Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 18-Nov-2022 | Report No: PIDC34529

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
India	P179337		Assam Secondary Healthcare System Reform Project (P179337)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	Jan 20, 2023	Apr 27, 2023	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Department of Economic Affair	Department of Health and Family Welfare	

Proposed Development Objective(s)

To strengthen management capacity, utilization, and quality of the secondary healthcare system in Assam

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	313.83
Total Financing	313.83
of which IBRD/IDA	251.03
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	251.03

Non-World Bank Group Financing

Counterpart Funding	62.80
Borrower/Recipient	62.80

Environmental and Social Risk Classification	Concept Review Decision
Substantial	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **India's economy will slow down, coming off a strong recovery in FY21/22 (April 2021-March 2022).** The spillovers from the Russia-Ukraine war and the global monetary policy tightening cycle are expected to weigh on India's economic outlook: elevated inflation on the back of higher prices of key commodities, heightened global uncertainty, and rising borrowing costs will affect domestic demand, while slowing global growth will dampen India's export growth. The growth in FY22/23 is expected to slow to 6.5 percent from 8.7 percent in FY21/22.[1] Domestic demand is expected to remain on a moderate recovery path, despite external headwinds. The government's strong capex program will support investment, while private consumption will benefit from consumer spending in high- and middle-income groups. Net exports will continue to drag on growth. The rising merchandise trade deficit will push the current account deficit to 3.2 percent of GDP in FY22/23. Due to recovering demand and elevated food and oil prices, headline inflation is expected to stay above the Reserve Bank of India's (RBI) tolerance range but should gradually ease to 5 percent next year.[1] The government's gradual fiscal consolidation efforts will be bolstered by strong revenue performance. Goods and Services Tax (GST) collections continue to be strong, having crossed the INR 1 trillion mark every month since July 2021, reaching as high as INR 1.67 trillion in April 2022.

2. **Although India has made remarkable progress in reducing extreme poverty over the past two decades, the COVID-19 pandemic has slowed progress, and poses risks to welfare.** Prior to the pandemic, the share of the population living below US$2.15 per person per day (2017 PPP) is estimated to have fallen from 22.5 in 2011 to 10 percent 2019.[2] This was accompanied by a sharp decline in multidimensional poverty, from 27.7 percent in 2005/06 to 16.4 percent in 2019/21.[3] However, the pace of poverty reduction has slowed in recent years, with key welfare indicators being slow to improve.[4] More than 40 percent of India's population lived below the lower-middle income poverty line even before the pandemic.[5] Inequality in consumption has remained stable, with a Gini index of around 35 over the past two decades. Child malnutrition has remained high, with 35.5 percent of children under the age of 5 being stunted and 67 percent of children aged 6-59 months being anemic in 2019-21.[6] Despite a substantial social protection response from the Government of India (GoI), the COVID-19 pandemic has likely reversed recent welfare gains, exposed vulnerabilities in the

[1]World Bank real GDP forecasts for FY22/23 published in Macro Poverty Outlook, October 2022
[2]World Bank Poverty and Inequality Platform. https://pip.worldbank.org/country-profiles/IND. In 2004, India's extreme poverty rate was 39.9 percent using the same international poverty line.
[3]UNDP (United Nations Development Programme), OPHI (Oxford Poverty and Human Development Initiative). 2022. 2022 Global Multidimensional Poverty Index (MPI): Unpacking deprivation bundles to reduce multidimensional poverty. New York.
[4]World Bank Poverty and Inequality Platform. https://pip.worldbank.org/country-profiles/IND.
[5]US$3.65 per capita per day (2017 PPP). World Bank Poverty and Inequality Platform. https://pip.worldbank.org/country-profiles/IND.
[6]Government of India, Ministry of Health and Family Welfare, 2022. National Family Health Survey (NFHS - 5), 2019–21 report.

labor market, and posed new risks to welfare. Urban unemployment has increased, with an increasing share of self-employed and casual wage workers, suggesting an incomplete and uneven recovery from the pandemic.[7]

