



Program Information Document (PID)

Concept Stage | Date Prepared/Updated: 01-Mar-2022 | Report No: PIDC257416

**BASIC INFORMATION****A. Basic Program Data**

Country India	Project ID P178252	Parent Project ID (if any)	Program Name Systems Reform Endeavour for Transformed Health Achievement in Gujarat (SRESTHA-G)
Region SOUTH ASIA	Estimated Appraisal Date 09-May-2022	Estimated Board Date 02-Aug-2022	Does this operation have an IPF component? No
Financing Instrument Program-for-Results Financing	Borrower(s) Department of Economic Affairs, Govt of India	Implementing Agency Health and Family Welfare Department (HFWD) through, Government of Gujarat	Practice Area (Lead) Health, Nutrition & Population

Proposed Program Development Objective(s)

The Program Development Objective is to improve service delivery in the state of Gujarat by strengthening the quality, equity, and comprehensiveness of primary health care, improving service delivery models for adolescent girls, and enhancing capacity of disease surveillance system

COST & FINANCING**SUMMARY (USD Millions)**

Government program Cost	7,984.14
Total Operation Cost	6,303.88
Total Program Cost	6,303.88
Total Financing	350.00
Financing Gap	5,953.88

FINANCING (USD Millions)

Total World Bank Group Financing	350.00
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World Bank Lending

350.00

Concept Review Decision

The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. **India's Gross Domestic Product (GDP) growth was already slowing when the COVID-19 outbreak unfolded.** Real GDP growth moderated from an average of 7.4 percent during FY15/16-FY18/19 to an estimated 3.7 percent in FY19/20¹. The growth deceleration was mostly due to (i) shocks to the financial sector, and (ii) decline in private consumption growth². Against this backdrop of pre-existing weaknesses, the outbreak of COVID-19 had a significant impact, with real GDP contracting by 6.6 percent in FY20/21³. On the fiscal side, the general government deficit widened significantly in FY20/21, owing to higher spending and low revenues⁴. With the easing of Covid-19 restrictions, GST collections have crossed INR 1 trillion mark every month from July to December 2021. The robust Goods and Services Tax (GST) revenues are expected to continue as the economic recovery gathers momentum. Given the significant uncertainty pertaining to epidemiological developments, the real GDP growth⁵ for FY21/22 is likely to be in the range of 7.5 to 12.5 percent, while growth in FY22/23 is expected to be 8.7 percent⁶. The expected recovery will put India among the world's fastest-growing economies over the next two years.

2. **Although India has made remarkable progress in reducing absolute poverty in recent years, the COVID-19 outbreak has delayed the course of poverty reduction⁷.** Between 2012 and 2017, India's poverty rate is estimated to have declined from 22.5 percent⁸ to values ranging from 8.1 to 11.3 percent⁹. However, recent projections of GDP per capita growth, taking into account the impact of the pandemic, suggest that poverty rates in 2020 have likely reverted to estimated levels in 2016¹⁰. Labor market indicators from high frequency surveys -including from the Centre for Monitoring Indian Economy (CMIE)- suggest that vulnerability has increased, particularly for urban households. Overall, the pandemic and its economic impacts are estimated to have raised urban poverty, creating a set of "new poor" that are relatively more likely to be engaged in the non-farm sector and to have received at least secondary education.

3. **Gujarat is among one of the country's more economically prosperous and urbanized states.** The state accounts for 7.7 percent of India's GDP, with annual GDP growth rate of 12.9 percent between 2015-21 which is higher than the national growth rate. Gujarat's per capita income has grown at a rate of 8.3 percent during 2012-20 against India's growth

¹ National Accounts Data, National Statistical Office, Ministry of Statistics and Program Implementation (MOSPI).

² National Accounts Data, National Statistical Office, MOSPI.

³ National Accounts Data, National Statistical Office, MOSPI.

⁴ Union budget 2021, 2022, Ministry of Finance.

⁵ World Bank Global Economic Prospects, January 2022.

⁶ World Bank real GDP forecasts for FY22/23 are broadly in line with the projections of the Government of India.

