



Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 17-Jun-2020 | Report No: PIDC28849

**BASIC INFORMATION****A. Basic Project Data**

Country India	Project ID P173589	Parent Project ID (if any)	Project Name Meghalaya Health Systems Strengthening Project (P173589)
Region SOUTH ASIA	Estimated Appraisal Date Sep 07, 2020	Estimated Board Date Dec 22, 2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of India	Implementing Agency Department of Health and Family Welfare, Government of Meghalaya	

Proposed Development Objective(s)

The project development objective (PDO) is to improve utilization and quality of health services in Meghalaya.

PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	50.00
Total Financing	50.00
of which IBRD/IDA	40.00
Financing Gap	0.00

DETAILS**World Bank Group Financing**

International Bank for Reconstruction and Development (IBRD)	40.00
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Non-World Bank Group Financing

Counterpart Funding	10.00
Borrower/Recipient	10.00



Environmental and Social Risk Classification

Moderate

Concept Review Decision

Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. India's Gross Domestic Product (GDP) growth has slowed in the past three years, and the COVID-19 outbreak is expected to have a significant impact. Growth has moderated from an average of 7.4 percent during FY15/16-FY18/19 to an estimated 4.2 percent in FY19/20. The growth deceleration was due mostly to unresolved domestic issues (impaired balance sheets in the banking and corporate sectors), which were compounded by stress in the non-banking segment of the financial sector, and a marked decline in consumption on the back of weak rural income growth. Against this backdrop, the outbreak of COVID-19 and the public health responses adopted to counter it have significantly altered the growth trajectory of the economy, which is now expected to contract in FY20/21. On the fiscal side, the general government deficit is expected to widen significantly to over 10 percent of GDP in FY20/21, owing to weak activity and revenues as well as higher spending needs. However, the current account balance is expected to improve in FY20/21, reflecting mostly a sizeable contraction in imports and a large decline in oil prices. Given this, India's foreign exchange reserves are expected to remain comfortable (equivalent to over 10 months of imports).
2. Since the 2000s, India has made remarkable progress in reducing absolute poverty. Between FY11/12 and 2015, poverty declined from 21.6 percent to an estimated 13.4 percent at the international poverty line (US\$1.90 per person per day in 2011 Purchasing Power Parity (PPP), continuing the earlier trend of rapid poverty reduction. Owing to 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 2015, 176 million Indians were living in extreme poverty, while 659 million—half the population—were below the higher poverty line commonly used for lower middle-income countries (US\$3.20 per person per day in 2011PPP). The covid-19 outbreak is likely to further moderate the rate of poverty reduction and risks people falling back into poverty. The slowdown in domestic consumption due to the necessary public health measures will adversely impact labor-intensive sectors, such as construction, retail trade, transportation, which provide livelihood opportunities for people with lower daily earnings and fewer years of schooling. The lowered demand is likely to reduce farmgate prices of agricultural commodities, increasing vulnerability for small farmers in the rural sector. Poorest households are also more vulnerable to the threat of contagion, as they are more likely to live and work in conditions where social distancing is difficult and are likely to spend a greater share of their budget on out-of-pocket healthcare expenditures if they fall sick. Government schemes to increase food allocations under the public distribution system and income support through direct transfers, social pensions and rural workfare programs are likely to contain these impacts to an extent.
3. India has seen significant improvements in the health sector over the past decade. Infant, under-five and maternal mortality rates have declined, and progress has been made in controlling communicable diseases, but



the burden of non-communicable diseases (NCDs) is growing. Socio-economic factors, especially poverty reduction, have contributed to health improvements, along with development of health services by the state and national governments, notably through investments since 2005 by the National Health Mission (NHM). A national social health insurance scheme, *Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna* (AB-PMJAY), was launched in 2018 to cover inpatient hospital care for the poor, aiming to benefit at least 40 percent of India's population. The Ayushman Bharat initiative also supports investments in a network of health and wellness centers to deliver comprehensive primary health care services, including for NCDs, under the NHM.