3. **Assam is the largest economy in northeast (NE) India, a commercial hub for the region and is the India's gateway to Southeast Asia. However, the state lags most large Indian states in the size of its economy and poverty reduction.** In FY19/20, Assam's real per-capita income was INR 60,660 (~ US$800), 35 percent below per-capita national income. The state's economy contracted by 0.4 percent in FY20/21 but it is estimated to have rebounded with over 9 percent growth in FY21/22.[8] Although Assam had rapidly reduced poverty between 1994 and 2005, the rate of decline has since slowed down and stagnated at high levels. Thirty two percent of the population is poor in Assam compared to 22 percent nationally.[9] Thirty three percent of its population is also multidimensionally poor, and there are geographic inequities—51 percent of population in Hailakandi district is multidimensionally poor as compared to 11 percent in Kamrup metro.[10] With a total population of 35 million among which 86 percent live in rural areas,[11] the state is the fourteenth most populous state and is highly rural.

Sectoral and Institutional Context

Health Outcomes and Utilization of health services

4. **Despite substantive improvements in some reproductive, maternal, neonatal and child health (RMNCH) outcomes and utilization of health services in the last decade, Assam still lags most Indian states in health outcomes and faces geographic inequities.** Assam has reduced its infant mortality and under-five mortality by a third,[12] and its maternal mortality ratio (MMR) by half from 390 to 205 in the last decade.[13] However, the state's health outcomes are still worse compared to national averages. MMR in particular stands out—the state's MMR is twice as high as the national estimate. Utilization of health services has improved and is mostly at par with the national levels: 87 percent of women give birth in a facility now compared to 24 percent in 2005, and antenatal care has improved from 66 to 85 percent.[14] However, there is variation across the state with 97 percent of women in Jorhat district gave birth in a facility compared to 64 percent in Dhubri district. Additionally, immunization rate is lower than the national average, and also varies geographically.

5. **In addition to the unfinished RMNCH agenda, the state also needs to address an emerging double burden of disease.** Like in most Indian states, the burden of non-communicable diseases (NCDs) is growing in Assam—56 percent of poor health is due to NCDs.[15] NCD burden in the state is slightly lower than the national average, with 12 percent women and 15 percent men in the state hypertensive, and 9 percent women and 15 percent men diabetic.[16]

6. **Climate change could further worsen health outcomes in Assam.** Ranked as one of India's most vulnerable states to climate and disaster impacts[17], Assam has high risks of extreme weather events such as flash floods, droughts, cyclones, and landslides, leading to loss of livelihoods, assets, and infrastructure. The state's weak health system leaves its

[7] World Bank Macro Poverty Outlook. October 2022. Estimates from PLFS data.
[8] Directorate of Economics and Statistics, Government of Assam.
[9] Reserve Bank of India (2020). Handbook of Statistics on Indian Economy, Table 154. https://www.rbi.org.in/scripts/PublicationsView.aspx?id=19887
[10] https://www.niti.gov.in/sites/default/files/2021-11/National_MPI_India-11242021.pdf
[11] State estimates for 2021 from Population projection for Indian states (2011-2036). Registrar general and census commission of India.
[12] National family health survey (NFHS) 2015-2016, and 2005-2006, http://rchiips.org/nfhs/
[13] Special Bulletins on MMR by Registrar General of India 2007-2009, 2017-2019
[14] NFHS 2019-2021, and 2005-2006, http://rchiips.org/nfhs/
[15] Health Dossier 2021, Assam. https://nhsrcindia.org/sites/default/files/practice_image/HealthDossier2021/Assam.pdf
[16] National family health survey 2019-21, http://rchiips.org/nfhs/
[17] https://www.ceew.in/publications/mapping-climate-change-vulnerability-index-of-india-a-district-level-assessment

population poorly prepared to respond to the impacts of climate change.[18] Additionally, poor health in turn further undermines the population's resilience to climatic shocks and their ability to adapt.