⁷ World Bank projections. The Government of India has deployed significant resources for social assistance, including towards urban poor households and migrants.

⁸ Consumption Expenditure Survey 2011-12, National Sample Survey Office (NSSO), Government of India.

⁹ World Bank estimates. Source: Poverty and Shared Prosperity Report, 2020.

¹⁰ World Bank estimates. Source: Macro Poverty Outlook, 2020.



rate of 6 percent. Moreover, as per the last available data (2018) ranking of Gujarat among Indian States has risen from 9th in 2011 to 3rd in 2018. Poverty levels in the state have declined from 33 percent in 2005 to 17 percent in 2012. However, despite being one of India's fastest growing states, poverty reduction in Gujarat has been slower than in other advanced states.¹¹ With a total population of 60 million among which 43 percent live in urban areas¹², the state is the ninth most populous state and is highly urbanized. The state, like most others, has a youthful population, with 66 percent of working-age (15-64 years) and 29 percent aged below 15 years.

Sectoral (or multi-sectoral) and Institutional Context of the Program

4. **Gujarat has seen a steady improvement in health status in the past. However, it lags its comparators and faces persisting within-state geographic inequities. Also, despite some encouraging gains, the state has an unfinished, and to an extent, a stagnating reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH+N) agenda.** For example, maternal mortality ratio for Gujarat has declined from 122 maternal deaths per 100,000 live births in 2010/12 to 75 in 2016/18; however, the rate is higher compared to Kerala (43) and Tamil Nadu (60).¹³ Utilization of some essential health services has also improved: institutional deliveries have increased from 53 to 94 percent, and full immunization from 45 to 76 percent between 2005/06 to 2019/20¹⁴. However, modern contraceptive prevalence has declined during the same period – from 57 to 54 percent. The state also has some stark differences across districts in key health outputs which require immediate attention. The state ranks around 30-34 (out of 36 states and UTs) on indicators related to child stunting (39 percent), wasting (25 percent) and underweight (39 percent)¹⁵. Anemia levels among women 15-49 years is 65 percent and higher for children under-five at 80 percent. The health and nutrition indicators of adolescent girls (AGs) have worsened or stagnated. 34 percent of women aged 15-24 continue to use unhygienic methods of protection during their menstrual period.

5. **Gujarat, like several other states, is undergoing an epidemiological transition, and faces a double burden of communicable and non-communicable diseases (NCDs). Access and utilization of NCD and mental health services remain poor in the state.** Three of the top five causes of poor health were maternal and neonatal disorders and communicable diseases in 2001 in the state, which was replaced by NCDs in 2019¹⁶. The state has worse cancer screening rates, and higher prevalence of hypertension and people with high blood glucose compared to the national average and other larger states with similar per-capita income¹⁷. On mental health, while Gujarat is among pioneer states to have a stand-alone state mental health policy and is implementing an innovative, evidence-based intervention to reorient mental health services¹⁸, 10 percent of rural and 5 percent of urban population continue to suffer from mental health problems¹⁹.

6. **Furthermore, climate change is expected to exacerbate human health risks.** Gujarat's geography makes it one of the most vulnerable states of India to the effects of climate change which manifests itself in the form of cyclones and storm surges on the western coast, rising temperatures and droughts in the arid and semi-arid regions, and extreme rainfall and flooding events throughout the state. Both extreme and slow onset climate events along with resource stress present a very significant challenge for human health in Gujarat as they will impact food security and will increase the frequency of dehydration, malnutrition, mental health, vector, and water borne diseases among others.

