environmental groups: active in the area; and any other person located at the project site / sites of displacement • They are to be	All three policy/system are similar in their approach that affected groups must be consulted with

Sl No	World Bank Environment Guidelines	ADB's Safeguard Policy Statement	GOI EIA/EC System	Gaps/Similarities
		groups/local NGOs) and (b) when draft EIA report is available and before the loan is appraised. The public consultation process must be described in the EIA and IEE reports. • If an EIA report has been completed before ADB involvement, ADB will review the public consultation and disclosure carried out. If it does not meet ADB requirements, the borrower must carry out supplemental activities which will then be reported in revised EA reports and submitted to the Bank.	given an opportunity to make oral/written suggestions to the SPCB/regulatory agency.	

VIII. MONITORING & EVALUATION

39. A monitoring system for BMW management is given in the QA Manual. BMW management wherever outsourced to a private agency needs to be managed better through e.g. clear specifications for services to be delivered.

40. There is a review system to assess the submissions, both NRHM and RCH. JRM & CRM review the sub Missions. Both the reviews have covered BMW & infection control on that is current status of the BMW management & infection control and have made recommendations on how to improve.

ANNEX 1

Checklist for Environmental Safeguard Assessment for Field Visits

Potential Environmental Impacts & Risks	Yes	No	Remarks
Screening criteria for the existing and proposed health facilities			
Is the area densely populated?			
Are development activities been carried out locally?			
Is the project area adjacent to or within any of following areas? - Environmentally sensitive areas			
- Cultural heritage site			
- Protected Area			
- Wetland			
- Mangrove			
- Estuarine			
- Buffer zone of protected area			
- Special area for protecting biodiversity			
- Bay			
Encroachment of historical/ cultural areas			
Environmental Assessment for the health facilities			
Generation of pollutants in during construction			
Discharges and waste disposals during construction phase leading to soil erosion, sedimentation, health hazards and impact on groundwater			
Accident risks associated with construction activities			
Increased noise pollution resulting from construction activities Air pollution; dust generation during construction and demolition			
Transportation activities causing pollution during construction			
Drainage conditions			
Is there stressed sanitary condition during construction phase?			
Wastewater discharges; contamination of groundwater			
Does the project provide any income generating avenues for local residents?			
Are any occupational health and infection control measures carried out?			
Is waste segregation carried out?			
Disposal method adopted for biomedical waste?			
Is there appropriate technology for managing, treating and disposing of waste?			
Is there risks related to occupational health and safety due to biomedical waste?			
Risk to aesthetics with the construction and refurbishing			
Environmental sanitation; hygiene			
Compliance to the BMW Rule			

NUHM Environmental and Social Impacts and Risks

1. What is the focus on environmental assessment/ safeguard in the programme?

2. Is there a framework for setting up an environmental management system in the programme?

3. What are the environmental indicators for the implementation of the programme?

    i. Site selection
    ii. Environmental sanitation
    iii. Waste treatment and disposals
    iv. Environmental regulation

ANNEX 2
Operational Guidelines on Quality Assurance in Public Health Facilities, 2013

Area of concern: F – Infection Control

The first principle of health care is "to do no harm". As Public Hospitals usually have high occupancy, the Infection control practices become more critical to avoid cross-infection and its spread. This area of concern covers Infection control practices, hand-hygiene, and antisepsis, Personal Protection, processing of equipment, environment control, and Biomedical Waste Management. Following is the brief description of the Standards within this area of concern.

Standards

Standard F1 The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection	Standard F1 is concerned with the implementation of Infection control programme at the facility. It is includes existence of functional infection control committee, microbiological surveillance, measurement of hospital acquired infection rates, periodic medical check-up and immunization of staff and monitoring of Infection control Practices. Hospital administration should be interacted to assess the functioning of infection control committee. Records should be reviewed for confirming the culture surveillance practices, monitoring of Hospital acquired infection, status of staff immunization, etc. Implementation of antibiotic policy can be assessed though staff interview, perusal of patient record and usage pattern of antibiotic.
Standard F2 The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis	Standard F2 is concerned with practices of hand-washing and antisepsis. Availability of Hand washing facilities with soap and running water should be observed at the point of use. Technique of hand-washing for assessing the practices, and effectiveness of training may be observed.
Standard F3 The facility ensures standard practices and materials for Personal protection	Standard F3 is concerned with usage of Personal Protection Equipment (PPE) such as gloves, ask, apron, etc. Interaction with staff may reveal the adequacy of supply of PPE.
Standard F4 The facility has standard procedures for processing of equipment and instruments	Standard F4 is concerned with standard procedures, related to processing of equipment and instruments. It includes adequate decontamination, cleaning, disinfection and sterilization of equipment and instruments. These practices should be observed and staff should be interviewed for compliance to certain standard procedures.
Standard F5 Physical layout and environmental control of the	Standard F5 pertains to environment cleaning. It assesses whether lay out and arrangement of

patient care areas ensures infection prevention	processes is conducive for the infection control or not. Environment cleaning processes like mopping, especially in critical areas like OT and ICU should be observed for the adequacy and technique.
Standard F6 The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.	Standard F6 is concerned with Management of Biomedical waste management including its segregation, transportation, disposal and management of sharps. Availability of equipment and practices of segregation can be directly observed. Staff should be interviewed about the procedure for management of the needle stick injuries. Storage and transportation of waste should be observed and records are verified.

Area of Concern - F: Infection Control

Measurable Elements

Standard F1	The facility has infection control Programme and procedures in place for prevention and measurement of hospital associated infection
ME F1.1	The facility has functional infection control committee
ME F1.2	The facility has provision for Passive and active culture surveillance of critical & high risk areas.
ME F1.3	The facility measures hospital associated infection rates
ME F1.4	There is Provision of Periodic Medical Check-up and immunization of staff.
ME F1.5	The facility has established procedures for regular monitoring of infection control practices.
ME F1.6	The facility has defined and established antibiotic policy.
Standard F2	The facility has defined and Implemented procedures for ensuring hand hygiene practices and antisepsis.
ME F2.1	Hand washing facilities are provided at point of use
ME F2.2	The facility staff is trained in hand washing practices and they adhere to standard hand washing practices.
ME F2.3	The facility ensures standard practices and materials for antisepsis.
Standard F3	The facility ensures standard practices and materials for Personal protection
ME F3.1	The facility ensures adequate personal protection Equipment as per requirements.
ME F3.2	The facility staff adheres to standard personal protection practices

Standard F4	The facility has standard procedures for processing of equipment and instruments.
ME F4.1	The facility ensures standard practices and materials for decontamination and cleaning of instruments and procedures areas.
ME F4.1	The facility ensures standard practices and materials for disinfection and sterilization of instruments and equipment
Standard F5	Physical layout and environmental control of the patient care areas ensures infection prevention.
ME F5.1	Layout of the department is conducive for the infection control practices
ME F5.1	The facility ensures availability of standard materials for cleaning and disinfection of patient care areas
ME F5.1	The facility ensures standard practices are followed for the cleaning and disinfection of patient care areas
ME F5.1	The facility ensures segregation infectious patients
ME F5.1	The facility ensures air quality of high risk area
Standard F6	The facility has defined and established procedures for segregation, collection, treatment and disposal of Bio Medical and hazardous Waste.
ME F6.1	The facility Ensures segregation of Bio Medical Waste as per guidelines and 'onsite' management of waste is carried out as per guidelines
ME F6.1	The facility ensures management of sharps as per guidelines.
ME F6.1	The facility ensures transportation and disposal of waste as per guidelines.

Source: Operational Guidelines for Quality Assurance in Public Health Facilities, 2013

ANNEX 3

Government of India
Ministry of Environment and Forests
****

Subject: Draft Bio-Medical Waste (Management and Handling) Rules, 2011

Ministry of Environment and Forests (MoEF), Govt. of India has notified the new draft Bio-Medical Waste (Management and Handling) Rules, 2011 under the Environment (Protection) Act, 1986 to replace the earlier Bio-Medical Waste (Management and Handling) Rules, 1998 and the amendments thereof. The draft Rules are notified for information of the public and inviting objections or suggestions, if any, within 60 days. These will be taken into consideration by the central Government while finalising the Rules.

Salient features of the draft Rules:

(1) These rules shall apply to all persons who generate, collect, receive, store, transport, treat, dispose, or handle bio medical waste in any form. The Rules shall not apply to radio active waste covered under the Atomic Energy Act, 1962, hazardous chemicals covered under the Manufacture, Storage and Import or Hazardous Chemicals Rules, 1989, the municipal waste covered under the Municipal Solid Waste (Management & Handling) Rules, 2000, the batteries waste covered under the Batteries (Management & Handling) Rules, 2001 and the hazardous wastes covered under the Hazardous Waste (Management, Handling and Transboundary Movement) Rules, 2008.

(2) Every occupier of an health care establishment (HCE) shall either set up requisite bio-medical waste treatment facilities like autoclave/microwave/hydroclave, shredder or any other technology as approved by the CPCB/MoEF for treatment of bio-medical waste generated in his premises as a part of on-site treatment of the institution, prior to commencement of its operation or ensure requisite treatment of the bio-medical waste at an approved common waste treatment facility or any approved waste treatment facility.

(3) It has been stipulated that irrespective of the quantum of bio-medical waste generation, every occupier of an institution which includes a hospital, nursing home, clinic, dispensary, veterinary institution, animal house, pathological laboratory, blood bank generating, collecting, receiving, storing, transporting, disposing and/or handling bio-medical waste, shall apply for grant of authorization to the prescribed authority.

(4) Bio-medical waste shall be segregated and kept in the colour coded containers or bags at the point of generation in accordance with Schedule II of the Rules prior to its storage, transportation, treatment and disposal. Colour coding for containers or bags (Yellow, Red, Blue and Black) for collection of various

Government of India
Ministry of Environment and Forests
****

Subject: Draft Bio-Medical Waste (Management and Handling) Rules, 2011

Ministry of Environment and Forests (MoEF), Govt. of India has notified the new draft Bio-Medical Waste (Management and Handling) Rules, 2011 under the Environment (Protection) Act, 1986 to replace the earlier Bio-Medical Waste (Management and Handling) Rules, 1998 and the amendments thereof. The draft Rules are notified for information of the public and inviting objections or suggestions, if any, within 60 days. These will be taken into consideration by the central Government while finalising the Rules.

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ANNEX 4
Infection Management and Environmental Plan, Policy Framework, 2007

Discussion Points in the Policy Framework

1. Infection Control
2. Treatment and Disposal of Bio-Medical Wastes
3. Segregation of Waste and Onsite Storage
4. Transportation of Bio-Medical Wastes
5. Handling Sharps
6. Use and Disposal of Auto-Disable (AD) Syringes
7. Use and Sterilization of Glass syringes
8. Mercury Waste Disposal
9. New Healthcare Facility – Site Selection
10. Healthcare Facilities – Guidelines for Design
11. Construction Management Guidelines
12. Drug Expiry Management
13. Awareness and Training
14. Monitoring & Evaluation
15. Action Plan

ANNEX 5
List of Persons Met

Madhya Pradesh
Indore

1. Dr. Ashok Dagaria, Chief Medical and Health Officer
2. Ms. Megha Burvey, Consultant, Taru Leading Edge Pvt. Ltd.
3. Mr. Amit Dubey, Consultant, Taru Leading Edge Pvt. Ltd.
4. Dr Suresh Aggarwal – Hoswin Environmental Services
5. Asad Warsi - Hoswin Environmental Services, Bhopal
6. Mr. H.S. Malviya, Executive Engineer, Madhya Pradesh Pollution Control Board
7. Dr. N.P. Shukla, Chairman, Madhya Pradesh Pollution Control Board

West Bengal
Kolkata

1. Ms. Sanghamitra Ghosh, Commissioner (Family Welfare), State Mission Director, NRHM
2. Dr B C Roy, New Barackpore Municipality

New Delhi
1. Dr. Himanshu Bhushan, Deputy Commissioner (MH), Ministry of Health & Family Welfare
2. Mr. Nikunja B. Dhal, Joint Secretary, Ministry of Health and Family Welfare
3. Preeti Pant

Tamil Nadu
Chennai

1. Dr. K. Vinay Kumar, Deputy Director of Health Services, Tamil Nadu Public Health Services
2. Mr. D.Sekar, Joint Chief Environmental Engineer, Tamil Nadu Pollution Control Board
3. Dr. M. Jagadeesan, Additional City Health Officer, Corporation of Chennai
4. Dr. S.Balasubramanian, Hosp. Admn. (WHO Fellow), Joint Director PH & PM (Epidemic) & State Surveillance Officer, Office of the Director of Public Health & Preventive Medicine
5. Dr Arool Ananth
6. Dr Radhakrishnan, Health Secy
7. Dr Srinivasan, Municipal Health Officer, Tambaram Municipality
8. Senthil Vel, Dy Director

ANNEX 6
Rapid Environmental Assessment (REA) Checklist

Instruction:
(i) The project team completes this checklist to support the environmental classification of a project. It is to be attached to the environmental categorization form and submitted to the Environment and Safeguards Division (RSES) for endorsement by Director, RSES and for approval by the Chief Compliance Officer

(ii) This checklist focuses on environmental issues and concerns. To ensure that social dimensions are adequately considered, refer also to ADB's (a) checklists on involuntary resettlement and Indigenous Peoples; (b) poverty reduction handbook; (c) staff guide to consultation and participation; and (d) gender checklists.

(iii) Answer the questions assuming the "without mitigation" case. The purpose is to identify potential impacts. Use the "remarks" section to discuss any anticipated mitigation measures.

Country/Project Title:

Sector Division:

Screening Questions	Yes	No	Remarks
A. PROJECT SITING IS THE PROJECT AREA ADJACENT TO OR WITHIN ANY OF THE FOLLOWING AREAS:			
▪ UNDERGROUND UTILITIES			
▪ CULTURAL HERITAGE SITE			
▪ PROTECTED AREA			
▪ WETLAND			
▪ MANGROVE			
▪ ESTUARINE			
▪ BUFFER ZONE OF PROTECTED AREA			
▪ SPECIAL AREA FOR PROTECTING BIODIVERSITY			
▪ BAY			
B. POTENTIAL ENVIRONMENTAL IMPACTS WILL THE PROJECT CAUSE…			
▪ Encroachment on historical/cultural areas?			
▪ Encroachment on precious ecology (e.g. sensitive or protected areas)?			

Screening Questions	Yes	No	Remarks
▪ Impacts on the sustainability of associated sanitation and solid waste disposal systems?			
▪ Dislocation or involuntary resettlement of people?			
▪ Disproportionate impacts on the poor, women and children, Indigenous Peoples or other vulnerable groups?			
▪ Accident risks associated with increased vehicular traffic, leading to loss of life?			
▪ Increased noise and air pollution resulting from increased traffic volume?			
▪ Occupational and community health and safety risks?			
▪ Risks and vulnerabilities related to occupational health and safety due to physical, chemical, biological, and radiological hazards during project construction and operation?			
▪ Generation of dust in sensitive areas during construction?			
▪ Requirements for disposal of fill, excavation, and/or spoil materials?			
▪ Noise and vibration due to blasting and other civil works?			
▪ Long-term impacts on groundwater flows as result of needing to drain the project site prior to construction?			
▪ Long-term impacts on local hydrology as a result of building hard surfaces in or near the building?			
▪ Large population influx during project construction and operation that causes increased burden on social infrastructure and services (such as water supply and sanitation systems)?			
▪ Social conflicts if workers from other regions or countries are hired?			
▪ Risks to community safety caused by fire, electric shock, or failure of the buildings safety features during operation?			
▪ Risks to community health and safety caused by management and disposal of waste?			

Screening Questions	Yes	No	Remarks
▪ Community safety risks due to both accidental and natural hazards, especially where the structural elements or components of the project are accessible to members of the affected community or where their failure could result in injury to the community throughout project construction, operation and decommissioning?			

SOCIAL SAFEGUARD ASSESSMENT – DIAGNOSTIC ASSESSMENT REPORT

EXECUTIVE SUMMARY

1. As per the Census of 2011, population of India was 121 crores of which urban population was 37.7 crores (316%). Out of 4,041 Statutory Towns listed in the Census of 2011, slums reported from 2,543 Towns (63%). In order to address the health concerns of the urban poor population, the Union Cabinet, approved on 1st May 2013 the launch of the National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM). The objective of NUHM is to provide quality primary healthcare services to the urban population, especially to the urban poor and other vulnerable sections of the society. The Mission covers all cities/towns each of which with a population of more than 50,000, all district headquarters and state capitals. The NUHM aims to improve the health status of the urban population, particularly of slum dwellers and other vulnerable persons by facilitating equitable access to quality health care through the involvement of Urban Local Bodies (ULBs). The Ministry of Health and Family Welfare, GOI is the executing agency, while the state governments and the ULBs where capacity exist, are the implementing agencies. States level and ULB level program management units are established to implement the approved Program Implementation Plans (PIPs).

