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Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 29-Nov-2018 | Report No: PIDISDSA25740

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
India	P167580	Uttar Pradesh Health Systems Strengthening Project – Additional Financing	P100304
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
India: Uttar Pradesh Health Systems Strengthening Project (UPHSSP)	SOUTH ASIA	22-Nov-2018	31-Jan-2019
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Department of Economic Affairs, Department of Health and Family Welfare, Government of Uttar Pradesh	Uttar Pradesh Health Systems Strengthening Project (UPHSSP), Uttar Pradesh Medical Supplies Corporation Ltd

Proposed Development Objective(s) Parent

The Project Development Objective of UPHSSP is to improve the efficiency, quality and accountability of health service delivery in Uttar Pradesh by strengthening the State Health Department's management and systems capacity.

Components

Component 1. Strengthening the Department of Health’s management and accountability systems
Component 2. Improve the Department of Health’s capacity to perform its quality assurance role and more effectively engage the priva te sector

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	150.00
Total Financing	150.00
of which IBRD/IDA	105.00
Financing Gap	0.00

DETAILS

World Bank Group Financing	
International Bank for Reconstruction and Development (IBRD)	105.00
Non-World Bank Group Financing	
Counterpart Funding	45.00
Local Govts. (Prov., District, City) of Borrowing Country	45.00

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **India continues to be the world's fastest growing major economy.** The economy has recovered from the disruptions caused by demonetization and the introduction of the GST in 2017. While growth dipped to 6.7 percent in FY17/18, it has accelerated in the last two quarters to reach 8.2 percent in Q1 FY18/2019. This was supported by a revival in industrial activity, strong private consumption, and a rise in exports of goods and services. At the same time, the external situation has become less favorable. The current account balance has deteriorated. A worsening trade deficit has led the current account deficit to widen (on the back of strong import demand, and higher oil prices) from a benign 0.7 percent of GDP in FY16/17 to 1.9 percent in FY17/18. Meanwhile, external headwinds - monetary policy 'normalization' in the US coupled with recent stress in some Emerging Market Economies- have triggered portfolio outflows from April 2018 onwards, putting additional pressure on the balance of payments.

2. **Since the 2000s, India has made remarkable progress in reducing absolute poverty.** Between FY2011/12 and 2015, poverty declined from 21.6 to an estimated 13.4 percent at the international poverty line (2011 PPP US$ 1.90 per person per day), continuing the earlier trend of robust reduction in poverty. Aided by robust economic growth, more than 90 million people escaped extreme poverty and improved their living standards during this period. Despite this success, poverty remains widespread in India. In 2015, with the latest estimates, 176 million Indians were living in extreme poverty while 659 million, or half the population, were below the higher poverty line commonly used for lower middle-income countries (2011 PPP US$ 3.20 per person per day). Recent trends in the construction sector and rural wages, a major source of employment for the poorer households, suggest that the pace of poverty eradication may have moderated.

Sectoral and Institutional Context

3. Uttar Pradesh (UP) is India's most populous state with an estimated population of nearly 200 million (17% of the population of India)[1]. Eighty-five percent of the population lives in rural areas and about 30 percent live below the poverty line[2]. Given the size of the state's population and poor health outcomes, UP will determine achievement of India's Sustainable Development Goals (SDG). Despite significant improvement in health indicators during the last decade, the state is still lagging compared to the national average. UP still has one of the highest maternal mortality ratios of 201 per 100,000 live births (versus the national average of 130)[3] and infant mortality rate at 43 per 1,000 live births (compared to national average of 34 per 1,000)[4]. The proportion of women having an institutional delivery is 68 percent (national average 79 percent), and full immunization is still at 53 percent (national average of 62 percent).

4. The implementation of health programs in the state is traditionally done by the Department of Health and Family Welfare (DOHFW) through their Directorates of Medical Health and Family Welfare. However, underlying constraints such as weak institutions and accountability mechanisms, and poor organizational performance hamper service delivery and therefore affect achievement of desired outcomes. The Government of India's National Rural Health Mission (NRHM; 2005-2012), focusing on improving basic health services has significantly boosted health financing in the state, mainly through investments in public sector infrastructure, contracting additional human resources and the provision of flexible financing to states. Given NRHM's mandate was mainly improving primary health services, improvement of district hospitals and institutional capacity of the state to provide health services was grossly neglected. To address this, UPHSSP was designed to focus on organizational strengthening and improved accountability to enable better service delivery and complement ongoing centrally supported programs.