¹¹ <https://documents1.worldbank.org/curated/en/933681504004310148/pdf/119147-BRI-P157572-Gujarat-Poverty.pdf>

¹² <https://www.censusindia2011.com/gujarat-population.html>

¹³ https://censusindia.gov.in/2011-Common/Sample_Registration_System.html

¹⁴ Various NHFS

¹⁵ NHFS 5, 2019/20

¹⁶ ICMR, PHFI, and IHME. GBD India Compare Data Visualization - <http://vizhub.healthdata.org/gbd-compare/india> (Accessed January 23, 2022)

¹⁷ Cancer screening rate: cervix cancer-0.2 percent; breast cancer-0.1%; and oral cancer-0.2 percent; 13 percent men and 12 percent women are mildly hypersensitive; and 9 percent men and 8 percent women have high blood sugar levels – source: NFHS-5

¹⁸ <https://cmhlp.org/projects/quality-rights-gujarat/>

¹⁹ National Mental Health Survey 2015/16



7. **Gujarat allocates higher proportion of budget in health relative to other comparator states; however, the investment is lower than the 8 percent target set in the 2017 National Health Policy (NHP).** Additionally, although Gujarat's average state health expenditure has remained at 6 percent between 2015-20, other large states have shown a higher proportion of state budget allocated for health sector in 2021-22 compared to previous five years. **Indicators of financial risk protection against catastrophic medical expenses have been improving over time.** Gujarat's mean out-of-pocket (OOP) spending per inpatient visit in 2017/18 was INR 15,448 which is below national average and comparable to Tamil Nadu, and much lower than other key states like Punjab, Maharashtra, and Kerala. Furthermore, 10 percent of the households in Gujarat incur catastrophic spending on healthcare which is lower than the national average of 15 percent but higher than in states like Assam and Tamil Nadu.

8. **While the utilization of services improved over time, some of the critical health indicators still lagging and can be attributed to four key systemic issues.** First, the service delivery model is mostly facility-based, and does not take a Comprehensive Primary Health Care (CPHC) approach although there is renewed push for a CPHC approach through Health and Wellness Centers (HWCs). Implementation to date in most states including Gujarat has focused on infrastructure and equipment, and not on ensuring an appropriate CPHC service delivery model which is people-oriented, with population-based screening and services for NCDs. Second, there are key governance issues hampering performance. Gujarat ranked 6th (among 19 larger states) in the latest NITI Aayog's Health Index 2020; ranking has improved marginally from previous 7th rank. While the state is amongst the best performers on structural quality (inputs and processes), its health system performance did not show improvement between 2018-19 and 2019-20, mostly due to poor performance in health monitoring and data integrity; governance; and health systems and service delivery. Third, despite remarkable progress in setting up health facility infrastructure, shortfall in human resources continues to be a challenge. This persisting gap in HR is a major challenge and service delivery redesign would have to factor in available capacity in the private sector as well. Finally, even though Gujarat has been one of the first states in India to focus on quality of care (QoC) initiatives in the health sector, the state's focus has mostly been only on accreditation and certification, and not on other critical QoC aspects. There is scope to further strengthen technology and data-driven decision making to improve program management as well as quality of services. The state also does not have an overarching QoC strategy. The QoC strategy that needs to be developed would need to focus on patient outcomes and critical dimensions of QoC.^{20,21}

9. **Despite the state's renewed multisectoral focus on adolescent health, fragmented service delivery models and disjointed implementation of the adolescent health strategy has meant persistently poor AGs' health and nutrition outcomes²².** Major educational investments, legislative actions, and programming efforts over the last few decades to increase girls' schooling and curb child marriage have yielded some positive results. Furthermore, the Government of Gujarat (GOG), through implementation of the national program *Rastriya Kishor Swasthya Karyakram* (RKSK) continues to emphasize adolescent health and welfare, with a strong focus on AGs. However, persistent gaps, particularly in health and nutrition outcomes of AGs remain because of a fragmented approach to service delivery, lack of effective multisectoral coordination, and poor monitoring of program performance.²³ The present institutional structure and outreach of the HFWD in Gujarat provides a unique entry point to resolve first-generation gaps in health and nutrition for AGs while simultaneously investing in inter-departmental platforms that drive improved outcomes across different pillars of human capital.

²⁰ The Lancet Commission on high-quality health care observed that for improving health systems at scale, approaches like accreditation and focusing on patient satisfaction have not been consistently effective in improving quality. See *High-quality health systems in the Sustainable Development Goals era: time for a revolution*. The Lancet Global Health, 6(11), pp.e1196-e1252.