2. The GOI requested Asian Development Bank (ADB)'s assistance to roll-out and scale-up the NUHM. The proposed Program will therefore support the NUHM as a whole. In this regard, the proposed small-scale project preparatory technical assistance (S-PPTA) conducted a technical and system assessment of the National Urban Health Mission (NUHM). The outputs of the S-PPTA will enable the Government of India (GOI) and Asian Development Bank (ADB) to design a results-based lending (RBL) program to support the NUHM implementation. Assessment was carried out to check whether NUHM has adequate implementation experience, capacity, and commitment to plan, implement, monitor, and report on the safeguard measures for the Program.

3. The assessment of possible impacts of the Program has been done through applying standard Impact Categorization Checklists and interactions with relevant stakeholders – officials of Health Department, District Collectors e, Revenue Department. Such discussions focused on understanding the processes of identification of project sites, land acquisition or transfer of state land to the Program and the measures adopted to deal with those unauthorised settlers or illegal occupants, if any. Moreover the assessment reviewed the state's preparedness in implementing the Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013. Consultations were held with persons living in the vicinity of the proposed Program sites in order to gain a first-hand understanding of their concerns regarding existing and proposed facilities.

4. Site assessments have helped to learn that that the proposed upgrades will not result in any involuntary impacts. Land sites identified for new facilities are unlikely to result in any adverse involuntary resettlement impacts or impacts on indigenous peoples. Also the assessment enabled to estimate the nature and type of impacts of the proposed interventions under the NUHM Program. The potential adverse social impacts are:

5. The potential social impacts and risks identified therefore included: i) encroachments or residential/commercial squatting for reasonable period of time despite the land being in

possession by health agency/department and being planned for construction of new facilities; ii) Ownership disputes on the land that are known at the time and are unresolved; iii) loss of shelter, business or livelihood. In case of renovation or upgradation of existing facilities, impacts on structures either residential or commercial vendors structure are likely to experience impact. Besides there could be permanent or temporary loss of income because the vendor has semi-permanent structure attached to the wall of the facility and likely to experience construction stage impacts. There could be mobile kiosks experiencing temporary loss of income as well. Further in case of rented facilities there could be occupants who are government staff who live and/or operate and renovation works may require them to move out. Other potential social impacts include: air and noise pollution; temporary impacts on structures, temporary disruption to access or passage, particularly in congested slums, unless mobile units are used; temporary loss of income of mobile kiosks contaminated drinking water and water borne diseases during the construction phase as a result of inadequate disposal of debris and blockage of natural drainage systems;

6. Regarding involuntary resettlement safeguards, the site visits helped to reconfirm that resettlement impacts of the Program are insignificant which can be initially categorized as category C. The Program will not have any impact on indigenous peoples. Based on this finding, the PSSA reconfirms the initial categorization of impacts on indigenous peoples as Category C.

7. The safeguard system assessment is therefore based on two different scenarios. First scenario, wherein there is no private land acquisition involved and minimal construction stage impacts are likely. Second scenario wherein there is constraint of government land and private land acquisition and resulting impacts of assets and livelihoods are unavoidable.
In case of the second scenario, the RFCTLAR&R Act, 2013 is applicable. It provides for payment of compensation at replacement cost and for the rehabilitation and resettlement of affected families. The Act is congruent with the ADB's Involuntary Resettlement Policy.

8. However, there are a few differences between the Act and the ADB's policy requirements: persons who live or depend on rights-of-way or public lands excluded from the Act's benefits and entitlements; and a three-year residency requirement for persons losing livelihood, to receive resettlement and rehabilitation benefits. In terms of institutional readiness as per the new Act, at present various states are in different stages of framing rules for implementation of the new act. Additionally, some states such as Gujarat, Karnataka, Kerala already have or have initiated the process of institutionalizing positions such as the R&R Commissioner. It is expected that other states too shall follow suit over the next few months and be ready with a full institutional set up as is required under the new Act.

9. As the RBL program will not finance civil works with potential social safeguard impacts, it shall screen proposed civil works for potential involuntary resettlement impacts. For this purpose, the types of facilities described earlier in Section C can be categorized into broadly four types. Two of the types including renovation/upgradation of existing facilities into UPHC/UCHC in rented buildings; and new UPHCs/UCHCs to be started in rented buildings are likely to have nil adverse impacts as details of rental locations are normally checked prior to leasing them and state health department therefore can ensure that these locations are free from any encumbrances to begin with. Mobile PHCs on the contrary provide an option to avoid impacts particularly in terms of any taking of any land or impacting any structure in congested urban areas/ slum locations. Hence, these two categories require no further screening. In case of proposed facilities involving renovation/ upgradation of existing facilities; or starting of new facilities in government buildings; or new constructions could lead to potential adverse social

impacts. Therefore the above two categories of refurbishment of existing facilities or new constructions require screening with respect to the assessment of potential adverse social safeguard impacts.

10. In order to facilitate effective screening and as agreed to by MOHFW three basic details will be included in State's annual PIP Procurement Plan for civil works. Firstly, whether the proposed facility is compounded (fenced) and thereby is devoid of any unauthorized occupation. Secondly, whether the renovation/upgradation involves structural changes to the ground floor of the facility i.e. involves horizontal expansion beyond the existing compound wall or involves vertical expansion in the form of additional floors/levels. Third aspect will consider whether, for new constructions, the proposed site is on vacant government land.

11. In terms of institutional support for effectively carrying out screening process, MOHFW will engage a qualified Safeguard Monitoring Consultant. The Consultant will carry out the screening in a two stage process – first by undertaking a desk review of PIPs wherein the Consultant will identify the facilities from different headings from the type and expenditure headers given in the Annual PIP and list them by the different types. Further screening of information will be conducted on quarterly NUHM progress reports for civil works with status indicated as "Sanctioned" (other two status categories are: In Progress; and Completed. Additionally, (i) standardization of civil works contracts including inserting of mandatory clauses requiring adherence to good construction practices and thereby enable avoidance of any temporary or permanent impacts on adjacent structures (excluding mobile vendors) and (ii) their reporting vide periodic reports to support effective screening, will be ensured. Subsequently field visits, if deemed necessary, will be undertaken to gather adequate evidence to verify, confirm and avoid facilities with potential social safeguard impacts or consider financing

12. These findings would be further validated by:

(i) monitoring complaints – received and addressed for all proposed civil works as per PIP, if any, within the existing grievance redressal mechanisms at the community level set up and that are proposed to be strengthened; and

(ii) by conducting third party/independent post procurement audits on a sample of civil works in seven states each year, as agreed to with MOHFW. The sample selected will include amongst other criteria those civil works with a potential of higher risks and prevalent capacity/compliance of the states to local laws, to be selected on the basis of a purposive sampling approach from the review of periodic reports.

I. INTRODUCTION

A. Context

13. According to the Census of 2011, the population of India was 121 crores of which 37.7 crores ((31.16%) were urbanl population. The urban poor suffer from poor health. As per the National Family Health Survey (NFHS) III (2005-06, under 5 year mortality rate (U5MR) among the urban poor was 72.7 per 1000 (?) which is significantly higher than the urban average of 51.9 per thousand (?). More than 46% of urban poor children are underweight and 60% of them miss total immunization package before reaching year 1. Poor environmental condition in slums[2]

2 A Slum has been defined as residential areas where dwellings are unfit for human habitation by reasons of dilapidation, overcrowding, faulty arrangements and design of such buildings, narrowness or faulty arrangement of

along with high population density makes them vulnerable to lung diseases such as asthma, and tuberculosis. Slums also have a high-incidence of vector-borne diseases (VBDs) and malaria.

14. Although urban poor lives not far from urban health facilities, their access to such facilities is restricted because of the inadequacy of the urban public health delivery system. Ineffective outreach and weak referral system also limit the access of urban poor to health care services. Social exclusion and lack of information and assistance at the secondary and tertiary hospitals make them ignorant about modern medical facilities and hospitals. The lack of money restricts their access to the private facilities. s. Percentage of persons below poverty line in 2011-12 was 13.7% (531.25 lakhs) in urban areas compared to 21.9% (2697.83 lakhs) in the whole country.[3]

15. Many components of the National Rural Health Mission cover urban areas as well. These include funding support for the Urban Health and Family Welfare Centres and Urban Health Posts, funding for National Health Programmes such as TB and Malaria, immunization programs; components of the Reproductive and Child Health Programme including the Janani Suraksha Yojana in urban areas, strengthening of health infrastructure at District and Block level Hospitals, and Maternity Centres under the National Rural Health Mission.. However, norms for urban area primary health infrastructure are not part of the NRHM which sets limit on the support for basic health infrastructure in urban areas. Moreover, Municipal Corporations, Municipalities, Notified Area Committees and Nagar (Town) Panchayats are out of the scope of the NRHM.

B. National Urban Health Mission (NUHM)

16. In order to effectively address the health concerns of the urban poor population, the Union Cabinet, GOI, on 1st May 2013, approved the National Urban Health Mission (NUHM) as a Sub-mission of the over-arching National Health Mission (NHM). The National Rural Health Mission (NRHM) is the other Sub-mission of National Health Mission. The objective of NUHM is to provide quality primary healthcare services to the urban population, especially the urban poor and other vulnerable sections of the society. The NUHM covers all cities/towns each of which is with a population of more than 50,000, all district headquarters and state capitals.

17. The NUHM aims to improve the health status of the urban population, particularly slum dwellers and other vulnerable persons, by facilitating equitable access to quality health care with the active involvement of Urban Local Bodies (ULBs). 17.4% of the total urban households are slum households (See **Box 1** for figures on Slums in India). The NUHM proposes to achieve its objectives by developing appropriate public health delivery mechanisms across cities/towns by creating new infrastructure, strengthening primary public health systems, entering into partnerships with the private sector, improving community capacity through community level institutions like Mahila Arogya Samiti (MAS) and link workers called Accredited Social Health Activists (ASHA), building institutional capacity of key stakeholders such as ULBs,, and by making special provision for the inclusion of most vulnerable amongst the poor. The NUHM will focus on:

(i) Urban Poor Population living in listed and unlisted slums

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street, lack of ventilation, light, or sanitation facilities or any combination of these factors which are detrimental to the safety and health.

3 Poverty Estimates For 2011-12, Press Information Bureau, Government of India

(ii) All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, and other temporary migrants.
(iii) Sanitation, clean drinking water, vector control.
(iv) Strengthening public health delivery capacity of urban local bodies.

18. The interventions under the NUHM will result in

(i) Reduction in Infant Mortality Rate (IMR)
(ii) Reduction in Maternal Mortality Ratio (MMR)
(iii) Universal access to reproductive health care
(iv) Convergence of all health related interventions.

Box 1: Slums in India

- Out of 4,041 Statutory Towns in Census 2011 Slums reported from 2,543 Towns (63%)
- Total Slum Enumeration Blocks (SEBs) in Census 2011 is about 1.08 lakh in the country
- Largest number of Slum EBs reported from Maharashtra (21,359)
- Notified[4] Slums: 37,072
- Recognised Slums : 30,846
- Identified Slums : 40,309
- Total: 1,08,227 Blocks (with 137.49 lakh households)
- Total urban households – 789 lakh
- Slum 137 lakh (17.4%)
- Non-Slum 652 lakh (82.6%)
- 38 % of the slum households are in 46 Million Plus Cities
- Top 5 States Reporting Slum Households

State	Proportion of Slum HHs to Urban HHs (%)
Andhra Pradesh	35.7
Chhattisgarh	31.9
Madhya Pradesh	28.3
Odisha	23.1
West Bengal	21.9

Source: Census of India, 2011

C. Results Based Lending Program for NUHM

[4] Notified – All notified areas in a town or city notified as 'Slum' by State, UT Administration or Local Government under any Act including a 'Slum Act; Recognized – All areas recognised as 'Slum' by State, UT Administration or Local Government, Housing and Slum Boards, which may have not been formally notified as slum under any act; Identified – A compact area of at least 300 population or about 60-70 households of poorly built congested tenements, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities

19. The GOI requested assistance from Asian Development Bank (ADB) to roll-out and scale-up the NUHM[5]. The NUHM addresses urban poor's constraints to seek health services and the health system's shortfall to meet their needs. The NUHM will (i) establish a system of urban primary health centers (UPHCs) with applicable norms and structures, that include community outreach services and referral linkages; (ii) incentivize states and ULBs to improve the poor's access to potable water, adequate sanitation, and vector control by providing untied funds for innovations and convergent actions for improved public health; and (iii) empower communities to demand health services and to address the wider environmental and social dimensions of health. It will engage them as an important link between UPHCs and the beneficiaries, and a core vehicle for effective outreach.

20. The proposed Program will support the NUHM. This is in line with the ADB's India Country Partnership Strategy 2013–2017 which promotes urban health as part of human capital development. This is also in line with the mid-term review of the Strategy 2020 which emphasizes support for inclusive growth, and an increased health sector lending from the current 2% to 3%–5%.

21. ADB through the instrument of Results Based lending (RBL) will add value to the NUHM by: (i) strengthening incentives and accountability for results by linking disbursement to results that are essential to meet the NUHM's outcome and strengthening the monitoring and evaluation (M&E) system at all levels; (ii) supporting urban health system capacity development at all levels including support for accessing knowledge, expertise, and international experience in urban health; (iii) assisting in risk mitigation and management by strengthening fiduciary oversight arrangements where it requires; and (iv) financing part of the expenditure program. In relevant states, interconnectivity with ADB-assisted urban development projects will be strengthened so that the NUHM will fully benefit from urban infrastructure investments.

D. Indicative Program Results

22. The impact of the NUHM will be the improved health of the urban population, particularly of the poor. The outcome will be an equitable and quality urban health system targeted to the poor established. Outputs and potential disbursement-linked indicators (DLI) are as follows:

(i) **Output 1: Urban primary healthcare delivery system created.** A network of about 4,500 UPHCs will be created for every 50,000 population, based on a mapping of slums and health facilities. The UPHCs will be equipped to deliver essential health service packages under defined norms of services. To improve quality of services, standard treatment protocols will be developed and applied regularly at the UPHCs. The UPHCs will be linked with community outreach services. About 39,000 accredited social health activists and 25,000 auxiliary nurse midwives will provide essential link between urban poor and the UPHC and effective community outreach services. The UPHCs will also be linked with referral hospitals services for secondary and tertiary health care. About 350 referral points will be created. The Program will further support innovative solutions such as public-private partnership to reach out special target groups. The use of information and communication technologies for disease surveillance and monitoring will also be supported. Potential DLIs may be: (a) the number of patients treated at UPHCs, which meet NUHM norms and quality standards for services, and referral linkage; (b) increase in the utilization of community

[5] The government has requested for a loan of $500 million to support NUHM on 29 November 2013.

outreach services by the poor; and (c) the number of states and cities which will be developed and applied credible models of public-private partnership or information and communication technologies solutions.

(ii) **Output 2: ULBs' capacity to manage and coordinate public health improved.** City level urban health committees will be formed to identify innovative health promotion actions to address wider determinants of health. These includes convergent actions across public health sectors, such as establishing and maintaining community toilets and promotion of sanitation practices led by community groups. Agreed innovative actions will be financed under an incentive pool funds for innovations. These actions will have strong community participation. About 155,000 community-based groups (Mahila Arogya Samiti) will organize communities to demand health services and will participate in formulating and implementing the innovative health promotional actions. Synergy with the Jawaharlal Nehru National Urban Renewal Mission, Basic Services to the Urban Poor will be sought to optimize use of the urban infrastructure build under such schemes. Furthermore, in several States, inter-connectivity with ADB-assisted urban development projects will be established. Potential DLIs may be the number of innovative public health promotion actions operational under defined norms to meet critical targets of public health. This will be evidenced by improved municipal services for public health, and reduced incidence of communicable diseases in the communities.

(iii) **Output 3: Urban health institutional capacity improved.** Capacity development in urban health system will be designed for each program output, as well as for improvement in M&E, fiduciary and safeguard systems. Actions will include: (i) strengthening existing health systems technical support agencies so that they expand their expertise to support urban health; (ii) establishing experts' pool to support states and cities capacity development plans, staff development, and international twining arrangements for schools of public health. Potential DLIs may be the number of NUHM capacity development plans approved and rolled-out at center, states, cities, and community levels.