C. Proposed Development Objective(s)

Original PDO

The Project Development Objective of UPHSSP is to improve the efficiency, quality and accountability of health service delivery in Uttar Pradesh by strengthening the State Health Department's management and systems capacity.

Current PDO

No Change in the PDO.

Key Results

5. The following key outcome indicators will measure the achievement of project objectives

- Percentage of health programs that had at least 3 quarterly performance reviews in the current FY. (accountability and efficiency)
- Percentage of Bank funding that support operating cost of cells (Sustainability)
- Percentage increase in ANC visits by women in 12 districts with social accountability intervention. (Quality)

1 Registrar General of India. 2011. Population Projections for India and States: 2001–2026.
2 http://documents.worldbank.org/curated/en/187721467995647501/pdf/105884-BRI-P157572-ADD-SERIES-India-state-briefs-PUBLIC-UttarPradesh-Proverty.pdf
3 Registrar General of India. 2014–16. Sample Registration System.
4 Registrar General of India. 2017. Sample Registration System.

- Number of hospitals that are receiving feedback on key performance indicators (efficiency, quality & accountability)
- Number of public facilities with quality certification. (Quality)

D. Project Description

6. The proposed AF of US$105 million IBRD Loan has been requested by the state government of UP through the Department of Economic Affairs, Government of India (GoI). Given the nature of project activities, the AF will use the IPF instrument using traditional input financing. The DLIs approach in original project has significantly contributed in bringing policy level changes related to institutional reform such as introduction of technical cells in the directorate, implementation of personal information system, regularization of facility level reporting etc. The activities under AF are leaning towards input-based financing and has limited scope for DLIs.

A. Proposed Changes in the Project

7. **Project coverage.** The AF will expand coverage from the current 51 district-level hospitals to an additional 92 district-level hospitals, with the objective of ensuring improvement in quality of care across all public facilities providing secondary care service in the state.

Revised project components. The proposed AF will support completing and deepening the improvement of the current 51 hospitals while also expanding a new, context-specific, bottom-up approach to service delivery improvement activities in the remaining 92 district-level hospitals in the state. Furthermore, the AF will support the development of institutional mechanisms to ensure that quality improvements are sustained beyond the achievement of Certification and this project's lifetime. The AF will also continue to support some of the systems strengthening activities under Component 1 while drawing a clear transition plan so that these are taken up by the permanent structures of the state government. The AF will focus on sustaining achievements made under Component 1 and scaling-up activities under Component 1 and Component 2. Details are mentioned below.

Component 1: Strengthening the Department of Health's management and accountability systems (US$13.3 million)

8. **Strengthening the Technical Cells in the Directorate.** While the technical cells are part of the Directorate, their operational costs are financed by the Bank. The AF will continue to fund the operating costs of the cells but will work towards a gradual transition where funding for them is provided through the state budget during implementation of project. Furthermore, the staffing levels and Terms-of-Reference of the EM, QA and PPP cells will be revised to include all programs and facilities run by the state, thus ensuring that the capacity that has been built is expanded and sustained beyond the end of the project. The AF will support the introduction of a systematic performance review process for all the programs implemented by the Directorate with the support of the cells. The project will monitor this and use it as a tracer indicator of strengthened capacity of the Directorate.

9. **Improving and Ensuring sustainability of social accountability interventions.** Social accountability interventions are currently being implemented in 12 districts. Basic social accountability interventions consisting of revitalizing Village Health, Sanitation and Nutrition Committees (VHSNCs) were implemented in 10 of the districts. In the remaining two, a set of interventions incorporating additional facilitation and leveraging of social networks to increase awareness of programs and services were piloted and their impact was evaluated through a randomized control trial. The impact evaluation showed substantial improvements in service utilization leading to improved health and nutrition outcomes for women and children. Therefore, the AF will support the scaling-up of the revised social accountability interventions to the remaining 10 project districts. In addition, the project will transfer knowledge and build the capacity of NHM to introduce the revised social accountability interventions to the remaining 63 districts of the state as well as to eventually take over in the 12 districts supported by the project.

10. **Project management support.** The AF will continue financing the PSU and the PA.