Health Systems Context: Financing and Financial Risk Protection

7. **Through concerted efforts to improve its budget allocation to health, Assam now (i) spends more public resources on health as a share of its budget compared to national average, and (ii) has lower out-of-pocket expenditure (OOPE) compared to most states. However, per capita government health spending still is lower than the national levels.** Assam spent 7.1 percent of its government expenditure on health in 2018/19 (national: 4.8 percent) compared to 4.9 percent in 2013/14 and is now close to the 8 percent target set in the 2017 National Health Policy (NHP). Additionally, OOPE is lower in the state than in India: one third of total health expenditure in Assam is from OOPE (INR 949) compared to half in India (INR 2,155 per capita). However, in absolute terms, the state spends less than national average on health (INR 1,426 compared to INR 1,815 per capita).[19]

8. **Financial risk protection in Assam is pro-poor and higher than national average.** Sixty seven percent of the households in the state have health insurance/financing scheme that covers at least one member as compared to the national average of 41 percent. In addition to the national PM-JAY and RSBY schemes,[20] the Assam government is implementing Atal Amrit Abhiyaan (AAA), a cashless scheme available to below poverty line (BPL) and low-income households to reduce OOPE and catastrophic health expenditures. As a result, the elderly, rural population, and those with lower levels of schooling are more likely to have insurance coverage in the state. Financial risk protection in Assam is also better than the national levels with 6 percent of the households bearing catastrophic healthcare spending against the national average of 15 percent.[21]

Health Systems Context: Service Delivery

9. **Although Assam has been steadily improving its health systems performance, the state of its secondary health system in particular leaves much to be desired.** Despite recent increase in its rank in Niti Aayog Health Index by three positions, the state still ranks 12 out of the 19 large states.[22] State performance deteriorated in areas of (i) shortage of specialists at district hospitals (DHs) and nurses in primary and community health centers, (ii) implementation of human resource management information system (HRMIS), (iii) lack of functional First Referral Units,[23] and (iv) lack of a functional cardiac care unit in any of the DHs in the state.

10. **Investment in secondary care and well-functioning referral system is critical to the state for (i) reducing its MMR and addressing its unfinished RMNCH agenda, and (ii) addressing growing burden of NCDs.** Thirty percent of all deliveries in rural Assam were in public hospitals and 40 percent in urban areas.[24] Despite high rates of institutional deliveries overall and in public hospitals in the state, MMR is high, indicating that (i) access to high quality obstetric care specially at secondary level needs to improve, and (ii) appropriate referral linkages are needed in addition to high quality primary care provision. Indeed, less than a third of the maternity wards and labor rooms in DHs in the state are LaQshya certified.[25] Second, while the state is making inroads in addressing the rising burden of NCDs at the primary level, it lacks the capacity for NCD management at the secondary level. At the primary level, comprehensive primary health care (CPHC) including NCD care is being provided in 34 percent of sub-centers (SCs) and 68 percent of primary health centers (PHCs)[26] and the government intends to cover all PHCs by 2022 and 92 percent of SCs by 2024. However, at the secondary level, adequate,

[18] https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health
[19] National Health Accounts 2018-19
[20] Pradhan Mantri Jan Arogya Yojana (PM JAY) and Rastriya Swasthya Bima Yojana (RSBY)
[21] At 10 percent level threshold
[22] https://www.niti.gov.in/sites/default/files/2021-12/NITI-WB_Health_Index_*Report*_24-12-21.pdf
[23] Facilities that provide 24-hours specialist care in medicine, obstetrics and gynecology, surgery, and pediatrics
[24] Government of India. NSS 75th Round-Key Indicators of Social Consumption in India: Health. New Delhi; 2019 (75th round of NSS)
[25] National certification program on obstetric and maternity care quality
[26] https://pib.gov.in/Pressreleaseshare.aspx?PRID=1783807

accessible, and appropriate specialist care for NCDs like cardiology, nephrology, neurology, cardiovascular surgery, neurosurgery, and urology are available only at few tertiary care hospitals.

11. **Ensuring access to high-quality and affordable hospital services is a prerequisite for patient survival, long-term health, and protection against catastrophic health spending. A well-functioning two-way referral system also needs to be prioritized to ensure care continuum for long-term care, retain trust in public health facilities and sustain utilization.**[27,28] Hospitals until very recently have been a neglected area of intervention in most emerging economies,[29] and Assam is no exception. With decades of investments in primary care, the low hanging challenges in infectious diseases and RMNCH issues are being incrementally addressed. While additional primary care improvements are needed, health systems reform needs to further prioritize secondary care to make substantial gains in addressing the second order challenges in infectious diseases and RMNCH and tackle the emerging NCD burden holistically. Harmonized linkage with secondary level care with focus on care continuum is also needed to ensure the effectiveness and success of the ongoing primary care investments.[30]