E. Indicative Implementation Arrangements

23. The Ministry of Health and Family Welfare of GOI will be the executing agency (EA) of the Programme, while the state governments and the ULBs where capacity exists are the implementing agencies. States and ULB level program management units are established to implement the approved PIPs.

F. The Diagnostic Social Assessment

24. The Initial Poverty and Social Assessment (IPSA) identified that "the NUHM will mainly revamp and strengthen Urban Family Welfare Centres/Urban Posts into Urban Primary Health Centres as per need. It identified the need to undertake a Program Safeguards System Assessment (PSSA) and develop actions to address potential involuntary resettlement. Therefore scope of the assignment was to carry out an assessment of the social safeguard system of the NUHM and undertake a poverty and social analysis to provide inputs to the summary poverty and social analysis. The purpose and scope was also guided by the proposed product i.e. Results Based Lending Program. Among the five key features of the RBL are: (i) Supporting government sector programs; (ii) Linking disbursements directly to results;

(iii) Fostering partnerships Supporting institutional development; and (iv) Managing risks adequately. The last two necessitate a thorough understanding of the Program to:

(i) Assess the capability of the social safeguard system of the NUHM to ensure that no adverse involuntary resettlement impacts or impacts on indigenous people will occur, particularly when refurbishing the urban primary health centers. In this regard, the S-PPTA:

a. review the existing applicable and relevant laws, regulations, rules, and procedures for managing and mitigating the social impacts of the overall Program, if any, vis-à-vis principles outlined in ADB's Safeguard Policy Statement (on Involuntary Resettlement and Indigenous Peoples) to ascertain whether the existing legal and regulatory framework can manage and mitigate the adverse social impacts of the overall Program;

b. identify gaps, if any, and recommend measures to address them – whether it be in terms of training and capacity enhancement.

(ii) Undertake a poverty and social analysis to provide inputs to the summary poverty and social analysis and support the M&E specialist in developing appropriate indicators for changes in benefit incidence, out-of-pocket expenditures, access to services by gender, and poverty.

II. METHODOLOGY

25. **Stage I.** Preliminary review of secondary literature: The focus of the preliminary review was to understand the nature of proposed infrastructure interventions and gauge the type and extent of adverse social impacts that are likely to impact on the land, structures, livelihood, and community properties

26. **Stage II.** Site visits for data gathering and assessment: In consultation with MOHFW, rapid field assessments were carried out to evaluate implementation readiness at select states, namely, West Bengal, Tamil Nadu and Madhya Pradesh. These states were selected based on the following criteria: i) A state which provides urban health services through municipal administrative framework (West Bengal); ii) a state with inadequate experience in health projects and weak urban systems (Madhya Pradesh); and iii) a strong state with good track record in health project implementation (Tamil Nadu). For the purpose of social safeguard assessment, visits were undertaken to Madhya Pradesh and West Bengal States. Field visits were conducted to select sites in the cities of Bhopal and Indore (Madhya Pradesh) and Kolkata (West Bengal) where either new health facilities were being proposed and/or existing facilities were being upgraded/renovated/refurbished. The field visits provided a good understanding on adverse social impacts that are likely to arise during the proposed interventions. Assessment was done by using ADB formats – Involuntary Resettlement Impact Categorization Checklist and also using the prepared format for system and process assessment **(see Annexure 2.1).** Secondly, consultations were held with relevant officials (Health Department, District Collectors, Revenue Department) to understand the process of land acquisition or transfer of state land to the Program and measures adopted for those unauthorised settlers or illegal occupants, if any. Of particular importance was the state's preparedness in implementing Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013. Consultations were also held with persons living in the vicinity of the proposed Program sites to gain a first-hand understanding of their concerns regarding existing and proposed

facilities, and also to elicit suggestions, feedback, if any. List of facilities planned for the year, government land transfer documents were also reviewed.

27. **Stage III.** Data compilation and preparation of Draft Diagnostic Assessment Report**:** A Diagnostic Assessment Report based on data obtained from field visits, understanding gained from reviews of available documents, was prepared.. The report discusses the proposed interventions; criteria considered in site selection; potential social impacts, comparison of the country safeguard regulatory system and gaps identified in relation to ADB safeguard principles, listed SPS 2009.

III. PROPOSED INFRASTRUCTURE INTERVENTIONS UNDER THE NUHM

28. The NUHM will provide:

(i) **One Urban Primary Health Centre for each cluster of 50,000 persons:** The UPHC as nodal point is to function under government with well-defined service guarantees and provisions for human resources, infrastructure, and equipment. Indian Public Health Standards will be developed for the UPHC.

(ii) **One Urban Community Health Centre for each cluster of 2.5-300,000 persons in cities each with more than 500,000 persons**: The U-CHC will function as in-patient and first referral level for the urban population, reducing the workload of sub-district/ district or medical college hospital in the city. One U-CHC for a cluster of 250,000 persons in non-metro cities each with more than 500,000 persons and for each metro city with more than 500,000 persons.

IV. MINIMIZATION OF IMPACTS

29. The proposed renovation/refurbishment of existing UPHCs and UCHCs and construction of new UCHCs will be guided by the Indian Public Health Standards Guidelines **(See Table 4.1)**.

Table 4.1: IPHS Guidelines for facilities

Facility	IPHS Guidelines
UPHC	• should be centrally located in an easily accessible area. The area chosen should have facilities for electricity, all weather road communication, adequate water supply and telephone. At a place, where a PHC is already located, another health centre/SC should not be established to avoid the wastage of human resources. • should be away from garbage collection, cattle shed, water logging area, etc. • PHC shall have proper boundary wall and gate. • building should have a prominent board displaying the name of the Centre in the local language at the gate and on the building. PHC should have pictorial, bilingual directional and layout sign-age of all the departments and public utilities (toilets, drinking water).
UCHC	• to the extent possible, the centre should be located at the centre of the block headquarter in order to improve access to the patients. • Area chosen should have the facility for electricity, all weather road communication, adequate water supply, telephone etc. • should be away from garbage collection, cattle shed, water logging area, etc. • should not be located in low lying area to prevent flooding. • should have dedicated, intact boundary wall with a gate.

30. The NUHM has already taken actions to meet the guidelines regarding planning of infrastructure:

(i) For the UPHC, land and other such infrastructure would be given free of cost by the State Government. State land will be made available for new UPHCs/UCHCs wherever required thereby avoiding of the acquisition of private land. For constructing new UPHCs and other additional infrastructure, land will be provided by the State Government
(ii) Existing facilities would be renovated & strengthened.
(iii) Facilities constructed under various government schemes such as JNURM & ULBs would be utilized to set up new UPHCs.
(iv) New UPHCs to be started in rented buildings.
(v) Mobile units will be deployed where it is difficult to find space in slums.

31. Further, Technical Resource Group (TRG) recommends the following

(i) At least 50 per cent of all Urban Primary Health Centres (UPHCs) must be located within or near (at a maximum distance of 0.5 kilometres) settlements and habitations of urban poor persons and unorganised workers, including slums (both notified and non-notified). Only in cases where all efforts to find land within these habitations for UPHCs fail, these can be located at a maximum distance of 0.5 kilometres from the boundary of these settlements.
(ii) For the UPHCs in the remaining parts of the city, areas which are not slums and in which the majority of residents belong to the middle classes with decent housing and civic infrastructure, existing public health centres such as CGHS and ESIC dispensaries should also be incorporated and upgraded.
(iii) Attempts must be made as far as possible to redeploy, extend and refurbish existing infrastructures: new infrastructure should be created only where none exists. Facility mapping could indicate available public health institutions, including state government and ULB dispensaries and hospitals, CGHS clinics and ESIC hospitals. There should be clear central government guidelines that all these health institutions should be regarded as a common pool to progressively ensure universal primary health coverage in urban areas. Since a great number of these existing facilities would be located in non-poor areas, NUHM can invest in additional rooms, staff, equipment and drugs in these institutions to provide UPHCs in these non-poor areas at relatively low levels of initial investment.
(iv) Existing physical health infrastructure can be made use for the NUHM. Most of the above facilities as well as out-patient premises of medical colleges are usually vacant in the evenings, and therefore is the most useful time for health-seeking by urban poor populations. These spaces should be used for running poly-clinic OPDs as a first referral from UPHCs. These could also be deployed on Sundays such as for special geriatric clinics.
(v) Mapping process of slums to include access audit wherein the location of the UPHC would be considers any social barriers exclude access to vulnerable groups including disabled and aged people.

32. The IPHS guidelines, the proposed approaches under NUHM implementation framework and recommended measures by TRG, if fully accepted, would together provide a comprehensive framework for avoidance of adverse social safeguard impacts and to minimize positive impacts on private assets, livelihoods of those without titles, and also avoid the problem of unauthorized occupants within health service premises.

V. APPLICABLE LEGAL AND REGULATORY FRAMEWORK

33. Renovation and refurbishment of current facilities and the construction of new health UPHCs or UCHCs are proposed under the NUHM. In this regard, the following policies, laws and guidelines are applicable. A summary of these applicable regulatory and legal frameworks is given in **Table 5.1.**

Table 5.1: Applicable Legal and Regulatory Framework

Name of Act, Rule, Guideline	Brief Contents	Relevance to Program
National		
The Clinical Establishments Registration and Regulation Act, 2010	• Defines clinical establishments • Provides details on institutional arrangements such as National Council for Clinical Establishments • Prescribes registration processes and standards for establishment	provides for registration and regulation of the clinical establishment in the country
Indian Public Health Standards, Guidelines, Revised 2012 Directorate of Health Services, Ministry of Health and Family Welfare, Government of India	• Location of PHC: The PHC should have a building of its own. The surroundings should be clean. It should be centrally located in an easily accessible area. PHC should be away from garbage collection, cattle shed, water logging area, etc. PHC shall have proper boundary wall and gate. • Location of the CHC: To the extent possible, the centre should be located at the centre of the block headquarter in order to improve access to the patients The area chosen should have the facility for electricity, all weather road communication, adequate water supply, telephone etc. It should be well planned with the entire necessary infrastructure. CHC should be away from garbage collection, cattle shed, water logging area, etc.	Provides guidelines for location of Primary Health Centres, Community Health Centres, Sub-Centres, Sub-District Sub-Divisional Hospital and District Hospital
Bio-Medical Waste (Management and Handling) Rules, 1998.	• "Bio-medical waste" means any waste, which is generated during the diagnosis, treatment or immunisation of human beings or animals or in research activities pertaining thereto or in the production or testing of biologicals, • Rules apply to all persons who generate, collect, receive, store, transport, treat, dispose, or handle bio medical waste in any form.	All medical facilities are likely to have these wastes requiring appropriate disposal and need to be factored into the facilities proposed
The Slum Areas (Improvement and Clearance) Act, 1956	• The Act that provides for the improvement and clearance of slums in certain Union Territories and for the protection of tenants in such areas from eviction. • Provides power to competent authority to require improvement of buildings unfit for human habitation and to order demolition of buildings unfit for human habitation • Provides power to Central Government to	Any infrastructure proposed within these slums would be subject to the provisions depending if it is new construction or on rent or there is any improvement to the existing facility within the slum area;

Table 5.1: Applicable Legal and Regulatory Framework		
Name of Act, Rule, Guideline	**Brief Contents**	**Relevance to Program**
	acquire land. Where on any representation from the competent authority it appears to the Central Government that, in order to enable the authority to execute any work of improvement in relation to any building in a slum area or to re-develop any clearance area, it is necessary that land within, adjoining or surrounded by any such area should be acquired, the Central Government may acquire the land • Provides protection of tenants in slum areas from eviction	besides the provision of compensation to owner and protection of tenants in slum too make it relevant
ADB's Safeguard Policy Statement, 2009	Involuntary Resettlement: The policy objective is to avoid involuntary resettlement wherever possible; to minimize involuntary resettlement by exploring project and design alternatives; to enhance, or at least restore, the livelihoods of all displaced persons in real terms relative to pre-project levels; and to improve the standards of living of the displaced poor and other vulnerable groups. The involuntary resettlement safeguards covers physical displacement (relocation, loss of residential land, or loss of shelter) and economic displacement (loss of land, assets, access to assets, income sources, or means of livelihoods) as a result of (i) involuntary acquisition of land, or (ii) involuntary restrictions on land use or on access to legally designated parks and protected areas. It covers them whether such losses and involuntary restrictions are full or partial, permanent or temporary. Ensure that displaced persons without titles to land or any recognized Indigenous Peoples: The policy objective is to design and implement projects in a way that fosters full respect for Indigenous Peoples' identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by the Indigenous Peoples themselves so that they (i) receive culturally appropriate social and economic benefits, (ii) do not suffer adverse impacts as a result of projects, and (iii) can participate actively in projects that affect them. The Indigenous Peoples safeguards are triggered if a project directly or indirectly affects the dignity, human rights, livelihood systems, or culture of Indigenous Peoples or affects the territories or natural or cultural resources that Indigenous Peoples own, use, occupy, or claim as an ancestral domain or asset. The term Indigenous Peoples is used in a generic sense to refer to a distinct, vulnerable, social and cultural group possessing characteristics in varying degrees: (i) self-	While Land and Building for Urban Primary Health Centres and other such infrastructure would be given free of cost by the State government. In case of land acquisition the policy will be triggered. The Program fully focuses on urban areas. It will not have any impact on indigenous peoples.

Table 5.1: Applicable Legal and Regulatory Framework		
Name of Act, Rule, Guideline	**Brief Contents**	**Relevance to Program**
	identification as members of a distinct indigenous cultural group and recognition of this identity by others; (ii) collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories; (iii) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and (iv) a distinct language, often different from the official language of the country or region. In considering these characteristics, national legislation, customary law, and any international conventions to which the country is a party will be taken into account. A group that has lost collective attachment to geographically distinct habitats or ancestral territories in the project area because of forced severance remains eligible for coverage under this policy.	
Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013 (And Draft Rules 2013)	The act replaces the earlier LA Act 1894. Its provisions relating to land acquisition compensation, rehabilitation and resettlement, apply, when the appropriate Government acquires land for its own use, hold and control, including for Public Sector Undertakings and for public purpose. The Act provides for enhanced compensation and assistances measures and adopts a more consultative and participatory approach in dealing with the Project Affected Persons It defines Affected Area, Affected family and lists down measures to mitigate for these along with mechanisms for implementation, monitoring and grievance redressal.	As health facilities proposed under the NUHM will be on state lands the need for land acquisition does not arise. If the need arises, the Act of 2013 proves a sufficient legal framework to deal with them which is compatible with ADB's involuntary Resettlement Policy.
The Right to Information Act, 2005, Government of India	The Act provides for setting out the practical regime of right to information for citizens to secure access to information under the control of public authorities, in order to promote transparency and accountability in the working of every public authority, the constitution of a Central Information Commission and State Information Commissions and for matters connected therewith or incidental thereto.	
Implementation Framework of NUHM	Defines the goals, objectives, strategies and Outcomes of NUHM, besides the institutional arrangements, financial resources and planning and appraisal process	Indicates the approach to be taken i.e. of renovation /refurbishment of existing facilities and construction of new facilities.
NUHM: Guidelines for Preparation of State PIP during 2013-14	Provides structure for state PIPs, the planning process including the need to prioritize cities, broad contents, time frame for activities.	Indicates details on the proposed physical infrastructure of UPHCs and UCHCs
The Madhya	• The premises where the clinical establishment	provides guidelines for

Table 5.1: Applicable Legal and Regulatory Framework		
Name of Act, Rule, Guideline	**Brief Contents**	**Relevance to Program**
Pradesh Upcharya Griha Tatha Rujopchar Sambandhi Sthapnaye (Ragistrikaran Tatha Anugyapan) Adhiniyam, 1973.	is actually located, should be separated front any residential quarter of persons not connected with the establishment i.e. there should be no free access. • The plan for construction of new clinical establishment must follow the measurements as laid down. • A plan of construction of the premises duly approved by the: Municipal or Corporation Authority, as the case may be, shall be furnished to show that the construction is exclusively meant for a clinical establishment to run. there, and if the construction is approved for residential , purpose, it should be converted accordingly with due approval of the respective Municipal, or , Corporation Authority concerned, as the case may be	the location of the Health infrastructure
The West Bengal Clinical Establishment Rules, 2003 by Department of health and Family Welfare, Government of West Bengal,		
ADB's Public Communications Policy (PCP, 2011)	Public Communications Policy (PCP) 2011 provides the scope and type of information ADB makes publicly available. PCP 2011 commits ADB to equal information access for all, recognizing the right of people to seek, receive, and share information. ADB's public communications policy strengthens disclosure of information to affected people and other stakeholders, including women, the poor and other vulnerable groups. It provides that information be given to them in a form and language they can understand, and is disclosed early enough for them to provide meaningful inputs into project design and implementation.	Disclosure of documents prepared under this RBL would be disclosed on ADB site and other relevant sites.