Component 2: Improve the Department of Health's capacity to perform its quality assurance role and more effectively engage the private sector (US$91.7 million)

11. The AF will continue supporting 51 hospitals. For the 27 that have achieved entry-level National Accreditation Board for Hospitals (NABH) certification by the end of the original project the focus will be on strengthening management capacity to sustain continuous quality improvement and retain their certification. For the remaining 24 out of 51 that are in progress, the focus will be on achieving entry-level NABH certification and starting the continuous quality improvement process. To strengthen management capacity towards continuous quality improvement, the project will support bottom-up improvement plans (see next para) as well as improved data collection systems. It will also create the institutional capability to analyze this data and provide feedback based on an agreed set of key performance indicators (KPIs). The AF will continue to fund equipment, additional human resources, technical assistance and outsourcing of non-clinical and clinical support services, using performance-based contracts, in these 51 hospitals.

12. Based on lessons learned over the past three years, the AF will introduce a bottom-up approach to quality improvement in both the current 51, as well as in the remaining 92 district hospitals in the state. This approach will focus on quality improvement plans focused on patient safety and experience, including respectful care. This will entail the hospitals designing, implementing, and monitoring their own quality improvement plans through the involvement of hospital administrators, frontline staff, local authorities, community representatives (such as members of the *Rogi Kalyan Samiti*[5]), and patients. Using this approach, stakeholders will be encouraged to carry out routine 'leadership walkarounds',[6] an approach found to be effective for enhancing patient safety in many advanced countries,[7] to identify problems in service delivery and quality of care by walking around the hospital with a structured template for

[5] Rogi Kalyan Samiti consist of following members: people representatives (MLA/MP); health officials; local district officials; leading members of community; local CHC/ FRU in-charge; representatives of Indian Medical Association; members of local bodies; and leading donors.

[6] Graham, M., et al. 2014. "Walkrounds in Practice: Corrupting or Enhancing a Quality Improvement Intervention? A Qualitative Study." *Jt Comm J Qual Patient Saf* 40 (7): 303–10.

[7] Tucker, A. L., and S. J. Singer. "The Effectiveness of Management by Walking Around: A Randomized Field Study." *Prod. Oper. Manag*. 24: 253–71.

observing service delivery and engaging with frontline staff and patients. Based on the priorities identified during this exercise, hospitals will develop an annual quality improvement plan, channel funds from available sources for implementing it, and monitor its progress using routinely collected data. The QA and SP Cells will provide technical support to the hospitals for developing, implementing and monitoring the quality improvement plans. In addition, this component will support a subset of the 92 hospitals that have successfully implemented quality improvement plans will be supported with additional human resource, medical equipment and technical support to achieve external quality certification.

13. The project will facilitate the creation of a peer-to-peer network, whereby knowledge and best practices can be shared both across departments within a hospital as well as across hospitals. Such collaborative networks have been found to be effective in improving quality of care through shared learning in other low- and middle-income country settings[8] and have also influenced motivation of staff to participate in quality improvement and patient safety measures.[9] In addition, the AF will provide additional emphasis on capacity building of hospital staff, focusing on both technical skills and motivation to perform better, through the medium of in-service training and by piloting performance-based incentives and rewards. Special emphasis will be placed on transferring knowledge from the original 51 hospitals to the remaining 92, including from the hospital managers currently placed and funded by the project in the 51 hospitals to the QA managers placed and funded by NHM in the 92 hospitals. To sustain project achievements, the position of hospital managers in the current 51 hospitals will transition to NHM funded QA managers by the end of the project.

14. The AF will pilot the innovations described below in 10-15 district hospitals.

15. *Filter clinics (or primary consultation clinics).* The objective of filter clinics is to strengthen the efficiency of outpatient and departments by improving patient flows, reducing the caseload of specialists, and reducing waiting time; thereby bringing dignity to the overall experience of seeking care.

16. *Green Hospitals.* The project will pilot interventions focused on making hospitals environmentally friendly and energy efficient. This includes using solar power, conserving water resources through rainwater harvesting and landscaping to make the spaces more pleasant and environmentally friendly.

17. Lastly, the AF will pilot *the outsourcing of mammography services*. A study in 2014 indicated that breast cancer is the second most common cancer among women in Uttar Pradesh[10]. Mammography is one of the tools for early detection of breast cancer[11] and at present not available at any secondary hospital in the state.

18. **Project costs.** Table 1 outlines component-wise costs and the AF allocations.