12. **Public hospitals are a large source of healthcare and in particular inpatient care for rural population in the state. However, the quality of care in these hospitals is poor, which impacts patient safety, demand, and utilization.** Twenty eight percent of households in the state rely on public hospitals for overall care compared to 20 percent in private sector. Public sector inpatient care-seeking is also high: 46 percent of rural and 35 percent of urban population use public hospitals for inpatient services in the state.[31] Therefore, poor quality public hospitals not only compromise patient safety but also dampen demand. Only 10 of the 14 essential health services and 9 of 14 prescribed diagnostic services are available in DHs in Assam.[32] Only 2 of the 25 existing DHs are National Quality Assurance Standards (NQAS) certified and only one offers all 14 essential services. Similarly, essential drug availability is inadequate: half of the essential drugs are not available in DHs and 44 percent of the patients noted not being able to procure their full prescription when seeking care in DHs.[33] As a result, hospitalization rates in Assam are half the national average.[34] The state has the lowest inpatient care uptake if childbirth is excluded, indicating both foregone care and supply-side issues. The reasons mentioned by beneficiaries for not accessing public hospital care in the state include (i) lack of trust, (ii) low quality, and (iii) service unavailability including drugs.[35]

13. **Lack of DHs, non-availability of beds, and poor capacity of these hospitals and state and district health management are other major causes of poor performance of the state's secondary health system.** Ten districts in the state have no DHs. DH level bed availability is also lower in the state compared to national average: DHs in Assam have 18 beds/100,000 population compared to the national average of 24 beds.[36] Additionally, human resources for health (HRH) at the existing DHs is severely constrained, with only 12 percent of the DHs meeting the requirement for doctors, zero percent for nurses and 52 percent for paramedical staff as per the Indian Public Health Standards (IPHS). In addition to micro-level interventions to address poor quality and access, meso- and macro-level interventions are also needed to comprehensively improve care provision. Managerial capacity gaps, and lack of autonomy and accountability of DH management impede secondary care effectiveness and efficiency. Furthermore, state and district level governance issues

[27] Ayushman Bharat Health and Wellness Center, 2021; Available at - https://static.pib.gov.in/WriteReadData/specificdocs/documents/2021/sep/doc202192010.pdf
[28] Brar et al 2022 doi: 10.4103/jfmpc.jfmpc_2560_20
[29] Lewis. 2015. "Better Hospitals, Better Health Systems: The Urgency of a Hospital Agenda." CGD Policy Paper 053. Washington DC: Center for Global Development
[30] Lahariya et al. 2020. doi: 10.4103/jfmpc.jfmpc_1240_19.
[31] 75th round of NSS. If we exclude childbirth, 77 percent of rural population and 48 percent of urban population in the state use public hospitals for inpatient care.
[32] Niti Aayog (2021). Best practices in the performance of District Hospitals in India.
[33] Comptroller and Auditor General of India. 2021 Report No. 3 of 2021 – Performance audit of select district hospitals, Government of Assam.
[34] Also because patients cannot easily reroute to private hospitals: Private sector presence is much lower in Assam compared to other states.
[35] Government of India. NSS 75th Round-Key Indicators of Social Consumption in India: Health. New Delhi; 2019
[36] Niti Aayog (2021). Best practices in the performance of District Hospitals in India. Note that bed occupancy rate could also improve, indicating poor quality and demand side issues: Average bed occupancy rate in Assam is 61, which is slightly higher than India average of 67 and lower than the ideal bed occupancy rate of 90.

such as fragmentation in procurement, maldistribution and poor management of HRH and institutional fragmentation further worsen service provision. For example, drug stockouts in hospitals are largely due to fragmented procurement systems at the state level and sub-par performance of State Medical Services Corporations (SMSC). Severe HRH gaps and skewed urban-rural HRH distribution are due to poor task rationalization, deployment, and regressive HRH policies.