VI. STATE SPECIFIC ASSESSMENTS

A. Madhya Pradesh

34. Madhya Pradesh proposes to cover 69 cities initially under the NUHM. Among these 50 are district headquarter towns and are being taken as first priority. In addition, there are 19 towns each of which with more than 50,000 persons which are also proposed to be covered. Although some Urban Family Welfare Centres (UFWC) are in the state, about 160 UPHCs are being constructed to fill in the infrastructure gap in primary healthcare in urban areas. UCHCs in Bhopal, Indore, Jabalpur, Gwalior and Ujjain, with 30-50 beds each, also constitute part of the infrastructure-building plan for the state, to cater to secondary care and establish higher order facilities for referral linkage. Before the construction of UPHCs commences, the state has to decide a strategy of utilizing the urban Anganwadi Centres under the ICDS as makeshift "health centres" to partially deliver facility-based services in health. In short strategies to implement NUHM involve:

(i) Relocation & strengthening of existing co-located Health Centers/ Posts/Civil dispensaries;
(ii) Upgrade and strengthening of identified facilities currently operational in govt. buildings as UPHCs and UCHCs;
(iii) Construction of new UPHCs where required;
(iv) Strengthening identified existing facilities (CDs/ maternity homes, etc.) & establishing new UCHCs

Box 6.1: Urban Poor in Madhya Pradesh
• Urban population of state: 2,00,59,666 (Census 2011)
• Urban Poor Population (listed slums): 4243074
• Expected Urban poor Population: 1418062
• No. of cities with Municipal Corporations: 14
• Total No. of Cities in M.P. to be covered: 69
• No. of Million Plus cities: 4

Source: State Health Department, Bhopal, Madhya Pradesh

35. As per their proposed PIP, the list of facilities proposed can be segregated into:

(i) In several additional cities (**See Annexure 6.1**) the following facilities will be provided:
   a. 32 new UPHCs are proposed and 8 UPHCs will be located in rented buildings
(ii) Existing facilities are to be relocated and strengthened as UPHCs in M.P. in District Headquarters
   a. 15 Civil dispensaries
   b. 39 UFWCs
(iii) 16 existing facilities will be renovated and strengthened as UPHCs and will continue to provide services at their present locations
   a. 10 Civil dispensaries
   b. 6 Urban Family Welfare Centres

36. In Madya Pradesh, the NUHM is being implemented by the Department of Public Health and Family Welfare, GoMP. The Civil Surgeon will be responsible for activities under the NUHM. The Chief Medical Health Officer (CMHO will be responsible for the entire Program. (?). To manage implementation level convergence issues, a City Coordination Committee (CCC) will be established in each city. The CCC is to be a component of the District Health Society. The infrastructure directorate within the department will develop the PHC infrastructure and execute civil works.

Box 6.3:Details on Slum population in Bhopal
➢ Urban Population (Census 2011): 17,98,213
➢ No. of Listed Slums: 380
➢ Population of listed slums (Census 2011): 4,49,699
➢ No. of Unlisted Slums : 108
➢ Approx Population of unlisted slums: 2,93,331
➢ No. of govt. health facilities (Primary level) : 22
➢ No. of Health Facilities run by Municipal Corp: 0

Source: Health Department, Bhopal, Madhya Pradesh

B. Bhopal

37. **Urban Primary Health Centre at Ashoka Garden.** A new UPHC is proposed at Ashoka Garden – an area that at present has no government facilities in the vicinity and is only served by private medical facilities. The area is located in a lower middle class locality with a pucca approach road. Surrounding houses are *pucca* houses. There are two newly built structures within the proposed site, of which one was planned as Community Hall for gatherings. The site at present does not have any squatters or encroachments on it. Post construction of the structures, the site would be fenced or covered with a compound wall to enable clear delineation. The facility shall cater to 6-7 adjacent slums that comprise nearly 10,000 persons. As construction too is nearly complete with external painting on-going, no potential social impacts are anticipated once operational.

Photo 6.1: UPHC Site at Ashoka Garden/Dashmesh Nagar slum

Proposed UPHC: Open area in front (L) and newly constructed Community Hall (R)

Temporary Structure outside boundary (L) and Metal railings and pucca path separates adjacent structures (R)

38. **UCHC at Kharond:** Four (4) sites – adjacent to each other within a distance 1-2 km have been identified for a UCHC at Kharond. Assessment of these sites are presented in **Table 6.1** below:

Table 6.1– Analysis of Alternatives of proposed options for CHC at Kharond

Site / Option Parameter	Option 1	Option 2	Option 3	Option 4
Ownership	Government land	Government land but disputed to land ceiling act	government land	government land

Table 6.1– Analysis of Alternatives of proposed options for CHC at Kharond				
Site / Option / Parameter	Option 1	Option 2	Option 3	Option 4
Access to Road	is less than 0.5 km from main road and has reasonable access path to site	lies adjacent to the main road/highway i.e. Ayodhya Bypass Road	lies within 1 km of highway. Slum population from another area is to relocate to this place but that could 2-3 years	lies close to the Karond circle, and Bhopal Memorial Hospital and Research Centre – facility created exclusively for rehabilitation of gas tragedy victims
Surroundings	has slum population surround but with pucca houses and connections and close to a existing medical college	has some shops adjacent. Is temporarily used for parking of trucks, etc.	is located on barren –non cultivable land. Has some apartment construction works within 250 meters	lies amidst other open empty plots.
Coverage	25 slums/ 1.5 lakh population	25 slums/1.5 lakh population	25 slums/1.5 lakh population	25 slums/1.5 lakh population
Encroachments/ Unauthorized occupants (Squatter)	None	None	None	None

39. Among these four sites, Option 1 is the most suitable for purposes of a 30-bedded UCHC, particularly as Option 2 has some legal dispute to it. **See Photo 6.2**

Photo 6.2 – Option 1 for UCHC: Fenced site (top); access path to site and slums structures near site (below)


Photo 6.3 – Site Options 2, 3 and 4


Site Option 2 near the highway; Few structures at the end of the site boundary


Site Option 3 (L) – barren lands; Site Option 4 near Ayodhya Bypass and nr. BMHRC (R)

40. **Upgradation of Suraj Nagar, Sevania Gaud, Civil Dispensary to UPHC:** The existing facility is located in a slum area in the near outskirts of Bhopal city and caters to nearly 9000 population. It is situated on land that belongs to the Health Department. It has OPD, 4-5 lab tests and vaccination facilities and on an average serves 30-40 patients per day. Most patients coming to the facility have BPL cards. Most ailments reported include skin related disorders

and road accidents/ injuries. The facility has an access road and a compound well segregating it from surrounding houses. It suffers from long power cuts, and tends to get water logged during rainy season as it located in a low lying area. The surrounding houses lacking means for waste disposal tend to dispose kitchen waste within the premises of the facility. However, interactions with facility staff revealed that the slum dwellers are cooperative.

Photo 6.4 - Upgradation of Civil Dispensary to UPHC at Suraj Nagar, Sevania Gaud

(clockwise from Top left) Main Entry Gate; Existing facility building; backyard with dumped garbage and adjacent pucca houses of slum

41. **Assessment.** The upgrade of the existing facility at Sevania Gaud within premises; opening of a PHC at the Ashok Garden within the newly constructed community structures and well segregated them from adjacent properties are unlikely to lead to any adverse social impacts. The field visit helped confirm that the proposed upgrade of the wall I will not result in any involuntary resettlement impacts or have any impact on the livelihoods. There are no encroachments or unauthorized occupation of premises. Option of the construction of CHC at one of the four encumbered free land sites too is unlikely to result in any adverse social impacts.

C. Indore

42. In Indore, the following infrastructure are proposed for the Year 2014−2015:

(i) Upgrade/renovation of 3 civil dispensaries into Urban PHC (Kamlakant Mody, Krishnapura, Vrindavan)

(ii) Upgrade/renovation of 5 Civil Dispensaries/Urban PHC into Urban CHC
   a. Baanganga
   b. Mangilal Churiya
   c. Aranya
   d. Hukumchand
   e. Rajendranagar

Box 6.3 – Details on Slum population in Indore
➢ Urban Population (Census 2011): 19,92,422
➢ No. of Listed Slums: 599
➢ Population of listed slums (Census 2011): 5,90,699
➢ No. of Unlisted Slums : 45
➢ Approx Population of unlisted slums: 2,38,300*
➢ No. of govt. health facilities (Primary level) : 13
➢ No. of Health Facilities run by Municipal Corp: 0

*Includes a lot of migrant/floating population of nearly 2 lakhs who travel for construction work.
Source: Health Department, Indore, Madhya Pradesh

43. Of these select sites, two were visited − a Civil Dispensary and a Primary Health Centre that are proposed for upgrade to 30 bedded Community Health Centres (UCHCs). Another new Community Health Centre at Banganga village within Indore District was also visited. Assessment of each site is given below:

(i) **Mangilal Churiya Dispensary at Ambedkar Nagar:** It is a facility that is being upgraded to CHC with 30 bedded facility premises. The existing facility has compound walls on all sides and any upgrade will take place within the facility. Therefore no impacts are envisaged on any surrounding areas. Also there are no squatters or encroachers within the compound. Certain social issues were brought to light such as:
   a. since houses adjoining the facility had no waste/garbage disposal, they tend to throw garbage onto the dispensary compound; Even though the height of the walls were increased, they tended to throw the garbage onto the roof.
   b. Adjoining areas were inhabited by lower middle class and therefore has some anti-social elements such as drug addicts who troubled people and got into fights but that has subsided at present

Photo 6.5: Mangilal Churiya Dispensary proposed to upgraded to UCHC


Mangilal Churiya Dispensary main gate (L), Compound walls of the facility (R)


Patients waiting inside premises (L) and Garbage thrown by surrounding houses within dispensary premises (R)

(ii) **Urban Primary Health Centre at Rajender nagar:** The existing UPHC is to be upgraded to a 30 bedded UCHC. It is a smaller facility than the dispensary at Ambedkar Nagar and is a located in middle class area, near the motorable road. Upgrade i.e. another floor will be added to the facility. It is a compounded facility with no encroachment or squatters and It serves about 3-4 slums that are in vicinity of 1-2 km. Potential impacts if any would be at the construction stage in terms of noise or air pollution.

Photo 6.6: UPHC at Rajendra Nagar and Compound Walls separating facility from adjoining houses

(iii) Site for UCHC at Baanganga: 10.34 acres of land for a new Community Health Centre (UCHC) at Banganga has already been transferred to the Health Department **(See Appendix 6.1 for copy of letter in local language)**. A notice board stating proposed site for Health centre has installed. However, the land was observed to have a few dwellings/tents. Upon discussion, it was ascertained these are temporarily occupied by seasonal migrant labor working in various construction activities in the area. Essentially the site is free of any encumbrances (**See Photo 6.7).**

Photo 6.7 – Site (10.34 acres) at Baanganga for proposed UCHC

Site for Baanganga UCHC (L); Labor Camps on site


Approach from the Main Road onto site

44. **Assessment.** Both facilities located in residential areas have compound walls segregating them from adjacent properties. The visit helped confirm that the proposed upgrade will not result in any involuntary resettlement impacts on land, structure or livelihood and also do not have any encroachments or unauthorized occupation of its premises. Minimal impacts, if at all any are likely to occur during construction stage. Land too for the new CHC is devoid of any encumbrances.

D. West Bengal

45. West Bengal is planning to roll out NUHM in at least

46. Assessments of 4 sites – 2 each proposed for renovation/refurbishment and 2 new UPHCs were carried out at Barasat municipality and Habra municipality. Details are presented below:

(i) **Health Administrative Units 1 at Nutanpukur and 2 at Mathobalodiya:** Both the Health Administrative Units 1 and 2 proposed for upgradation into UPHCs are located within Barasat municipality. The facilities are located within highly congested areas with narrow access roads They have two storeys (Ground + first floor) and are also compounded facilities. In case HAU No.1 there exists facility

for expansion at the backside of the facility as all land belongs to the municipality. The surroundings are primary residential structures besides school, etc. Besides as the municipality rules, provisions exists for vertical expansion, if necessary. Both these units serve population in excess of 50,000. Good construction practices proposed in the Environment Management Plan such as fixed work hours, delineated zone for construction, etc. shall suffice to mitigate any adverse impacts or temporary disturbances arising during construction stage. **(See Photo 6. 8 below)**

Photo 6.8 Health Administrative Units 1 (above) and 2 (below) – Main entrance and compound wall

(ii) **Kamartuba site for a new UPHC:** The site measures approximately 7200 sq.ft (668 sq.mtrs) and is located approximately 200 meters to the main Jessore road. The land also belongs to the municipality. There is a good access road leading upto the site. It is estimated to cover approximately 20000 urban slum population in Modakpara and Sattarpara areas. There is an overhead watertank, a bus terminal and market area surrounding the facility in three directions with the

fourth open. There is also an existing community hall that could be quickly shifted into for commencing operations if required. The site has no encroachments or squatters on it. **See Photo 6.9**

Photo 6.9: Kamartuba site for UPHC – open land and pucca access road

(iii) **Banipur site for a new UPHC:** It measures approximately 40 kattas (or 1.5 acres) and is located within Itna slum colony. The land belongs to the Habra Municipality. The area has an urban population of nearly 55000 has approximately 25000 slum population. There exists a sub-centre that is already operational. With good access road and requisite available space that is also clearly away from surrounding areas, there is likely to be no impact on the surroundings even during the construction stage. The existing sub-centre structure might be retained till construction of the new UPHC is complete. As there is an existing sub-centre structure, it can if required commence operations right away with some requisite modifications. In terms of management of bio-medical wastes there is a MOU between the municipality and agency named Sembranki. As it is partly compounded facility, it is occasionally used by children to play. As there is enough space for construction within the site, these facilities for children might be retained. The site has no encroachments or squatters on it. **See Photo 6.10 below**

Photo 6.10: Banipur site for UPHC: open land with existing sub-centre and pucca access road

47. Assessment: Site visits helped confirm that the upgradation of the existing HAUs and also the proposed new UPHCs are free of any encroachments and/or squatters. The existing facilities have compound walls that segregated them from adjacent properties, besides being connected with appropriate access and therefore are unlikely to lead to any social impacts. They shall not result in any involuntary impacts on land, structure or livelihood and any constructed related impacts can be well managed by adopting safe construction practices.

VII. STAKEHOLDER CONSULTATIONS

48. Interactions were held with key stakeholders – Officials of the Health department and District administration and a few community members including slum dwellers. Discussions by state and city/town are presented below:

A. Madhya Pradesh

49. In Madhya Pradesh, discussions were held with the Officials of the Health department and a few community members including slum dwellers using the health Facilities. Besides, the team interacted with District Collector, Bhopal district and with the Sub-Divisional Magistrate at Indore district to ascertain the State's readiness in implementation of the new Land Acquisition Act and thereby its implications on private land required, if any, for facilities under NUHM. Summary of interactions by City and by department is presented below:

B. Indore

50. **Health Department.** Interactions were held with officials of the Health Department.

(i) 5 UPHCs were planned last year while 5-7 UPHCs are planned for this year. The District Hospital was previously a Milk Dairy plant and therefore not as per IHS standards.
(ii) In terms of population to cater, there are 599 listed slums and 46 unlisted slums with a total slum population of 8.2 lakhs.
(iii) There are increasing constraints in getting government lands for facilities, while the other option is to rent facilities. MLA/Revenue Collector are approached by the health department for provision of land. Recently for a CHC, 10.34 acres of land has been sanctioned and transferred to Health Department at Baanganga within Indore.
(iv) The District Health Society is chaired by the Collector every month and it includes other district heads as well. Together they hear any grievances and resolve any issues.

51. **Discussions with patients.** Interactions were held with patients at Mangilal Churiya Dispensary revealed that they were living in the vicinity of the dispensary:

(i) For most of the patients it was within 0.5 to 2 km of their residence;
(ii) Cards were made with help from Anganwadi females;
(iii) Come here for vaccination of their children and also treatment of diseases like TB and get medicines; were provided free of cost medication, treatment, including even scanning and x ray facilities; and
(iv) as they have always used these facilities only they were unaware of rates charged outside for similar facilities.