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[8] English, M. 2013. “Designing a Theory-informed, Contextually Appropriate Intervention Strategy to Improve Delivery of Paediatric Services in Kenyan Hospitals.” *Implement Sci* 8: 39.
[9] Lalani, M. 2018. “Building Motivation to Participate in a Quality Improvement Collaborative in NHS Hospital Trusts in Southeast England: A Qualitative Participatory Evaluation.” *BMJ Open.* 8 (4): e020930. doi: 10.1136/bmjopen-2017-020930.
[10] Maithili, D., S. Agrawal, and B. Vikram. 2014. “Human Resources for Cancer Control in Uttar Pradesh, India: A Case Study for Low and Middle Income Countries.” *Front Oncol* 4: 237. Published September 4, 2014. doi:10.3389/fonc.2014.00237.
[11] Pandey, S., and Chandravati. 2013. “Breast Screening in North India: A Cost-effective Cancer Prevention Strategy.” *Asian Pac J Cancer Prev* 14: 853–857. doi: 10.7314/APJCP.2013.14.2.853.

Table 1. Original and AF Project Costs (in US$, millions)

	Original Project		AF		Total World Bank Financing: Original + AF
Project Costs by Component	**Total Original Project Cost**	**Total Original World Bank Financing**	**Total AF Project Cost**	**Total World Bank AF**	
Component 1: Strengthening the Department of Health's management and accountability systems	55	51	19	13.3	64.3
Component 2: Improve the Department of Health's capacity to perform its quality assurance role and more effectively engage the private sector	115	101	131	91.7	192.7
Total	**170**	**152**	**150.0**	**105.0**	**257**

19. **Project Closing Date.** The Closing Date of the original project will be extended to align with the Closing Date of the proposed AF, November 30, 2021.

20. **Results Framework.** The Results Framework (RF) has been updated to reflect the changes introduced in the AF and to reflect the revised implementation period. Some of the indicators from the original project that have been achieved will be dropped, while others for which either definitions or targets have been have changed will be introduced.

E. Implementation

Institutional and Implementation Arrangements

21. The only change to the implementation arrangements is the addition of the Uttar Pradesh Medical Supply Corporation Ltd (UPMSCL) as an implementation agency. UPMSCL is a public sector undertaking under the UP Department of Health and Family Welfare that specializes in procuring medical equipment and will be part of the project for procurement of medical equipment only. (See procurement section for more details).

22. The Project Governing Board (PGB) under chairmanship of Chief Secretary, GOUP and Project Steering Committee (PSC) under the chairmanship of the Principal Secretary, DOHFW will continue to provide governance support and financial approvals to the project.

23. To facilitate the transition of activities supported by the project to the Directorate and NHM, a Project Coordination Committee (PCC), under the Chairmanship of the Principal Secretary Health & Family Welfare, and a Project Coordination Team (PCT), under the leadership of the Project Director (Secretary, Health and Family Welfare, GoUP), will be formed.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The Project will be implemented across all the districts of the State of Uttar Pradesh (UP), India. Bulk of project investments will be within the premises of existing hospitals and other healthcare centers as well as on improving institutional capacities for better quality care. The State of UP comprises of generally flat terrain, terai region or Himalayan foothill forests, ravines and large tracts of sodic lands. The largest portion of the Ganga basin lies in UP. Project activities are unlikely to have any significant or irreversible impacts of the State's physical characteristics.

G. Environmental and Social Safeguards Specialists on the Team

Sangeeta Kumari, Social Specialist
Anupam Joshi, Environmental Specialist
Sharlene Jehanbux Chichgar, Environmental Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	
Performance Standards for Private Sector Activities OP/BP 4.03	No	
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/BP 4.12	No	
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
ENVIRONMENT:The project is assessed to be an Environment Assessment Category B with no significant and irreversible environmental impacts anticipated. Investments in hospitals include the revamping of hospitals and improvement in quality of health services. This will improve the footfall in the hospitals, leading to generation, handling, management and disposal of biomedical wastes. Under Components 1 and 2, the current focus on BMW management will shift to Health Care Waste Management (HCWM), covering a broader spectrum including e-waste and hazardous waste, general waste, and other aspects such as energy consumption, plantation, sanitation, and so on. And hence, project does not have any immediate safeguard impacts. Thus, initiatives under the AF will include (a) emphasis on management of general waste at the health care facility level apart from BMW and (b) management of e-waste and hazardous waste based on the present regulatory framework and study on hazardous waste, especially the radiology waste from 143 hospitals, which has been initiated from September 2016.