²¹ The national quality policy and strategy handbook of WHO also emphasizes institutionalization of culture of quality and lists several interventions apart from accreditation critical for delivering high quality healthcare. Source: <https://www.who.int/publications/i/item/9789241565561>

²² As per NFHS, anemia among women age 15-19 years is at 69%, around 22% women continue to marry before age of 18 years and around 34% women age 15-24 years continue to use unhygienic methods of protection during their menstrual period.

²³ Barua, A., Watson, K., Plesons, M., Chandra-Mouli, V. & Sharma, K., 2020. Adolescent health programming in India: a rapid review. *Reproductive Health*, 17, pp.1-10.



10. **Gujarat had done relatively well in disease surveillance. However, the COVID-19 pandemic has shown that the surveillance system needs improvements.** Key issues are: (i) many vertical programs with siloed surveillance systems²⁴; (ii) low private sector reporting; (iii) mortality and morbidity data not linked to the Integrated Health Information Portal (IHIP); and (iv) NCD surveillance yet to take off. Further, on the laboratory side, the state capacity is predominantly based on rapid diagnostic kits (RDK)²⁵ and advanced capacity beyond RDKs (diagnostics, RT-PCR, and genome sequencing) for outbreak response remains a challenge. Furthermore, with laboratory network divided in different groups, test data reporting is also fragmented²⁶. COVID-19 pandemic has re-emphasized the critical importance of “One Health” surveillance (OHS) on the principles of multisectoral and multi-institutional coordination for responding to outbreaks involving humans, animals, and their environment²⁷ and this needs to be adopted by Gujarat as well.

Relationship to CAS/CPF

11. **The Program is fully aligned to the India Country Partnership Framework (CPF) FY18–22.** The key Program focus of building Human Capital is well aligned with CPF’s “Focus Area 3: Investing in Human Capital”. The proposed results areas are 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 health care’. The Program is also well aligned with three of the four CPF catalytic approaches: (a) engaging a federal India, by adhering to CPF’s focus on “states at center” approach and facilitating innovations; (b) strengthening public health institutions, by improving implementation capacity, creating enabling environment to implement innovative models of CPHC (including private sector engagement) and empowering local governments to spearhead the reform process; and (c) supporting a Lighthouse India, with focus on knowledge generation.

Rationale for Bank Engagement and Choice of Financing Instrument

12. **Gujarat’s human capital accumulation is dependent on the state launching significant reforms and innovations to improve primary healthcare, with a focus on improving health and welfare of AGs.** Reforms in the areas of disease surveillance and quality of care would be equally critical for the state. The Bank has an excellent track record in supporting such reforms through financing as well as technical assistance (TA) honed from global, regional, and in-country experience. Within India, the Bank can leverage its expertise from implementing several central and state level operations focused on health systems strengthening, repositioning PHC and emergency response. Moreover, current interventions for AGs have not had much impact, and the learnings from Bank’s multisectoral human capital work can be contextualized in Gujarat to improve the AGs’ health and welfare. Finally, Bank involvement will enable Program financing to be further bolstered by an additional Bank-executed Trust Fund supporting TA on redesigning primary healthcare. As the state has well-established fiduciary systems and a clearly defined health sector program, the Program for Results (PforR) approach is proposed as the most suitable financing instrument for this Program to further enhance the efficiency and effectiveness of the state’s healthcare delivery system as Gujarat launches its next generation of health reforms and service delivery models for its improved human capital.

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

Program Development Objective(s)

13. The Program Development Objective is to improve service delivery in the state of Gujarat by strengthening the quality, equity, and comprehensiveness of primary health care, improving service delivery models for adolescent girls, and enhancing capacity of disease surveillance system.

PDO Level Results Indicators

²⁴ For e.g. TB, HIV, Dengue, Malaria, Hepatitis, Measles, Diphtheria, Neonatal Tetanus etc.

²⁵ Iyer, V., Choudhury, N., Rajiva, A., Cottagiri, S.A., Sharma, A. and Mavalankar, D., 2019. Laboratory Capacity for Surveillance of Infectious Diseases in Gujarat: Quantity, Quality, Effects and Way Forward. *Health*, 11(07), p.998.