52. District **Administration.** Interaction was held with SDM responsible for land cases for Indore Health Department.

(i) In terms of process involved, it was indicated that upon request from Health department, being received by the Collector office, the land is identified and inspected by the SDM office; Then as per the government procedures of transfer of land including payment as required, the same is transferred to the Health department.
(ii) At present the state of Madhya Pradesh is still formulating Draft rules for implementation of the new Land Acquisition Act and also no new cases of acquisition under the new Act have been taken up;
(iii) Municipal corporation does not have much of a role in supporting the health department

C. Bhopal

53. Health Department

(i) Coverage is happening with 50 cities in Madhya Pradesh in the first year of NUHM.

(ii) Major implementation challenge is not so much land as that can be arranged with the support of Collector's office or with interested MLA, but it is more to do with shortage of qualified medical officers. In term of availability of nursing staff, there is both a shortage at present as well one that is looming as there is a state policy of recruiting only from those graduating from within the state. List of facilities proposed are segregated into:

a. in the additional cities being taken up in this year under the mission.
b. that have been identified for relocation as they were either colocated within DH or Civil Hospital thus making them redundant.
c. that run in govt buildings and satisfies the other criteria and will be upgraded as UPHCs and will be continued in the present locations.

(iii) Decisions relating to urban health are primarily made by Health Directorate and implementation by the District Health Society e.g. it has the authority to decide locations to where necessary or feasible to establish PHCs.

(iv) Role of ULB – Municipal Corporation is limited even though they are to have City Health Officer; however they do have a role in Waste Collection as they have an MOU with the Bhopal Incinerator Limited (BIL);

(v) Lot more support is obtained from the current local MLA who provides support in identifying land and also other facilities e.g. at Ashoka Garden near Dashmesh Nagar slum. The MLA office has provided a new community hall that can be used for Health Facility. It will cater to significantly large slum population as at present the area is un-served by any government medical facility;

(vi) There is map available indicating areas that are un-served i.e. have no government health facility within proximity.

(vii) Rate of X-ray is approximately close to Rs. 300/- outside while other tests are even more costly. Consultations and medicines are a significant expenditure of residents of such areas which are not covered or in proximity to Medical facility.

54. **District Administration.** Interaction was held with Collector, Bhopal district are presented below:

(i) Considering the importance of health wherein investment can give visible returns within a few months, arranging land for new facilities is not a problem. It can be identified within the city or else permission can be given to increase the height of the existing facility i.e. constructing additional floors.

(ii) Land for facilities that cater to slums can organized either within the slum or within 0.5 to 2 km distance within slums and in an urban area 2 km is no distance;

(iii) In terms of process involved, it was indicated that upon request from Health department, being received by the Collector office, the land is identified and inspected by the SDM office; Then as per the government procedures of transfer of land including payment as required, the same is transferred to the Health department.

(iv) Municipal Corporation ought to have greater role but at present their role is insignificant; however, between Chief Medical and Health Officer with support

from Collector office can effectively implement NUHM in the city; Collector's office too will get requisite personnel for this purpose to effectively monitor the implementation.

(v) The PIP for Bhopal in its preparation process and it will undergo detailed discussion with representative of other relevant departments before submission to MOHFW;

(vi) Provision of unauthorized occupants exists on lands that belong to Revenue department but not for lands owned by other departments. At present 80% of those unauthorized occupants belong to the latter category. Street vendors too in Madhya Pradesh, particularly in Bhopal and Indore are covered by the Street Vendors legislation – Madhya Pradesh Path-Vikreta (Jeevika ka sanrakshan aur path-vikray ka vinimiyan) Kanoon or Madhya Pradesh Street Vendors (protection of livelihood and regulation of street vendors) Act wherein aspects of hygiene – a direct link to health issues is taken into consideration;

(vii) At present the state of Madhya Pradesh is formulating Draft rules for implementation of the new Act involving the Revenue department.

D. West Bengal

55. In West Bengal, discussions were held with the Additional Mission Director and Nodal Officer of the National Urban Health Mission, besides Municipality Chairman at Barasat Municipality, Project Officer (Health), State Urban Development Agency, Medical Officer at Habra Municapality to ascertain the site availability, approach to dealing with encroachments particularly as these are densely populated areas. Summary of interactions is presented below:

56. **National Urban Health Mission office.** Summary of interactions held with ADM and Nodal officer are summarized below:

(i) Rollout of NUHM is planned in nearly municapalities across the state based on the criteria of 50000 population and district headquarters, etc. as proposed under NUHM;

(ii) State Urban Development Agency will be provided with the funds under NUHM for all municipalities except for Kolkata which qualifies as one of the seven Mega cities and therefore will receive funds directly;

(iii) With regard to who will create the necessary infrastructure, hiring of medical personnel decisions are yet to be taken; however eventually it will be under the respective ULBs;

(iv) Shortage of qualified medical personnel is a constraint faced here too as in other states;

(v) Lands are made available by municipality and normally they ensure that there no encroachments

(vi) West Bengal being the most densely populated state of the country there are likely to be cases of encroachment. However at present at least in Kolkata there are no encroachments in the proposed sites. There is at least one recent instance wherein rolling out such infrastructure in urban areas was stalled because of unauthorized occupants requiring to be evicted but not provided with alternate plots for relocation.

(vii) In case of other sector projects such as a road project from Kolkata to North Bengal, widening is difficult due to such encroachments

57. **Barasat Municipality.** Summary of discussions with Municipality Chairman and Medical officer, Barasat municipality is presented below:

(i) Health Administrative units cater to all surrounding urban population; however in case of BPL, house visits are undertaken by voluntary health workers from this facility;
(ii) do not have OPDs per se but have immunization facilities; on such days average persons visiting the facility is close to 80;
(iii) Besides, provision of training, store rooms, Medical officer, these facilities have provision for trainings;
(iv) Adjacent areas being slum these facilities at Nutunpukur and Mathobaluriya cater to a significant population
(v) In case of HAU at Nutunpukur, there is enough space for expansion both vertically and horizontally as there is provision for adding one more floor if necessary and also as the land behind the structure belongs to municipality.
(vi) Charges for consultation, doctor visit plus medicines would add upto nearly Rs. 400/- whereas at the facility it is all made available free of charge.

58. **Habra Municipality.** Summary of discussions with Medical officer, Habra Municipality is presented below:

(i) Only 3 new UPHCs are proposed.
(ii) Lands for two of these sites are municipality's own land. Land for the third site at Nagartuba, is presently in the process of donation and the formalities for the same should be completed within a month
(iii) All the three UPHCs are expected to cater large urban populations of which more than 50% belong to slums; E.g. Nagartuba UPHC shall cater to 45000 population of which 25000 will be slum population, while Banipur (Itna colony) and Kamartuba facilities – each shall cater to nearly 55000 population of which 30000 will be slum population.
(iv) All these facilities are well accessible
(v) It is also proposed that a diagnostic (outside of NUHM) shall provide necessary diagnostic facilities to all these three new UPHCs at rates subsidized up to nearly 50% of the district hospital cost; and
(vi) Besides the existing sub-centres at one of the locations is doing very well and is well supported by local population.

VIII. POTENTIAL SOCIAL IMPACTS

59. Assessment of sites enabled to estimate the nature and type of impacts that are likely due to the proposed interventions under the NUHM program. The estimate has been made considering that NUHM will implemented in many sites in many states but have not been assessed as it is beyond the scope of the S-PPTA. The adverse social impacts likely are as follows:

(i) encroachments or residential/commercial squatting for reasonable period of time despite the land being in possession by health agency/department and being planned for construction of new facilities.
(ii) loss of shelter, business or livelihood. In case of renovation or upgradation of existing facilities, impacts on structures either residential or commercial vendors structure are likely to experience impact.

(iii) Besides there could be permanent or temporary loss of income because the vendor has semi-permanent structure attached to the wall of the facility and likely to experience construction stage impacts. There could be mobile kiosks experiencing temporary loss of income as well.

(iv) Further, in case of rented facilities, there could be occupants who are government staff who live and/or operate and renovation works may require them to move out.

(v) Other potential social impacts include: air and noise pollution; temporary impacts on structures, temporary disruption to access or passage, particularly in congested slums, unless mobile units are used; contaminated drinking water and water borne diseases during the construction phase as a result of inadequate disposal of debris and blockage of natural drainage systems.

60. In the case of involuntary resettlement safeguards, the PSSA found that resettlement impacts of the program are insignificant. The PSSA reconfirmed the initial categorization of resettlement impacts (category C). The program will not have any impact on indigenous peoples as the NUHM itself will cater to all slum population – that will comprise of many social groups – SC, ST and others are already mixed with mainstream and therefore do not fall under the definition of Indigenous Peoples as per the definition in ADB' Safeguard Policy, 2009. Based on this finding, the PSSA reconfirmed the initial categorization of impacts on indigenous peoples (category C). The confirmation of these initial categorizations will not, however, preclude the screening and categorization of each subproject for such safeguard impacts by using the guidelines and checklists of the program's ESMF.

IX. SAFEGUARDS SYSTEM ASSESSMENT

61. As per Constitution of India, Health is a concurrent subject with both Centre and States having legislative powers. In the case of NUHM, the MOHFW Centre is responsible to provide Policy and guidelines, and the state is responsible for their application. The MOHFW provides an overall framework for implementation of NUHM by states, including guidelines for the preparation of PIPs and also for approval of annual PIPs and sanction funds. Each state has the responsibility for providing the necessary physical infrastructure and manpower to rollout the Program which include the site identification and selection – building and land sites, and managing associated risks.

62. As evidenced from the site assessments, lands for new facilities are being provided by the State Government. In addition, village *panchayats* will also provide buildings and/or lands for new UPHCs or UCHCs in their areas of authority. Many existing facilities are being renovated within their current premises, and new ones are also being taken on rent. However, the rapid urbanization of towns and cities enhances the constraint of availing free government lands in the future. Hence the possibility of acquisition of private land or buildings structures for setting up new facilities cannot be fully ruled out. In this regard, the newly enacted Act that is effective January 1 2014 i.e. RFCTLARR Act, 2013 provides an adequate mitigation framework for such impacts.

63. The RFCTLAR&R Act, 2013 enacted by GOI and made effective since January 1, 2014, for the first time in a unified legislation, includes the provisions of rehabilitation and resettlement as integrated components in the legal process of land acquisition for public purposes. The onus of responsibility for rehabilitation and resettlement of project-affected persons has been directly shifted to the State (see Annexure 8.1 for brief provisions of the Act). The Asian Development Bank (ADB), as a development institution, implements a policy, which approaches resettlement

as a development issue, and strives to reinstate or improve the sustainable income base for the affected people. The section presents an assessment of the country system vis-a-vis the ADB's Safeguard Policy Statement, 2009 and by a comparison of principles and approaches in addressing social safeguard concerns, highlights the similarities and gaps therein that need to be addressed.

64. Following the promulgation of a new 'umbrella' or 'mother' legislation for land acquisition – RFCTLARR Act, 2013 by the Centre, all states and agencies have to amend their existing laws (policies and acts) and systems for implementation of the new Act.

65. **Congruence between the Act and ADB's Involuntary Resettlement Policy and Good Practices**. The new Act is largely in consistent with the IR policy principles of the SPS 2009. The critical synergies and provisions in common between the two are presented below:

(i) mandatory ex-ante social assessments to determine whether land acquisition serves a public purpose;
(ii) do not prescribe any threshold in terms of number of APs to formulate a plan;
(iii) requirements for ascertaining minimum land requirements, assessing the impact of land acquisition on livelihoods, shelter, public infrastructure , and community assets ;
(iv) focus on minimizing adverse impacts, assessment of cost and benefits of acquisition, compensation formulas meeting replacement cost; livelihoods support for affected persons; comprehensive resettlement and rehabilitation benefits and assistance; census of the affected families to record their socio-economic profile and potential losses, and inventory of affected public and community assets, options and choices for affected families and special provisions for disadvantaged groups; and a legal mandate that affected persons must receive compensation and assistance before their property is taken; and;
(v) Consultations and disclosure, and post-implementation audits.

66. **Key Differences:** There are a few notable differences between the Act and the ADB's IR Policy:

(i) Persons who live or depend on rights-of-way or public lands are excluded from benefits and entitlements, although their interests in such lands are recognized;
(ii) A three-year residency in the area is to be completed by persons who lose their livelihood to receive resettlement and rehabilitation benefits. The SPS takes the census or socio-economic survey date as the cut-off date for such entitlements;
(iii) Under the Act remains based on depreciation method as under previous Act.
(iv) Provision for Negotiated settlement is not included in the new Act. Negotiated settlement is one of the key provisions in SPS 2009.
(v) Institutional arrangements such as provisions for Administrator, R&R; Commissioner R&R, Rehabilitation and Resettlement Committee, and establishment of Land Acquisition, Rehabilitation and Resettlement Authority get operationalized only when there is private acquisition of land; and not otherwise when there impacts even without acquisition of land such as on those living on public/govt. lands or on rights of away; SPS covers private, common and government lands.

67. Table 8.1 provides a detailed comparison on the policy objectives, triggers and scope and principles of the ADB's policy vis-à-vis the Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013.

Table 8.1: Comparison of ADB's Safeguards Policy Statement, 2009 on Involuntary Resettlement with provisions of India's RFCTLARR, 2013			
Sl No	**ADB's Safeguard Policy Statement**	**India's RFCTLARR, 2013**	**Gaps/Similarities**
		Objectives	
1	Involuntary resettlement should be avoided wherever possible	This objective is equally emphasized under RFCTLAR&R, Act 2013 through different principles and requirements.	RFCTLAR&R, 2013 meets SPS, 2009 requirements.
2	Minimize involuntary resettlement by exploring project and design alternatives	The Act equally emphasizes the requirement for alternatives.	same as above
3	Improve, or at least restore, the livelihoods of all displaced persons	The Act through various provisions such as compensation, R&R Awards, etc. aims to achieve the objective. It spells out the objective in the preamble	same as above
4	Improve the standards of living of the displaced poor and other vulnerable groups to at least national minimum standards.	The Act through various provisions such as compensation, R&R Awards, exclusive provisions for vulnerable, etc aims to achieve the objective. It spells out the objective in its preamble	same as above
		Scope and Trigger	
5	Covers physical displacement (relocation, loss of residential land, or loss of shelter) and economic displacement (loss of land, assets, access to assets, income sources, or means of livelihoods) as a result of (i) involuntary acquisition of land, or (ii) involuntary restrictions on land use or on access to legally designated parks and protected areas. It covers them whether such losses and involuntary restrictions are full or partial, permanent or temporary.	The Act covers land acquisition compensation, rehabilitation and resettlement of project-affected persons.	The Act is not as comprehensive as ADB's IR Policy with regard to encroachments and squatters on land, although their interests are considered in compensation and rehabilitation calculations.
Principle No.	**IR Principles of ADB SPS 2009 and RFCTLARR Act, 2013**		
1	Screen the project early on to identify past, present, and future involuntary resettlement impacts and risks. Determine the scope of resettlement planning through a	When the State intends to acquire private land it undertakes a Social Impact Assessment study which includes: (a) assessment as to whether the proposed acquisition serves a public purpose; (b) estimation of affected families and the number of families among them likely to be displaced; (c) extent of lands, public and private,	RFCTLAR&R Act 2013 explicitly layouts clear cut principles, procedures and systems for conducting census, socio economic

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	survey and/or census of displaced persons, including a gender analysis, specifically related to resettlement impacts and risks.	houses, settlements and other common properties likely to be affected by the proposed acquisition; (d) whether the extent of land proposed for acquisition is the absolute bare minimum extent needed for the project (e) whether and acquisition at an alternate place has been considered and found not feasible; study of social impacts of the project, and the nature and cost of addressing them and the impact of these costs on the overall costs of the project vis-à-vis benefits of the project	surveys including gender analysis and preparation of resettlement plans (Chapter II, Sections 4,5,6,7,8).
2	• Carry out meaningful consultation with displaced persons and all other related stakeholders and ensure their participation in planning, implementation and monitoring of resettlement program. Pay particular attention to the needs of vulnerable groups, especially those below the poverty line, the landless, the elderly, women and children, and Indigenous Peoples, and those without legal title to land, and ensure their participation in consultations. • Establish a grievance redress mechanism to receive and facilitate resolution of the affected persons' concerns. • Support the social and cultural institutions of displaced persons and their host population.	• When the State Government intends to acquire land: • It ensures that public hearings are held in project affected areas, after giving adequate publicity about the dates, time and venues for the public hearings, to ascertain the views, concerns and suggestions of the affected families. • It l ensures that the Social Impact Assessment study report and the Social Impact Management Plan are made available in the local language to the Panchayat, Municipality or Municipal Corporation, as the case may be, and is published in local languages in the project-affected areas • Upon appraisal of the SIA report by the constituted Expert Group, the recommendations of the Expert Croup shall be made available in local languages of the project area to the local bodies as a the case may be and shall be published in the affected areas in local newspapers. • The decision of the State shall be made available in the local language to the local body as the case may be and shall be published newspapers in the affected areas for the benefit of project-affected persons. • The draft Rehabilitation and Resettlement scheme prepared based on SIA and consultations will be distributed widely in the affected area and will be discussed at the • concerned Gram Sabhas or Municipalities. • A public hearing shall be conducted in such manner as may be prescribed, after giving adequate publicity about the date' time and venue for the public hearing at the affected area: • provided that in case where an affected area involves more than one Gram Panchayat or Municipality, public hearings shall be conducted in every Gram Sabha and Municipality where more	RFCTLAR&R, 2013 has extensive requirements for consultations with affected persons and the disclosure of outputs at every stage. It meets SPS, 2009 requirements.