14. **The dire shortage of nurses in DHs is an antithesis to the state being the hub for pre-service education for nursing in the NE.** Assam has 176 public and private nursing institutes offering Auxiliary Nurse Midwife (ANM), General Nursing and Midwifery (GNM), Bachelor of Science (B.Sc.), Master of Science (M.Sc.) and other courses. Challenges in nursing education include poor infrastructure, shortage of nurse tutors/faculty, and outdated curriculum. The demand for nursing courses at these sub-par institutes is low, exacerbating the supply of qualified nursing professionals in the state. Quality assurance of nursing institutes is limited and fragmentation of the nursing cadre across the various health directorates has weakened nursing leadership for larger reforms. In addition to regressive HRH policies, sanctioned nursing positions not commensurate with IPHS standards and unfilled vacancies have exacerbated shortage of well-trained nurses in DHs. Similar challenges are observed with dental education infrastructure and capacity at the secondary care level, especially to manage referrals from the primary level for appropriate oral healthcare.

15. **Given the limited fiscal space in the state, catalytic investments at the secondary healthcare level can unlock substantial additional federal financing for Assam's health sector.** The Government of Assam (GoA) already spends close to the NHP 2017 target on health. Focused investments in secondary care quality, access and governance in Assam will trigger additional (i) US$30,000 per DH per year for three years on account of full NQAS certification, (ii) financing from Prime Minister – Ayushman Bharat Infrastructure Mission (PM-ABHIM) and the XV Finance Commission (XV FC) for medical equipment, and (iii) PM-JAY insurance financing for inpatient care from the federal level. Improvements in Niti Aayog health ranking could unlock an additional 5 percent allocation of federal funds for health for the state.

16. **With ongoing focus on primary and recent investments in tertiary care, GoA and the Department of Economic Affairs (DEA) intend to prioritize financing and addressing of implementation gaps at the secondary level for a comprehensive health system reform.** The overall national and state focus on CPHC is financed by the National Health Mission (NHM), PM-ABHIM and XV FC. Together with partner support, GoA is currently investing in tertiary hospitals. With primary and tertiary care largely financed by NHM, partners, and state, and limited financing from these sources for secondary health care, there is an urgent need to invest in secondary healthcare system to safeguard access and continuum of care. Therefore, GoA has created the fiscal space to prioritize IDA borrowing and technical assistance for strengthening the secondary healthcare system in the state, complementing continued improvements in primary and tertiary care.

Relationship to CPF

17. **The proposed project is consistent with the World Bank Group Country Partnership Framework (CPF) FY18–FY22; report No. 126667-IN, July 25, 2018, discussed at the Board in September 2018.** It contributes to Focus Area 3: Investing in Human Capital and is directly linked to the CPF's key objective 3.4, which is 'to improve the quality of health service delivery and financing and access to quality healthcare'. It proposes to adopt two of the four catalytic approaches outlined in the CPF: (i) engaging a federal India, with the focus of "states at the center" to deliver more effectively and efficiently, and (ii) strengthening public health institutions, to deliver quality health services leveraging innovative approaches, including the private sector. The project has a potential to contribute to Lighthouse India showcasing how improved management capacity of DHs can effectively maximize health financing schemes.

C. Proposed Development Objective(s)

To strengthen management capacity, utilization, and quality of the secondary healthcare system in Assam

Key Results

a) Increase in average performance score of district hospitals (percentage) (*management capacity*)
b) Increase in number of admissions of ANM/GNM/B.Sc. nursing students in the government run nursing schools and colleges (percentage) (utilization and management capacity)
c) Increase in service utilization (IPD and OPD) in targeted district hospitals (number) (*utilization*)
d) Increase in district hospitals with quality certification (number) (*quality*)
e) Decrease in stockout of essential medicines in targeted district hospitals (percentage) (*quality*)

D. Concept Description

18. **Based on global evidence, the Assam Secondary Healthcare System Reform Project combines results- and input-based financing approaches to improve management capacity, utilization, and quality of the public health sector.** It uses a complementary systems approach at multiple levels (state, district, and facility/community) to (i) address meso- and macro-level secondary care issues—improving governance, coordination, and policy level challenges, and (ii) improve portfolio of services and quality of care at the district facility level along with strengthened referral linkages to both primary and tertiary care. The proposed three components are as follows.