²⁶ Labs at primary health centers are under Adl. Dir Public Health, while labs at community health centers are under Adl. Dir. Medical Services. Similarly, labs at medical colleges are managed by Adl. Dir. Medical Education. There is no linkages or integration among these different groups of laboratory networks.

²⁷ Yasobant, S., Patel, K., Saxena, D. and Falkenberg, T., 2020. COVID-19 in India: Making a case for the one health surveillance system. *Indian journal of public health*, 64(6), p.135.



14. The PDO will be measured through the following PDO-level results indicators.
 - i. Number of districts implementing CPHC model (RA# 1)
 - ii. Number screened for select NCD conditions at public health facilities (RA# 1)
 - iii. Number/ proportion of AGs reached under the Program with new package of services (RA# 2)
 - iv. Number of districts using surveillance system for improved outbreak response (RA# 3)
 - v. Quality of care strategy developed, and quality improvement initiatives implemented (RA# 4)

To the extent feasible, the Program would track, and report on geographical inequities as well as urban-rural differences

D. Program Description

PforR Program Boundary

15. ***The state has a clearly defined mission for its health sector - “increasing life expectancy through various health and medical care interventions contributing to overall Improvement in Human Development Index of the Gujarat to a level comparable with developed countries”.*** The GOG has also aligned its interventions around the 2017 NHP goal of “attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation, through increased access, improving quality and lowering the cost of health care delivery” and Sustainable Development Goal 3 – “ensure healthy lives and promote well-being for all at all age”. ***Key programs under Gujarat’s HFWD considered to achieve the above goals are largely centered around the following*** – National Health Mission (NHM), Medical and Public Health, Family Welfare, Medical Services and Medical Education²⁸. The recently launched PM-ABHIM²⁹ scheme will further strengthen the healthcare infrastructure, which will be complemented by FC-XV³⁰ grants to local administrative bodies. Preliminary discussions with GOG suggest that both PM-ABHIM and FC-XV grants would be routed through NHM.

16. ***The SRESTHA-G will support the Government of Gujarat’s aim to advance human capital gains.*** The Program will aim to address gaps in primary health care, disease surveillance, quality of care, digital health, and lagging health and welfare outcomes for AGs. The operation design will explicitly build on the ongoing efforts on primary health care to boost their impact and will focus on strengthening institutional capacity for improving quality, access and affordability of health services including for vulnerable populations. TA necessary to develop and implement innovative service delivery models would be mobilized to catalyze results under this operation.

17. ***The proposed PforR Program (“P”) is a well-defined subset of the government program (“p”) that includes parts of NHM and other sub-directorates of HFWD.*** GOG has an estimated budget of US\$8.1 billion for 5 years³¹; however, total government program budget (“p”) to deliver on goals defined earlier is US\$7.9 billion. The government program (“p”) is managed by the Commissionerate, Medical Services, Medical Education and Research (“the Commissionerate”), HFWD, GOG and its associated sub-directorates. The PforR Program (“P”) with an estimated value of US\$6.3 billion for 5 years includes CPHC reforms, strengthened disease surveillance, focus on AGs, quality of care, digital health and citizen engagement (excluding major constructions and insurance scheme). Bank contribution to the Program expenditure framework for five years will be US\$350 million (equivalent to 5.6 percent of the total Program financing). These estimates and PforR program boundary will be further refined and finalized during project preparation.

²⁸ excluding Employees’ State Insurance-ESI, AYUSH-Indian systems of medicine, and Food & Drugs Control-FDC

²⁹ Pradhan Mantri Ayushman Bharat Health Infrastructure Mission

³⁰ 15th Finance Commission of India

³¹ Includes, primary, secondary and tertiary healthcare services, employee insurance programs, food and drugs administration, AYUSH systems – expenditure is around salaries, administration, construction, procurement etc.



18. **Following results areas are proposed which will be further detailed out during the preparations:**

- Result Area #1: Improving service delivery for CPHC including NCDs and mental health
- Result Area #2: Improving service delivery models for AGs
- Result Area #3: Strengthening disease surveillance and early detection of outbreak and response
- Result Area #4: Strengthening QoC with a focus on governance, accountability, institutional and management capacity and citizen engagement

To the extent feasible, the Program would track, and report on geographical inequities as well as urban-rural differences.