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		than twenty-five percent of and belonging to that Gram Sabha or Municipality is being acquired: • Consultation with the Gram sabha in scheduled Areas shall be in accordance with the provisions of the Provisions of the Panchayats (Extension to the Scheduled Areas) Act, 1996. • Government shall, for the purpose of providing speedy disposal of disputes relating to land acquisition, compensation, rehabilitation and resettlement establish, by notification, one or more Authorities to be known as "the Land Acquisition, Rehabilitation and Resettlement Authority" to exercise jurisdiction, powers and authority conferred on it by or under this Act. • Clear rules and process are laid out in Rules Notification prepared for implementation of the Act (Chapter 1, 2, Form III)	
3 & 4	• Improve, or at least restore, the livelihoods of all displaced persons through (i) land-based resettlement strategies when affected livelihoods are land based where possible or cash compensation at replacement value for land when the loss of land does not undermine livelihoods, (ii) prompt replacement of assets with access to assets of equal or higher value, (iii) prompt compensation at full replacement cost for assets that cannot be restored, and (iv) additional revenues and services through benefit sharing schemes where possible. • Provide physically and economically displaced persons with needed assistance, including the	• Compensation is payable at Market value and its computation varies between project location in urban or in rural areas. Depending on the distance of the project from urban area, a multiplier between 1 and 2 is applicable. • In addition to compensation a solatium of 100% on the total compensation to be paid will be added • Land for land along with land development provisions are provided • Provisions of options (a) where jobs are created through the project, after providing suitable training and skill development in the required field OR one time payment of five lakhs rupees per affected family; OR (c) annuity policies that shall pay not less than two thousand rupees per month Per family for twenty years • Each affected family which is displaced from the land acquired shall be given a monthly subsistence allowance equivalent to three thousand rupees per month for a period of one Year from the date of award (For vulnerable SC and STC). In addition to this amount, the Scheduled Castes and the Scheduled Tribes displaced from Scheduled Areas shall receive an amount equivalent to fifty thousand rupees. • Each affected family which is displaced shall get a one-time financial assistance of fifty thousand rupees as transportation cost for shifting of the family building materials, belongings and	• The Act meets this principle. • The Act provides for the market value which is more or equal to the replacement cost of the acquired property. • In case of structures the Act does not take into depreciation i.e. the valuation of assessing buildings and structures under the act remains based on depreciation method as under previous Act. • To make it operational, the Act presented detailed methods and formulas to arrive at market value. Several measures for generating additional revenues and benefit

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	following: (i) if there is relocation, secured tenure to relocation land, better housing at resettlement sites with comparable access to employment and production opportunities, integration of resettled persons economically and socially into their host communities, and extension of project benefits to host communities; (ii) transitional support and development assistance, such as land development, credit facilities, training, or employment opportunities; and (iii) civic infrastructure and community services, as required.	cattle. • Each affected family shall be given a one-time "Resettlement Allowance" of fifty thousand rupees only • The stamp duty and other fees payable for registration of the land or house allotted to the affected families shall be borne by the Requiring Body. • The land for house allotted to the affected families shall be free from all encumbrances. The land or house allotted may be in the joint names of wife and husband of the affected family. • Rehabilitation and Resettlement Award shall include all of the following, families (a) rehabilitation and resettlement amount payable to the family; (b) bank account number of the person to which the rehabilitation and resettlement award amount is to be transferred; (c) particulars of house site and house to be allotted, in case of displaced families; (d); particulars of land allotted to the displaced families; (e) particulars of one time subsistence allowance and transportation allowance; in case of displaced families; (f) particulars of payment for cattle shed and petty shops; (g) particulars of one-time amount to artisans and small traders; (i) derails of mandatory employment to be provided to the members of the affected families; (i) particulars of any fishing rights that may be involved; f) particulars of annuity and other entitlements to be provided; (*) particulars of special provisions for the Scheduled Castes and the Scheduled; • R&R amounts are also take into account the rise in the price index.	sharing provisions were included in the Act • As regards the multiplier applicable in computing compensation, as the facilities under NUHM are proposed in urban areas, 1.0 multiplier will be used, in addition *solatium* will also be paid. • The detailed R&R scheme aims to appropriately rehabilitate the affected families; also inflation is account for in the R&R scheme.
5	Improve the standards of living of the displaced poor and other vulnerable groups, including women, to at least national minimum standards. In rural areas provide them with legal and affordable access to land and resources, and in urban areas provide them with appropriate income sources and legal and affordable access to adequate housing.	In addition to the R&R package, SC/ST families will be entitled to the following additional benefits: 1. Land to be given to each family in every project even in the case of irrigation projects; 2. One time financial assistance of Rs. 50,000 per family; 3. Families settled outside the district shall be entitled to an additional 25% R&R benefits; 4. Payment of one third of the compensation amount at very outset; 5. Preference in relocation and resettlement in area in same compact block; 6. Free land for community and social gatherings; 7. In case of displacement, a Development Plan is to be prepared.	RFCTLAR&R, 2013 meets SPS, 2009 requirements.

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		8. Continuation of reservation and other Schedule V and Schedule VI area benefits from displaced area to resettlement area.	
6	Develop procedures in a transparent, consistent, and equitable manner if land acquisition is through negotiated settlement	Negotiated settlement provision has not been provided, except in case of land taken for private companies.	No provision for this under RFCTLAR&R, 2013.
7	Ensure that displaced persons without titles to land or any recognizable legal rights to land are eligible for resettlement assistance and compensation for loss of non-land assets.	The Act provides a variety of compensation packages to displaced persons without titles to land or any recognizable legal rights to land:. It defines an 'affected family' as: • whose land or other immovable property has been acquired; • who does not own any land but a member or members of such family may be agricultural labourers, tenants including any form of tenancy or holding of usufruct right, share-croppers to artisans or who may be working in the affected area for three years prior to the acquisition of the land, whose primary source of livelihood stand affected by the acquisition of land; • whose primary source of livelihood for three years prior to the acquisition of the land is dependent on forests or water bodies and includes gatherers of forest produce, hunters, fisher folk and boatrnen and such livelihood is affected due to acquisition of land; • a member of the family who has been assigned land by the State Government or the Central Government under any of its schemes and such land is under acquisition; • a family residing on any land in the urban areas for preceding three years or more prior to the acquisition of the land or whose primary source of livelihood for three years prior to the acquisition of the land is affected by the acquisition of such land	The Act provides for resettlement assistance tonon-titleholders residing on any (private) land in the urban areas during preceding three years or more prior to the acquisition of the land.,
11	Integration of resettled persons economically and socially into their host communities, and extension of project benefits to host communities		RFCTLAR&R, 2013 meets SPS, 2009 requirements, but is not explicit
8, 9 & 10	• Prepare a resettlement plan elaborating on displaced persons' entitlements, the	Refer to provisions listed above against principles 2, 3, 4 and 5. • The State Government shall ensure that the Social Impact Assessment study report and the Social Impact Management	RFCTLAR&R, 2013 meets SPS, 2009 requirements as the provisions for a

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	income and livelihood restoration strategy, institutional arrangements, monitoring and reporting framework, budget, and time-bound implementation schedule. • Disclose a draft resettlement plan, including documentation of the consultation process in a timely manner, before project appraisal, in an accessible place and a form and language(s) understandable to affected persons and other stakeholders. • Disclose the final resettlement plan and its updates to affected persons and other stakeholders. Conceive and execute involuntary resettlement as part of a development project or program. Include the full costs of resettlement in the presentation of project's costs and benefits. • Conceive and execute involuntary resettlement as part of a development project or program. Include the full costs of resettlement in the presentation of project's costs and benefits.	Plan are prepared and made available in the local language to the Panchayat, Municipality or Municipal Corporation, as the case may be and uploaded on the website of the appropriate Government. • Mitigation Plan titled "Rehabilitation and Resettlement Scheme" following the SIA survey and its approval by the Expert Group (in place of RAP preparation) consultations, consent and disclosure are strongly proposed requirements in the new Act • The Act explicitly states all costs of Resettlement and Rehabilitation is part of Development Project	preparation of Social Impact Management Plan following the SIA. This SIMP and a Rehabilitation and Resettlement Scheme together suffice to cover all impacts and mitigation measures therein.
11	• Pay compensation and provide other resettlement entitlements before physical	Land will be acquired only after meeting the following actions: • the full payment of compensation within three months from the date of award	RFCTLAR&R, 2013 meets SPS, 2009 requirements.

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Sl No	**ADB's Safeguard Policy Statement**	**India's RFCTLARR, 2013**	**Gaps/Similarities**
	or economic displacement. • Implement the resettlement plan under close supervision throughout project implementation	• Payment of rehabilitation and resettlement entitlements (within a period of six months) • The Act also ensures that infrastructural entitlements at resettlement sites are provided within 18 months after the date of award. • For close supervision of the resettlement implementation, the Stare Government shall appoint Commissioner for rehabilitation and resettlement of affected families under. • The Commissioner shall be responsible for supervising the formulation of rehabilitation and resettlement schemes or plans and proper implementation of such schemes or plans	
12	Monitor and assess resettlement outcomes, their impacts on the standards of living of displaced persons, and whether the objectives of the resettlement plan have been achieved by taking into account the baseline conditions and the results of resettlement monitoring. Disclose monitoring reports.	Three monitoring mechanism are in place (two at the project level and two – one each at the state and at the National level) • The Commissioner shall be responsible post-implementation social audit in consultation with the Gram Sabha in rural areas and municipality in urban areas. • A Committee under the chairmanship of the Collector to be called the Rehabilitation and Resettlement Committee, to monitor and review the progress of implementation of the Rehabilitation and Resettlement scheme and to carry out post-implementation social audits in consultation with municipality in urban areas. The Rehabilitation and Resettlement Committee shall include: (a) a representative of women residing in the affected area; (b) a representative each of the Scheduled -Castes and the Scheduled Tribes residing in the affected area (c) a representative of a voluntary organisation working in the area; (d) a representative of a nationalised bank; (e) the Land Acquisition Officer of the project; (f) the Chairpersons of the panchayats or municipalities located in the affected area or their nominees; (g) the Chairperson of the District Planning Committee or his nominee (h) the Member of Parliament and Member of the Legislative Assembly of the concerned area or their nominees; (i) a representative of the Requiring Body; and (j) Administrator for Rehabilitation and Resettlement as the Member-Convenor. • The Central Government may, whenever necessary for national or inter-State projects, constitute a National Monitoring	While RFCTLAR&R, 2013 matches SPS, 2009 requirements; but the disclosure of Monitoring reports is not mandated specifically.

Table 8.1: Comparison of ADB's Safeguards Policy Statement, 2009 on Involuntary Resettlement with provisions of India's RFCTLARR, 2013			
Sl No	**ADB's Safeguard Policy Statement**	**India's RFCTLARR, 2013**	**Gaps/Similarities**
		Committee for reviewing and monitoring the implementation of rehabilitation and resettlement schemes or plans • The State Government shall constitute a State Monitoring Committee for reviewing and monitoring the implementation of rehabilitation and resettlement schemes or plans	
Key Definitions and differences			
1	Project Displaced Persons (physically/economically)	The Act recognizes only THs. Also livelihood losers but those living in the affected area not less than three years after the declaration of the area as affected area.	RFCTLAR&R 2013 varies in some cases from SPS 2009.
2	Cut Off Date	Issuance of Preliminary Notification under Section 11 (1) for all affected persons – without and with Titles	Establishment of cut-off date is left to the implementation agency/borrower

68. The new Act fully incorporates or exceeds many of the ADB's SPS 2009 on Involuntary Resettlement. At present however States are in different stages of framing rules for implementation of the new act. While some states such as Gujarat, Karnataka, Orissa and Andhra Pradesh are ready with draft rules for discussion within the state legislative assembly before approving and adopting them, other states are still in the process of drafting the requisite rules. Additionally, some states such as Gujarat, Karnataka, Kerala already have or have initiated the process of institutionalizing positions such as the R&R Commissioner. It is expected that other states too shall follow suit over the next few months.

69. **Approach to Screening of Proposed Civil Works.** As the ADB's RBL will not finance civil work with potential social safeguards impacts, therefore a screening approach will be adopted to screen civil works with potential impacts on involuntary resettlement. See **Appendix 1** for the detailed note on the approach to screening of proposed civil works.

ANNEX 1

APPROACH TO SCREENING OF ANNUAL PIPS/ PROCUREMENT PLAN FOR CIVIL WORKS

A. Category of Civil Works

1. A review of the Program Implementation Plans (PIPs) for all participating states and union territories (UTs), indicates that 2,804 urban primary health centers (UPHCs) and 99 urban community health centers (UCHCs) are proposed in the year 2013-14. Further these plans indicate that many states might take new constructions in subsequent years as required. **Table 1** below provides breakup of these proposed facilities in the PIPs by type.

TYPES OF FACILITIES FOR ALL STATES AND UTs APPROVED FOR FY 2013-14 - SUMMARY		
Type	**Description of Type**	**Nos.**
UPHCs		
1	Renovation/ Upgradation of existing facility into UPHC in govt. buildings	1,555
2	Renovation/ Upgradation of existing facility into UPHC in rented buildings	257
3	Number of new UPHCs to be started in govt. buildings	5
4	Number of new UPHCs to be started in rented buildings	747
5	Number of Mobile PHCs	82
6	Building of new UPHCs	158
	Total UPHCs	**2,804**
UCHCs		
1	Renovation/ Upgradation of existing referral facility into UCHC in Govt buildings	78
2	Renovation/ Upgradation of existing referral facility into UCHC in Rented buildings	0
3	Number of new UCHCs to be started in rented buildings	0
4	Building of new UCHCs	21
	Total UCHCs	**99**

2. As evident from above table, there are broadly four types of facilities. Of these,

   (i) In case of UPHCs, Type 2 and 4 are likely to have nil adverse impacts as details of rental locations are normally checked prior to leasing them and therefore can be ensured that these locations are free from any encumbrances to begin with;
   (ii) Type 5 i.e. mobile PHCs on the contrary are an option to avoid impacts particularly in terms of any taking of any land or impacting any structure in congested urban areas/ slum locations.

3. Hence, the above categories require no screening

   (i) In case of UPHCs, Types 1, 3 and 6, involving renovation/ upgradation or starting of new facilities in government buildings or new constructions could potentially have some adverse social impacts.
   (ii) In case of UCHCs only Types 1 and 4 are likely to cause adverse impacts. Other Types 2 and 3 are likely to have nil adverse impacts as details of rental locations are normally checked prior to leasing them. As per current set of PIPs, these are presently nil but such type of facilities facilities could be taken up in subsequent years. Hence, these types are maintained for present and provided for in screening/planning approach.

4. Therefore the above two categories of refurbishment of existing facilities or new constructions require screening with respect to the potential adverse impacts.

B. Proposed Screening Approach

5. Effective screening of proposed facilities requires either robust data to be provided in the annual PIPs and quarterly NUHM progress reports, or on-site verification to enable ruling out (for funding) a particular facility or for its further consideration. Considering that requesting for such necessary information is presently outside the mandate of MOHFW, the screening approach is designed to be simple and efficient where MOHFW may still help facilitate.

6. **Stage I:** Upon receipt by MOHFW of the annual PIPs from the participating states, the Safeguards Officer – person designated for Screening and Monitoring of social and environment safeguards aspects, will screen these reports. S/he will identify the facilities from different headings from the type and expenditure headers given in the Annual PIP and list them by the different Types (as given in Table 1). For this purpose, MOHFW should revise state PIP guidelines by wherein states would provide all the information as part of their Procurement Plans. In case the given information is insufficient to carry out effective screening, additional information as required will be collected be via by phone/email. Further screening of information will be conducted on quarterly NUHM progress reports for civil works with status indicated as "Sanctioned" (other two status categories are: In Progress; and Completed.