SOCIAL: The project has no adverse social impact and is not expected to undertake any land acquisition or resettlement and hence OP4.12 is not triggered. The state does not have a significant proportion of Scheduled Tribe (ST) population and account for only about 0.6 percent of the state's population spread over many districts, and hence OP4.10 is not triggered. However, there are a few scattered tribal people (recognizable by their special customs) among the state's very large (200 million) population. The project has identified opportunities and continue to act upon to improve social accountability mechanism in improving access to health care services to poor, marginalised and vulnerable population including scheduled caste (SC) and scheduled tribe (ST) population, and plans to mainstream the social accountability process under the National Health Mission (NHM) to be scaled up in future from current 12 districts to all 75 districts of the state.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
ENVIRONMENT: The current project design don't have any indirect or long term impact on environment. The activities under AF will strengthen institutional capacity and improve the coordination, implementation and management of environmental issues related to health service delivery. The improved management system at the hospital level for attaining quality of service and patient safety will mitigate the risk of any adverse effect from medical waste.

SOCIAL: The project is expected to further strengthen the systems and process developed during in the earlier phase of the project and plans to improve health services for marginalized and vulnerable population including mainstreaming them into the DoHFW activities and NHM. This will also help improve the health outcomes of the marginalized and vulnerable population in the longer term. No negative impacts (direct or indirect, short- or long-term) are expected from the project.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
ENVIRONMENT: The external quality certification in India emphasis on implementation of bio-medical waste management. Given the objective of the project is to drive towards attaining quality certification, the issue of medical waste is addressed through institutional system which is beyond project.

SOCIAL: There is no adverse social impact arising from the project activities. The project already has a pro-poor focus,

and improve equity in health in the state, and continue in the additional financing phase.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

ENVIRONMENT: The Environment Management Plan (EMP) has been prepared for the original project, which details the proposed activities under the project. The existing EMP is adequate to address the potential risks and impacts of the proposed activities, as the AF will expand the activities to cover additional facilities but the nature and scale of potential impacts will not change. There is now sufficient experience available to mitigate adverse impacts arising out of biomedical waste management. Lessons learnt from the ongoing project will help further strengthen safeguards during AF. For example, the effective use of IEC materials, technical training for different levels of healthcare workers and performance based contracts for BMW management will be applied during the AF. The Environment Management Cell is established within the Directorate of Medical and Health by issuance of a Government Order. The EMC will comprise officials from the Department of M&H, and closely work with officials from other relevant departments (such as the UP Pollution Control Board). Based on a needs assessment, the EMC has developed the IEC material for management of health care waste and infection control activities, all the medical staff in the state are trained and project has piloted implementation of performance based contract for collection and disposable of waste in Lucknow district that will be replicated across the state.

SOCIAL: The Original project was informed by Social Assessment (SA) that was carried out by the Borrower, including consultations with vulnerable communities, service providers and non-governmental organizations, at the beginning of project preparation. It further informed the preparation of Equity Action Plan to ensure that vulnerable population are addressed through the project activities including system development and management improvements. The Technical Assistance was also provided under the project to assist and build state’s capacity in carrying out the project activities. The additional financing phase plans to continue and finetune the ongoing activities to fulfil the already agreed agenda under the project with no major changes in the project activities and institutional arrangements including the technical assistance. It also plans to mainstream the key activities under the DoHFW and NHM activities. The grievance redress system is in place, a website developed by the project (www.uphssp.org) has key project information and system for reporting grievance. The information related to project also has a public view and is a good step towards increasing transparency of key data related to the public health care sector. Secondly, for procurement related complaints, the project has set up the system that register all the complaints and respond within stipulated time period.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The key stakeholders are the citizens of UP, especially the poor, and health care organizations and providers in the public and private sectors (including NGOs). They would continue to be consulted on a regular basis during project implementation through workshops and field exercises to provide inputs to and feedback on project activities. The social accountability mechanisms setup and being implemented provides opportunities to improve the responsiveness, efficiency and quality of health service delivery, as well as enhance positive house hold health behaviors. All stakeholder groups would be involved in this effort.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors

"In country" Disclosure

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

CONTACT POINT

World Bank

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APPROVAL

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