4. Meghalaya is part of the North East region, geographically isolated with a distinct tribal identity. Meghalaya (“the abode of the clouds” in Sanskrit) became a state in 1972, with a Legislative Assembly and three autonomous Hill Councils, covering all 11 districts, 6 municipal councils, 22 towns and 6,459 villages in the state. With a population of 3 million (2011), the state is on average poorer than rest of India, but more equitable, as only 12 per cent of the population live below the national poverty line in comparison to 22 per cent at the national level (2011-12).¹ About 80 percent of the state population live in rural areas (2011), often in hilly terrain with poor connectivity. With 86 percent of the population categorized as Scheduled Tribe, Meghalaya's main ethnic communities are the Khasis, the Garos and the Jaintias.

Sectoral and Institutional Context

5. Compared to national averages, Meghalaya’s performance on key health outcomes is mixed, with significant improvement over time, but with a large rural-urban disparities and growing burden of NCDs. In 2015-16, the total fertility rate of 3.0 in the state was considerably higher than the national average of 2.2. While the infant mortality rate in Meghalaya of 30 per 1,000 live births was significantly better than the national rate of 41, the prevalence of stunting among under-five children was 43.8 percent, compared to the national estimate of 38.4 percent. Infant mortality in the state decreased by one-third in a decade, from 45 per 1,000 in 2005-06 to 30 per 1,000 in 2015-16, an improvement similar to the average across India. Over the same period, child stunting decreased by about one-fifth, also similar to India as a whole.² In 2015-16, 5.6 percent of women and 8.3 percent of men had high or very high blood sugar levels (an indicator of diabetes), proportions somewhat lower than the averages across India.³ Nonetheless, it is estimated that in 2017, NCDs (including hypertension, diabetes, cardiac conditions and cancers) accounted for about 55 percent of all deaths in Meghalaya, with another 7 percent due to injuries.⁴

6. The government health system in the state is composed of 443 Sub-Centres, 108 Primary Health Centres (PHC), 28 Community Health Centres (CHC), 1 Sub-District Hospital, 12 District Hospitals, 1 maternal care hospital, 1 chest hospital and 1 mental health hospital.⁵ Meghalaya ranks third among eight smaller states on the NITI AAYOG Health Index.⁶ With regard to key primary health service utilization indicators, coverage in Meghalaya is similar to or lower than national averages. In 2015-16, only 61.4 percent of children aged 12-23 months were fully

¹ In 2017-18, Meghalaya’s per capita net domestic product at current prices was INR 81,098, 30 percent lower than the national figure of INR115,293. (Reserve Bank of India. 2019. Database on Indian Economy. March 3. <https://dbie.rbi.org.in/DBIE/dbie.rbi?site=statistics>)

² International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. http://rchiips.org/NFHS/factsheet_NFHS-4.shtml

³ IIPS and ICF. 2017.

⁴ Indian Council of Medical Research, Public Health Foundation of India and Institute for Health Metrics and Evaluation. 2017. India: Health of the Nation's States – The India State-Level Disease Burden Initiative. <http://www.healthdata.org/disease-burden-India>

⁵ Government of India. 2020. Meghalaya Factsheet, 4th Quarter 2018-19. Regional Resource Centre for North Eastern States. http://www.rrcnes.gov.in/hmis/2018-19/meghalaya_factsheet_18-19_4th_qtr.pdf

⁶ Government of India. 2019a. Healthy States Progressive India: Report on the Ranks of States and Union Territories, Health Index June 2019. NITI Aayog. <http://social.niti.gov.in/>



immunized in the state (national average: 62 percent). Only 51.4 percent of births in Meghalaya were in a health facility (national average: 79 percent). However, there have been significant improvements over time. Full immunization coverage doubled in one decade, from 32 percent in 2005-06 to 61 percent in 2015-16. The proportion of deliveries that were cared for in health facilities increased by three-quarters in Meghalaya during the same period, compared to a doubling in India as a whole.⁷ At the referral level, only 60 percent of the 41 District Hospitals and CHCs designated as First Referral Units are functional.⁸