7. Details required for effective screening by Stages are given in **Table 2.**

Table 2: Details for screening – Stage wise

Types of Proposed /Sanctioned facility	Type of information requested (Stage I)		Screening by site visit if required (Stage II)
Renovation/ Upgradation of existing facility into UPHC/UCHC in govt. buildings New UPHCs/UCHCs to be started in govt. buildings Renovation/ Upgradation of existing referral facility into UCHC in Govt. buildings	• Is the facility compounded? • Does the renovation/ upgradation involve structural changes to the ground floor (horizontal expansion beyond the existing compound wall) **OR** • addition of more floors/levels	(Yes/No) (Yes/No) (Yes/No)	If details given in Procurement Plan/over phone are insufficient to conclusively prove of no impacts, then • visit actual locations with the ADB's IR checklist, take photos • collect layouts in addition to information in Procurement plan • interact with Health department, select community members, • Get details on location of the proposed facility • Ownership: Which govt. department owns the building • Current occupants of the facility i.e. are there any occupants who are not formally related to the Health Facility? • Any vendors who are either mobile vendors or have semi-permanent structures

Types of Proposed /Sanctioned facility	Type of information requested (Stage I)		Screening by site visit if required (Stage II)
Building of new UPHCs Building of new UCHCs	• Is the site vacant government land? • Is the land compounded or fenced?	(Yes/No) (Yes/No)	If details given in Procurement Plan/over phone are insufficient to conclusively prove, then • Location of the proposed area (in the form of a sketch, or layout if available). If unclear, request for photographs • If the facility is located in a highly congested location • Ownership /transfer details of such new lands to be provided. • Are there any unauthorized occupants? What type – cultivating or having shops, residential structures or Community structures? • Assets listing as per ADB IR checklist

Note: Key assumption to this approach: As part of their routine work, the State health departments (Infrastructure directorate or wing) generally do have such necessary documentation (layouts indicating adjacent, features maps indicating locations of slums (albeit old); ownership /transfer details of such new lands and will be willing to provide if asked for. Presently MOHFW does not request as it is not in their mandate and therefore does not obtain.

8. Additionally, (i) standardization of civil works contracts including inserting of mandatory clauses requiring adherence to good construction practices and thereby enable avoidance of any temporary or permanent impacts on adjacent structures (excluding mobile vendors) and (ii) their reporting vide periodic reports to support effective screening, will be ensured.

9. **Stage II:** After collection and compilation of these details and screening, visits required for the second stage of screening should be a manageable minimum number of locations. This stage would essentially involve physical visit to the select sites, holding of interactions, to check on encroachment or squatting on government land. Among these priority locations are expected to be:

(i) the seven megacities where most likely there could be encroachments (as per current PIPs, Chennai and Kolkata have 10 such new UCHCs facilities and none of the seven megacities have any new UPHCs proposed); and
(ii) other densely populated cities depending on their slum population coverage for the proposed facility.

C. Process post screening

10. A qualified Safeguard Monitoring Consultant will be engaged by MOHFW to screen state PIPs and identify sites which may have social safeguard impact. Once both Stages i.e. Stage I comprising desk review and Stage II comprising site visits is completed as required, s/he will provide an independent monitoring report to MOHFW and ADB that comprises:

(i) issues identified on the proposed facilities by state and site, if any, and which require no more information and therefore can be taken up under ADB funding; and

(ii) recommendations to inform MOHFW and ADB team to enable reaching a decision on whether to take up the proposed facility under ADB funding or advise the state to altogether avoid the activity.

11. These findings would be further validated by:

(i) monitoring complaints – received and addressed for all proposed civil works as per PIP, if any, within the existing grievance redressal mechanisms at the community level set up and that are proposed to be strengthened;

(ii) by conducting third party/independent post procurement audits on a sample of civil works in five states each year, as agreed to with MOHFW. The sample selected will include amongst other criteria those civil works with a potential of higher risks and prevalent capacity/compliance of the states to local laws, to be selected on the basis of a purposive sampling approach from the review of periodic reports; and

(iii) Managing of all grievances relating to the health systems is the responsibility of the District Health Society (DHS) and includes aspects of infrastructure, procurement, overall administration, etc. The society is a body that comprises many Heads/key members from other departments such as Revenue, Administration, etc. and has the District Collector as the Chairperson. It shall be responsible to record and provide resolution to any grievances received from the APs. Orientation shall be provided to the members of the DHS to effectively record any grievances relating to social safeguard impacts and report them in the quarterly progress reports to enable effective screening by the Safeguards Monitoring Consultant at MOHFW, and decision making with regard to ADB financing.

D. Funding approach based on findings

12. As the RBL program will not finance civil works with potential social safeguard impacts, the approach adopted to screening civil works with potential impacts on involuntary resettlement comprises the two stage screening process as described above to avoid facilities with significant safeguard issues and/or gather adequate evidence of minimal or nil safeguard impacts.

Table 3: Likely Impacts and Approach to Mitigation by type of facility

Sanctioned Facility	Type of likely issues/impact	Approach to be followed based on screening
Construction of new facilities (UPHCs or UCHCs) on existing vacant govt. lands	• has encroachments or has residential/commercial squatters for reasonable period of time despite being in possession by health agency/department • Ownership disputes on the land that is proposed by the health department that are known at the time and are unresolved • Is likely to result in involuntary resettlement and thereby loss of shelter, business or livelihood	• If land is compounded or fenced, then take up for ADB financing
Renovation/ Upgradation of existing facility into UPHC/UCHCs in govt. buildings or to be started in govt. buildings	Impacts on Vendors/Residential structure: Likely to experience impact on structure and/or loss of income either because: • s/he has semi-permanent (use of RCC or tiled roof) in which case the structure attached the wall of the facility and is likely to experience impact arising from the renovation (during construction stage) as identified from desk based screening of layouts and other obtained documents	• If compounded and has no structural changes to ground floor and thereby has no impacts on residential or permanent structure adjacent to compound wall facility, then take for ADB financing • Temporary disruption to businesses during construction stage can be verified by site visits. Further (i) insertion of appropriate clauses in construction contracts followed by adoption of good construction practices in the civil works contracts can ensure construction operations can be undertaken with the delineated boundaries and thereby avoid temporary or permanent impacts; However If reported as unavoidable then exclude from financing; and (ii) complaints, if any, received by the GRM can be monitored for their redressal process.
	Temporary loss of income of mobile kiosks, if any	If mobile vendor/commercial squatter exists then provide one month advance notice to vacate the area. The infrastructure directorate/department of the State Health Department will post a notice outside the facility premises indicating the proposed construction work dates
Starting of new facilities in rented buildings	Impacts on occupants who are government staff and live/operate from rented facility and are required to move out	Any government staff residing in government accommodation are not entitled for any compensation for shifting • either they will be provided with an alternative government accommodation OR • as per government rule they will receive housing allowances and necessary support for shifting.

ANNEX 2.1

INVOLUNTARY RESETTLEMENT IMPACT CATEGORIZATION CHECKLIST

Probable Involuntary Resettlement Effects	Yes	No	Not Known	Remarks	Probable Involuntary Resettlement Effects
Involuntary Acquisition of Land					
1. Will there be land acquisition?					
2. Is the site for land acquisition known?					
3. Is the ownership status and current usage of land to be acquired known?					
4. Will easement be utilized within an existing Right of Way (ROW)?					
5. Will there be loss of shelter and residential land due to land acquisition?					
6. Will there be loss of agricultural and other productive assets due to land acquisition?					
7. Will there be losses of crops, trees, and fixed assets due to land acquisition?					
8. Will there be loss of businesses or enterprises due to land acquisition?					
9. Will there be loss of income sources and means of livelihoods due to land acquisition?					
Involuntary restrictions on land use or on access to legally designated parks and protected areas					
10. Will people lose access to natural resources, communal facilities and services?					
11. If land use is changed, will it have an adverse impact on social and economic activities?					
12. Will access to land and resources owned communally or by the state be restricted?					
Information on Displaced Persons:					
Any estimate of the likely number of persons that will be displaced by the project? [ ] Yes [ ] No If Yes, approximately how many					
Are any of them poor, female-heads of households, or vulnerable to poverty risks? [ ] Yes [ ] No					
Are any displaced persons from indigenous or ethnic minority groups? [ ] Yes [ ] No					

INDIGENOUS PEOPLES IMPACT CATEGORIZATION

Indigenous Peoples Impact Screening Checklist

KEY CONCERNS (Please provide elaborations on the Remarks column)	YES	NO	NOT KNOWN	Remarks
A. Indigenous Peoples Identification				
1. Are there socio-cultural groups present in or use the project area who may be considered as "tribes" (hill tribes, schedules tribes, tribal peoples), "minorities" (ethnic or national minorities), or "indigenous communities" in the project area?				
2. Are there national or local laws or policies as well as anthropological researches/studies that consider these groups present in or using the project area as belonging to "ethnic minorities", scheduled tribes, tribal peoples, national minorities, or cultural communities?				
3. Do such groups self-identify as being part of a distinct social and cultural group?				
4. Do such groups maintain collective attachments to distinct habitats or ancestral territories and/or to the natural resources in these habitats and territories?				
5. Do such groups maintain cultural, economic, social, and political institutions distinct from the dominant society and culture?				
6. Do such groups speak a distinct language or dialect?				
7. Has such groups been historically, socially and economically marginalized, disempowered, excluded, and/or discriminated against?				
8. Are such groups represented as "Indigenous Peoples" or as "ethnic minorities" or "scheduled tribes" or "tribal populations" in any formal decision-making bodies at the national or local levels?				
B. Identification of Potential Impacts				
9. Will the project directly or indirectly benefit or target Indigenous Peoples?				
10. Will the project directly or indirectly affect Indigenous Peoples' traditional socio-cultural and belief practices? (e.g. child-rearing, health, education, arts, and governance)				
11. Will the project affect the livelihood systems of Indigenous Peoples? (e.g., food production system, natural resource management, crafts and trade, employment status)				
12. Will the project be in an area (land or territory) occupied, owned, or used by Indigenous Peoples, and/or claimed as ancestral domain?				
C. Identification of Special Requirements *Will the project activities include:*				
13. Commercial development of the cultural resources and knowledge of Indigenous Peoples?				
14. Physical displacement from traditional or customary lands?				

KEY CONCERNS (Please provide elaborations on the Remarks column)	YES	NO	NOT KNOWN	Remarks
15. Commercial development of natural resources (such as minerals, hydrocarbons, forests, water, hunting or fishing grounds) within customary lands under use that would impact the livelihoods or the cultural, ceremonial, spiritual uses that define the identity and community of Indigenous Peoples?				
16. Establishing legal recognition of rights to lands and territories that are traditionally owned or customarily used, occupied or claimed by indigenous peoples ?				
17. Acquisition of lands that are traditionally owned or customarily used, occupied or claimed by indigenous peoples?				

D. Anticipated project impacts on Indigenous Peoples

Project component/ activity/ output	Anticipated positive effect	Anticipated negative effect
1.		
2.		
3.		
4.		
5.		

Safeguard Policy Principles (Involuntary Resettlement)	**Aspects to explore**
Screening for project impacts (Land take by type for new health centres and refurbishment of existing ones)	• If screening for impacts was carried out in identification of sites
	• what is the mechanism to identify the affected?
	• what is the scale of land take or disturbance to asset if any taking place under the plans formulated under NUHM
	• if land is being taken or rented, what are the criteria for selection of these sites or criteria for screening
	• what is the legal framework applicable to acquire land? Is land also acquired through negotiation settlement method?
	• If building is being taken on rent, what are the norms followed towards compensation for the owner (and also tenant, if any)
Meaningful consultations	• If affected have been consulted and adequately informed
	• If participation and involvement has been ensured at all stages of planning, implementation stages
	• If there is a functioning grievance or complaint handling system specific to issues relating to impacts
Process of compensation and provision of assistance	• how are individuals being compensated particularly if there is any land take or renting of building
	• how are these entitlements being paid i.e. what process is being followed
	• how are losses induced by the infrastructure development or refurbishment of PHCs being managed
	• any other provisions or measures that have been provided
Provisions for those without legal titles i.e. those encroaching on the government land that is likely to be refurbished resulting in impacts on them	• what provisions if any are provided to those living within the government land and are required to be evicted i.e. affected persons without formal ownership records
Disclosure a draft RAP	• if and how mitigation plans get disclosed and/or communicated back to affected community
Institutional mechanism	• what legal framework exists to manage the above particularly those without formal ownership records
Monitoring mechanism	• what is the mechanism if any exists for monitoring of the actions taken e.g. such as a higher level committee, etc.
how are grievances addressed and if there is any grievance redressal system operational	• what is the procedure if any exists for hearing any complaints or grievances within the system

Safeguard Policy Principles (Indigenous Peoples)	Aspects to explore
Screen for presence and if impacted by project	• If Tribals are presented
	• If impacted, what is likely extent of impacts
Undertake meaningful gender sensitive SIA	• if impacted, then has a SIA with full considerations of options preferred by Tribals, been carried out
	• if any other socially and culturally appropriate benefits have been identified
Undertake meaningful consultation	• If consultations have been carried out to solicit and enhance their participation in planning, implementation and monitoring; and tailoring their participation in project benefits and also grievance mechanism
Consent of Indigenous People	• If there exists broad community support for the proposed intervention
Avoid and If not possible then ensure adequate participation at all stages	• document if efforts were made to avoid or minimize impacts, analyse alternatives and what efforts were made to involve them at all stages
Disclosure a draft IPP	• if and how mitigation plans get disclosed and/or communicated back to affected community
Monitoring mechanism	• where monitoring takes and if so, what are the components of the monitoring mechanism and if it is participatory

ANNEX 6.1

MADHYA PRADESH AND WEST BENGAL

List of facilities in the additional cities being taken up in this year under the mission

S.No	District	City	Location of Facility	Type of facility CD/UFWC/Urban post/Maternity home/any other please mention
1	Gwaliour	Dabra (Pichhore)	DH	UFWC
2	Indore	Mhow		
3	Dhar	Pithampur	New PHC	
4	Hoshangabad	Itarsi	Old Itarsi	
5	Ujjain	Nagda	CH	UFWC
			New PHC	
6	Bhind	Gohad	New PHC	
7	Betul	Sarni	New PHC	
8	Vidisha	Basoda	CH	UFWC, Relocate
9	Ratlam	Jaora	CH	UFWC
10	Sagar	Bina	CH	UFWC
11	Shajapur	Shujalpur	CH	UFWC
12	Sehore	Ashta	CH	UFWC
13	Guna	Raghogarh	Rural PHC is present will be utilized. Requirement for HR support	
14	Rajgarh	Biaora	CH	UFWC
15	Narsingpur	Gadarwara	CH	UFWC/ CD
16	Barwani	Sendhwa	CH	UFWC
17	Vidisha	Sironj		
18	Sagar	Khurai		
		SUB TOTAL1		
NEW PHC CONSTRUCTION IN REMANING DISTRICT HEAD QUARTERS				
1	**Annupur**			New PHC
2	**Dindori**			New PHC
3	**Raisen**			New PHC
4	**Barwani**			New PHC
5	**Damoh**			New PHC
6	**Neemuch**			New PHC
7	**Shahdol**			New PHC
8	**Balaghat**			New PHC
9	**Harda**			New PHC
10	**Singrouli**			New PHC
11	**Agar (new district)**			New PHC
Additional PHC on rental basis in three large cities				
1	**Bhopal 1**			New PHC
2	**Bhopal 2**			New PHC
3	**Bhopal 3**			New PHC
4	**Bhopal 4**			New PHC
5	**Indore1**			New PHC
6	**Indore2**			New PHC
7	**Gwalior1**			New PHC
8	**Gwalior2**			New PHC
New PHC Construction in three large cities				
1	**Bhopal 1**			New PHC Construction

2	**Bhopal 2**		New PHC Construction
3	**Gwalior 1**		New PHC Construction
4	**Gwalior 2**		New PHC Construction
5	**Indore 1**		New PHC Construction
6	**Indore 2**		New PHC Construction
NEW PHC CONSTRUCTION IN OTHER CITIES			
1	**PITHAMPUR**		New PHC Construction
2	**SIRONJ**		New PHC Construction
3	**KHURAI**		New PHC Construction