19. ***Component 1: Improved governance and management capacity of health systems at state, district, and facility level.*** The first component takes a results-based financing approach (Internal Performance Agreements—IPAs[37]) aligning incentives of state, district, and facility level institutions to improve provision of 14 essential health services. This component will trigger institutional and process reforms for improved HRH, planning, health infrastructure and procurement, and create an enabling environment for DHs to incrementally graduate to full quality accreditation. By supporting and incentivizing improvements in health governance, management, and planning by select Directorates servicing the health sector, it will also contribute to improving access and quality. The component is based on global evidence that results-based approach as compared to only input-based financing significantly improves outcomes at secondary care level in low- and middle-income countries, for e. g. in Argentina and Kyrgyzstan.[38]

20. ***Component 2: Improved process quality and utilization of secondary healthcare system.*** The second component using input-based financing will provide technical assistance for process quality improvements in DHs, pre-service education reforms and development of HRH strategy and management framework for the health workforce leading to improved quality. Additionally, this component will support innovations to improve health systems efficiency, and address demand side issues to improve health seeking behavior in the state, thereby improving service utilization.

21. ***Component 3: Improved structural quality and access to secondary care.*** The third component will support infrastructure development by upgradation of existing Community Health Centres (CHCs)/Sub-Divisional Hospitals (SDHs) to district hospitals (DHs) to improve access to secondary care in compliance with national standards in upto 10 locations and improve structural quality by investing in functionality of existing health infrastructure such as 25 DHs, 5 nursing

[37] Internal Performance Agreements are the inter-departmental non-legal agreements which provides grant financing against meeting key performance indicators. Beneficiaries of these agreements include directorates within the health department, district health societies and district hospitals.
[38] deWalque, et al 2022. doi:10.1596/978-1-4648-1825-7

schools/ collages, Dental collage and common treatment facility for improved bio medical waste management in two locations.

22. ***Component 4: Contingency Emergency Response Component (CERC).*** This component provides a mechanism for provision of immediate response to an Eligible Crisis or Emergency, as needed.

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

Summary of Screening of Environmental and Social Risks and Impacts

23. The key environmental health and safety risks are attributed to the major civil works under Component 3: upgradation and rehabilitation of DHs, central biomedical waste treatment facilities (CBMWTFs), and nursing colleges, bio medical waste management and disposal, infection control and worker health safety in the existing health facilities that do not envisage land acquisition and resettlement. Reasons for the current social risk rating is moderate owing to (i) temporary disruption/delay of health services due to change in location of existing medical facilities (to nearby areas) during upgradation and renovation of DHs, (ii) temporary relocation of staff accommodation, (iii) impact on workers' and communities' health and safety during construction related activities, (iv) insufficient systems to address employment related issues such as Sexual Exploitation and Abuse/ Sexual Harassment (SEA/SH), gender pay gap and discrimination at the workplace in the health sector, (v) inadequate systems to include vulnerable populations (women/SC/ST/BPL) from receiving project benefits, and (vi) weak grievance redressal mechanisms. Current capacity assessment reveals that there is no clearly defined institutional setup to supervise and manage the environmental and social activities under the project. The risk rating will be reassessed during appraisal and revised, if required.

24. To mitigate E&S risks and impacts, an Environmental and Social Management Framework (ESMF), Stakeholder Engagement Plan (SEP), Labor Management Procedure (LMP) will be prepared and disclosed prior to appraisal. ESIA and ESMP for DHs/ CBMWTFs for which technical design/details and location are available prior to project appraisal will also be prepared, consulted, and disclosed prior to appraisal.

25. **Climate co-benefits**: The project will contribute to building climate and disaster resilience by mainstreaming climate change considerations in project design. Under components 1 and 2, the project will strengthen the provision of high-quality healthcare across the state, particularly in areas that are highly vulnerable to climate impacts on health. It will further strengthen health services through rapid response capacity for climate-sensitive outcomes, including surveillance and monitoring and awareness-raising. Under component 3, the project will support the construction of climate and disaster-resilient DHs. Newly constructed DHs will further include energy-efficient measures such as LEDs, star-rated appliances, efficient cooling solutions, etc. It will also focus on training the health cadre on emergency response systems and building their knowledge of climate-induced diseases.

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APPROVAL

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