E. Initial Environmental and Social Screening

19. The program will support minor civil works for small-scale repair and refurbishments and equipping health centers with better quality of facilities including medical waste disposal arrangements etc. These interventions are expected to take place on the property of existing facilities; therefore, environmental and social impacts are expected to be temporary, predictable, and easily mitigated.

20. **Environmental aspects:** Rated as Moderate. As the program delivers health services, the most relevant environmental impacts and risks are related to the minor dust, noise and other nuances associated with the limited proposed construction works as well as the potential increase in construction solid and operational biomedical waste, and the subsequent additional pressures on the existing collection, transport and disposal infrastructure. Medical waste collection service providers are connected down to the PHC level; however, HWCs do not have independent arrangements and bring their waste to the PHC level for collection. The state has 15 central biomedical waste management treatment facilities, and there is sufficient capacity to cater to current and short-term needs.

21. **Social aspects and CE:** The social risks of the Program, rated as 'Moderate', are related to (i) access and exclusion to health services of marginalized population groups including AGs from ST, SC and elite capture; (ii) occupation health and safety of both construction and health workers including exposure to biomedical products and wastes as well as infectious materials and diseases, including COVID19, and (iii) Life and Fire Safety and EMP for workers and patients in health centers. The preliminary assessment reflects that the Program does not anticipate any land acquisition and/ or involuntary resettlement as no major civil works are proposed. Required labor will be limited and is available locally.

22. **Environmental and Social Systems Assessment (ESSA):** An ESSA will be prepared to assist the Program to better (i) determine the environmental, social, labor, occupational and community health and safety impacts and risks associated with both the minor civil works and health centers operations (ii) understand existing government capacity and systems to mitigate such impacts and risks. The ESSA will include, but not be limited to: (i) defining screening and exclusion criteria for activities that could have significant adverse on the environment and/or affected people; (ii) assessment of management arrangements for appropriate pollution prevention and control and OHS measures for the minor civil works, (iii) adequate handling and disposal of construction, biomedical, hazardous and E-waste (iv) IA and regulatory authority capacity assessment to commit resources and implement actions necessary for effective environment and social management; (v) stakeholder assessment (HFWD, Gujarat Pollution Control Board, infection control committees, private sector, communities etc.); (vi) monitoring and management capacity assessment of laboratories and testing systems; (vii) assessment of infection control systems, and (viii) life and fire safety provisions in health centers and appropriate EPR, including training. To avoid exclusion risks and maximize access it will be important to assess the geographic, socio-cultural practices, and traditional beliefs in the provision of health services in the backward and tribal districts which are lagging in most health indicators. The draft ESSA will be consulted with key stakeholders and disclosed prior to appraisal.

23. **Climate Co-Benefits:** The Program seeks to alleviate climate-induced health risks with enhanced service delivery, to enable preparation and response to climate impacts and thus has significant adaptation co-benefits. Under RA1, the



project seeks to establish a people-centred CPHC approach in Gujarat and strengthen links between various levels of facilities and enhance service delivery that will also allow for health-related compensation in the face of climate shocks. RA1 along with RA3, aims to develop along a PHC system which is shock-proof and can be resilient even at times of pandemic and future climatic shocks to continue to deliver essential services which will contribute to adaptation. RA3 will establish early warning systems, monitoring and surveillance of trends that occur in diseases and insecticide resistance, and the impact of climate change on disease outbreaks in the region, include climate and disaster risk screening in health system risk assessments and planning. Under RA2, strengthening multisectoral approaches to improve the health and welfare of AGs will also include climate considerations as climate stresses have an inordinate impact on vulnerable populations like women and children. Under the adoption of the State's first HC Strategy, the project will build human resources and institutional capacities in health and in relevant multisector programming and facilitate comprehensive environmental (climate-related) health training. Climate mitigation measures such as adoption of renewable energy and energy efficiency will be encouraged.

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