Existing facilities to be relocated and strengthened as UPHCs in M.P. in DHQs

S.No	City	Name of the facility / Location	Type of facility CD/UFWC/Urban post/Maternity home/any other please mention
1	Ujjain	Kartik chouk	C D
	Ujjain	Jaisinghpura	C D
	Ujjain	Sanjay nagar	C D
2	Indore	DRP Line	CD
	Indore	Bhagirathpura	CD
	Indore	Holkar College	
	Indore	Dist. Hosp.	UFWTC
3	Jablpur	UFWC, VICTORIA	UFWC
	Jablpur	UFWC, EIGIN	UFWC
	Jablpur	POLIPATHER	UFWC
	Jablpur	GORAKHPUR	C D
	Jablpur	HATHITAL	UFWC
	Jablpur	PARASWADA	UFWC
	Jablpur	GARHA	UFWC
	Jablpur	KAJARWARA	UFWC
	Jablpur	WRIT H TOWN	UFWC
4	Ratlam	FP Center Ratlam	UFWC
	Ratlam	Hakimwada	UFWC
	Ratlam	Hatki Chouki	UFWC
5	Gwalior	Janakganj	
	Gwalior	Phaka Bazar	CD
6	Bhopal	Bag Sevaniya	CD
	Bhopal	1100 Quarters	UFWC
	Bhopal	Panchsheel Nagar	UFWC
7	Katni	DH Katni	UFWC
8	Sagar	City Dispensry Chameli Chowk Sagar	CD
9	Rewa	UFWC	UFWC
10	Khandwa	UFWC	UFWC
11	Morena	civil Dispensary	CD
12	Sheopur	UFWC, DH	UFWC
13	Ashoknagar	UFWC	UFWC
14	Bhind	CD	CD
15	Seoni	DH	UFWC
16	Khargone	DH Khargone	UFWC
17	Chhindwara	Chhindwara	CD
18	Sidhi	DH	UFWC
19	Mandsaur	UPH C	UPHC
20	Narsinghpur	Narsinghpur	UFWC
21	Alirajpur	Alirajpur	UFWC
22	Guna	Cant Hospital	CD
23	Jhabua	DH	UFWC
24	Shajapur	DH	UFWC
25	Shivpuri	Distt.Hospital	UFWC
26	Vidisha	Vidisha dh	UFWC
27	Panna	DH	UFWC

S.No	City	Name of the facility / Location	Type of facility CD/UFWC/Urban post/Maternity home/any other please mention
28	Rajgarh	Distt. Hospital	UFWC
29	Tikamgarh	DH, UFWC	UFWC
30	Betul	Betul, DH	UFWC
31	CHHATARPUR		UFWC
32	Datia	City diepensary	cd
33	Hoshangabad	Old Itarsi	CD
34	Anuppur	DH Anuppur	UFWC
35	Dhar	District Hospital	UFWC
36	Burhanur	DH	UFWC
37	Umaria	District Hospital	UFWC
38	Sehore	Danga Pidith Dispensary	UFWC
39	Dewas	DH	UFWC

List of 16 existing facilities will be renovated and strengthened as UPHCs

S.No	City	Name of the facility	Type of facility CD/UFWC/Urban post/Maternity home/any other please mention
	Ujjain	Bhairavgarh	C D
2	Indore	Residency	CD
3	Indore	Krishnapura	CD
4	Indore	Vrandavan Colony	CD
5	Indore	Juni Indore	CD
6	Jablpur	RANJHI	UFWC
7	Jablpur	VEHICLE	UFWC
8	Jablpur	SHANKAR SHAH NAGAR,POLIPATHAR	C D
9	Jablpur	CANTT	UFWC
10	Jablpur	MADAN MAHAL	UFWC
11	Gwalior	Civil Dispansary, Golpahariya	CD
12	Gwalior	Tathipur	UFWC
13	Gwalior	Harijan Basti Dispensary, Gedewali Sadak	CD
14	Gwalior	Harijan Basti Dispensary,, dullapur	CD
15	Bhopal	Barkheda Pathani	CD
16	Bhopal	Professior Colony	

WEST BENGAL

District-Wise No. of UPHC & CHC taken-up for renovation and New construction as per 2013-14 approval

SL.No.	Name of ULB	District	No. of UPHC	No. of UCHC
1	Kolkatta Metropolitan Corporation	Kolkatta	35	2
2	Howrah Municipality Corporation	Howrah	21	
3	Durgapur Municipality Corporation	Burdwah	11	
4	Asanol Municipality Corporation	Asanol Health District	11	
5	Chandannagar Municipality Corporation	Hooghly	3	
6	Siliguri Municipality Corporation	Siliguri MP	10	
7	Coochbehar Municipality	Coochbehar	2	
8	Jalpaiguri Municipality	Jalpaiguri	2	
9	Darjeeling Municipality	Darjeeling	2	
10	Raiganj Municipality	Uttar Dinajpur	4	
11	Balurghat Municipality	Dakshin Dinajpur	3	
12	Englishbazar Municipality	Maldah	4	
13	Berhampore Municipality	Murshidabad	4	
14	Krishnanagar Municipality	Nadia	3	
15	Burdwan Municipality	Burdwan	6	
16	Bankura Municipality	Bankura	3	
17	Bishnupur Municipality	Bishnupur Health District	1	
18	Suri Municipality	Birbhum	1	
19	Rampurhat Municipality	Rampurhat Health District	1	
20	Purulia Municipality	Purulia	2	
21	Hooghly Chinsura Municipality	Hooghly	4	
22	Dankuni Municipality		2	
23	Uluberia Municipality	Howrah	4	
24	Barasat Municipality	North 24-Pgs	6	
25	Bhatpara Municipality		8	
26	Habra Municipality		3	
27	Medinipur Municipality	Paschim Medinipur	3	
28	Jhargram Municipality	Jhargram Health District	1	
29	Tamluk Municipality	Purba Menipur	1	
30	Bashirhat Municipality	Bashirhat Health District	3	
31	Maheshtala Municipality	South 24-Pgs	9	
32	Diamond Harbour Municipality	Diamond Harbour Health District	1	
TOTAL:			**174**	**2**

LIST OF PERSONS MET

Madhya Pradesh

Bhopal
8. Mr. Nishant Warwade, Collector, Bhopal District
9. Dr. Shukhla, Chief Medical and Health Officer
10. Dr. Veena Sinha, Civil Surgeon, Jai Prakash Narayan Hospital

Indore
11. Mr. Ashok Dagaria, CHMO, Indore Health Department,
12. Ms. Monica,
13. Mr. Rajesh Kasera, SDM, Indore Collectorate

West Bengal

Health and Family Welfare Department, Government of West Bengal
14. Dr. Ajay Bhattacharya, Additional Mission Director, National Health Misssion and Joint Secretary,
15. Dr. Tapan Saha, Nodal Officer, National Urban Health Mission, Government of West Bengal
16. Dr. Shivani Goswami, Project Officer Health, State Urban Development Agency

Barasat Municipality
17. Mr. Sunil Mukherjee, Municipality Chairman

Habra Municipality
18. Dr. Manosh Das, Medical Officer

SALIENT FEATURES OF THE NEW ACT RFCTLAR&R ACT 2013

1. The National Rehabilitation & Resettlement Policy (NRRP), 2007 for Project Affected Families (PAFs) was prepared by the Department of Land Resources, Ministry of Rural Development, Government of India (GoI). The policy stipulated the minimum benefits to be ensured for persons displaced due to acquisition of land for public purposes. Based on the objectives of NRRP 2007, the Land Acquisition Act, 1984 was replaced with new Act, the Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013 (RFCTLR&R Act 2013). Subsequent to the passage of the bill by the Parliament of India and approval of the President of India, the Act was notified by the Government of India, with effect from January 01, 2014. The provisions of the Act are applicable fully to all the States except for the State of Jammu & Kashmir. The Act 2013 of India for the first time included the provisions of rehabilitation and resettlement as integrated components in the legal process of land acquisition for public purposes. The onus of responsibility for rehabilitation and resettlement of project affected people has been directly shifted to the State.

2. **Definition of Public Purpose**

(i) Land for strategic purposes relating to armed forces, national security or defence, police, safety of the people;
(ii) Land for infrastructure:(i) items listed in circular of Government of India, Department of Economic Affairs (Infrastructure Section) number 13/6/2009-INF dated the 27th March, 2012 excluding private hospitals, private educational institutions and private hotels; (ii) projects involving agro-processing, supply of inputs to agriculture, warehousing, cold storage facilities, marketing infrastructure for agriculture and allied activities such dairy, fisheries, and meat processing as set up or owned by the appropriate; (iii) project for industrial corridors or mining activities, national investment and manufacturing zones as designated in the national manufacturing Policy; (iv) project for water harvesting and water conservation structures, sanitation; (v) project for Government administered and government aided educational and research schemes or institutions; (vi) project for sports, health care, tourism, transportation, space programme; (vii) any infrastructure facility as may be notified in this regard by the Central Government and after tabling of such notification in Parliament;
(iii) Land for the project affected people;
(iv) Land for planned development or improvement of village or urban sites or for residential purpose to weaker sections;
(v) Land for persons residing in areas affected by natural calamities or displaced

3. The Urgency Clause can only be invoked in the following cases:

(i) National defence and security purposes.
(ii) Resettlement & Rehabilitation needs in the event of natural calamities such as floods or earthquakes.
(iii) In case there is double displacement of any individual they will receive an additional compensation of up to 75% of the compensation already provided for under the new law.

4. **Definition of 'Affected Families'**

(i) **Land Owners:**

a. Family or company whose land/other immovable properties have been acquired;
b. Those who are assigned land by the Governments under various schemes;
c. Right holders under the Forest Rights Act, 2006

(ii) **Livelihood Losers:**

a. Over the last three years, a family whose livelihood is primarily dependent on the land being acquired, including agriculture labourers, tenants or sharecroppers
b. Over the last three years, families which are dependent on forests or water bodies for their livelihoods when these are acquired; including forest gatherers, hunters, fisher folk and boatmen
c. Over the last three years, any family whose livelihood is dependent primarily on the land being acquired in the urban areas or any family who is residing on the land being acquired in the urban areas

5. **Safeguarding Food Security**

(i) Multi-crop irrigated land will not be acquired except as a demonstrably last resort measure, which in no case should lead to acquisition of more than such limits as have been set by the State Government under this law.
(ii) Wherever multi-crop irrigated land is acquired an equivalent area of cultivable wasteland shall be developed for agricultural purposes (or an amount equivalent to the value of the land acquired shall be deposited with the appropriate Government for investment in agriculture for enhancing food-security).
(iii) States are also required to set a limit on the area of agricultural land that can be acquired in any given district.

6. Note: 1. and 2 above shall not apply in the case of linear projects (such as railways, highways, major district roads, power lines, and irrigation canals)

7. **Minimum Compensation for Land Acquisition.** A Comprehensive Compensation Package is presented in the First Schedule.

8. **Market value of the land:**

(i) the minimum land value, if any, specified in the Indian Stamp Act, 1899 for the registration of sale deeds in the area, where the land is situated; or
(ii) the average of the sale price for similar type of land situated in the immediate areas adjoining the land being acquired, ascertained from fifty per cent of the sale deeds registered during the preceding three years, where higher price has been paid; or whichever is higher:
    a. Provided that the market value so calculated for rural areas shall be multiplied by a multiplier factor up to 2 (two).
    b. Value of the assets attached to land: Building/Trees/Wells/Crop etc. as valued by relevant govt. authority; Total compensation = 1+2
    c. Solatium: 100% of total compensation
(iii) Where land is acquired for urbanisation, 20% of the developed land will be reserved and offered to landowning project affected families, in proportion to their land acquired and at a price equal to cost of acquisition and the cost of

development. In case the project affected family wishes to avail of this offer, an equivalent amount will be deducted from the land acquisition compensation package payable to it.

(iv) The Company for whom land is being acquired may offer shares limited to 25 % of the compensation amount. In case the project affected family wishes to avail of this offer, an equivalent amount will be deducted from the land acquisition compensation package payable to it.

9. **Minimum R&R Entitlements.** A Comprehensive R&R Package is presented in the Second Schedule.

(i) Subsistence allowance at Rs. 3000 per month per family for 12 months;
(ii) The affected families shall be entitled to: (a) Where jobs are created through the project, mandatory employment for one member per affected family or (b) Rupees 5 lakh per family; or (c) Rupees 2000 per month per family as annuity for 20 years, with appropriate index for inflation; The option of availing (a) or (b) or (c) shall be that of the affected family.
(iii) If a house is lost in rural areas, a constructed house shall be provided as per the Indira Awas Yojana specifications. If a house is lost in urban areas, a constructed house shall be provided, which will be not less than 50 sq m in plinth area. In either case the equivalent cost of the house may also be provided in lieu of the house as per the preference of the project affected family;
(iv) One acre of land to each family in the command area, if land is acquired for an irrigation project if possible BUT the same shall be in lieu of Compensation;
(v) Rs 50,000 for transportation;
(vi) A one-time Resettlement Allowance of Rs 50,000.

10. **Special Provisions for SCs /STs.** In addition to the R&R package, SC/ST families will be entitled to the following additional benefits:

(i) Land to be given to each family in every project even in the case of irrigation projects;
(ii) One time financial assistance of Rs. 50,000 per family;
(iii) Families settled outside the district shall be entitled to an additional 25% R&R benefits;
(iv) Payment of one third of the compensation amount at very outset;
(v) Preference in relocation and resettlement in area in same compact block;
(vi) Free land for community and social gatherings;
(vii) In case of displacement, a Development Plan is to be prepared.
(viii) Continuation of reservation and other Schedule V and Schedule VI area benefits from displaced area to resettlement area.

11. **Enhanced Role for Panchayati Raj Institutions especially Gram Sabhas**

(i) **SIA in consultation with PRIs:** The Social Impact Assessment has to be carried out in consultation with the representatives of the Panchayati Raj Institutions.
(ii) **SIA reports to be shared:** Reports prepared under the Social Impact Assessment are to be shared with these individuals in their local language along with a summary.

(iii) **Representation in Expert Group:** The Expert Group has to have two members belonging to the Panchayati Raj Institutions. This is a powerful body that has the power to reject a project.

(iv) **Hearings in All Gram Sabhas:** In case where an affected area involves more than one Gram Panchayat or Municipality, public hearings shall be conducted in every Gram Sabha where more than twenty five per cent of land belonging to that Gram Sabha is being acquired.

(v) **Consent of Gram Sabha:** The Consent of Gram Sabha is mandatory for acquisitions in Scheduled Areas under the Fifth Schedule referred to in the Constitution.

(vi) **Representation of Panchayat Chairpersons on R&R Committee at Project Level:** The Rehabilitation and Resettlement Committee at Project Level has to have the Chairpersons of the Panchayat located in the affected area or their nominees as representatives.

(vii) **Panchayat Ghars** have to be provided as per the list of Infrastructural amenities given in the Third Schedule.

12. **Special Provisions for Farmers**

(i) **Farmers Acquisition only if necessary:** The Collector has to make sure that no other unutilised lands are available before he moves to acquire farm land.

(ii) **Enhanced Compensation:** All farmers in rural areas will get up to 4 times the highest sales prices in a given area.

(iii) **Strict Restrictions on Multi-Crop Acquisition:** The acquisition of agricultural land and multi-crop land has to be carried out as a last resort.

(iv) **Consent:** shall be prior-consent required from 70 per cent of land losers and those working on government assigned lands only in the case of Public-Private Partnership projects and 80 per cent in the case of private companies. This consent also includes consent to the amount of compensation that shall be paid.

(v) **Return of Unutilised land:** Land not used can now be returned to the original owners if the State so decides.

(vi) **Share in Sale of Acquired Land Increased:** The share that has to be distributed amongst farmers in the increased land value (when the acquired land is sold off to another party) has been set at 40%.

(vii) **Income Tax Exemption:** All amounts accruing under this act have been exempted from Income tax and from Stamp duty.

(viii) **Damage to crops to be included in price:** The final award has to include damage to any standing crops which might have been harmed due to the process of acquisition (including the preliminary inspection).

(ix) **Share in Developed Land:** In case their land is acquired for urbanisation purposes twenty per cent of the developed land will be reserved and offered to these farmers in proportion to the area of their land acquired and at a price equal to the cost of acquisition and the cost of development.

(x) **Fishing Rights:** In the case of irrigation or hydropower projects, affected families may be allowed fishing rights in the reservoirs, in such manner as may be prescribed by the appropriate Government.

13. **Public Disclosure Policy.** All documents mandatorily to be made available in the public domain and on the website.

14. Only R&R provisions will apply when private companies purchase land for a project, and the same exceeds the area thresholds set by the State Governments for such purchase.