7. The state health budget was US\$116 million in 2018-19. Per capita expenditure on health (2015-16) was INR 2,223, less than half of other smaller NE states like Arunachal Pradesh Mizoram, though significantly higher than the national average. Total health expenditure as a share of the total state expenditure is 6.73 percent, higher than the average of North Eastern States (6.3 percent) and the major non-EAG states (5.34 percent).⁹ Reporting on deliveries in health facilities from the state's health management information system (HMIS) shows an acceptable deviation of around 13 percent from 2015-16 household survey data. Around 90 percent of regular reporting from Meghalaya to the national Integrated Disease Surveillance Program is complete.¹⁰ However, use of data for management is hampered by numerous and fragmented information system applications, little horizontal integration, and poor functionality across platforms. In 2018-19, almost 33 percent of staff nurse positions and 25 percent of general physician positions were vacant. These include the one-third of Medical Officer posts that were unfilled in PHCs. Almost 60 percent of specialist posts are vacant, which include 42 percent vacancies at in District Hospitals. The state has one medical college and is yet to establish its own Medical Council. Lack of opportunities for higher education and continuing medical education have contributed to a shortage of specialists. There are gaps in monitoring, supervision and performance management, in post creation and staff allocation planning, and pay and promotion policies.¹¹

8. The state is implementing three national schemes to improve access to medicines: The Free Drugs and Diagnostics Service Initiative, *Jan Aushadhi* (generic medicines) and *Amrit Pharmacy* (social marketing of generic medicines). However, the uptake of these services is hampered by weaknesses in procurement and supply chain management systems. Procurement and distribution of medicines are done in a fragmented manner, responding to immediate needs but often not based on medium-term planning of district and facility-level requirements. Quality assurance and inventory management require improvements, while warehouses face problems of seepage and storage space.¹² The government has improved referral, transport, and ambulance services, but challenges in isolated and hilly areas require further action. Community-level strategies, leveraging information technology, should be explored to improve emergency transportation.

9. There has been limited implementation of and follow-up to quality assurance systems. The quality assurance teams for the National Quality Assurance Standards (NQAS) are functional since 2010, in 2018-19, only 23 out of 108 PHCs and 7 out of 28 CHCs implemented the NQAS grading system,¹³ though we see an improvement in the incremental indicator performance against the quality indicator "proportion of District Hospital / Sub-Divisional Hospital with quality assurance certificates" as per the NITI Aayog Health Index Report 2019. In 2017-18, none of the 28 Community Health Centres and only one of the 13 Sub-District and District Hospitals were awarded this

⁷ IIPS and ICF. 2017.

⁸ Government of India. 2019a.

⁹ National Health Profile, 2019. Central Bureau of Health intelligence, Ministry of Health and Family welfare, Government of India

¹⁰ Government of India. 2019a.

¹¹ World Bank. 2014. Rural Recruitment, Retention and Job Performance in Meghalaya: A Qualitative Study.

¹² World Bank. 2014. Supply Chain Management System Development Strategies and Plans: Meghalaya.

¹³ Government of India. 2019a.



certificate.¹⁴ Biomedical waste is largely being managed at the facility level; system-level improvements are needed in several areas, including local waste disposal practices, treatment of effluent biomedical waste from hospitals, and the need for a common treatment facility.

10. The Megha Health Insurance Scheme (MHIS) covers in-patient hospital services provided by 156 government facilities and 16 private hospitals, including some tertiary-level services outside of Meghalaya. During the period 2013-2017, MHIS paid claims of INR 30.9 crore (US\$4.9 million) to government services and INR 34.2 crore (US\$5.4 million) to private sector services. In 2017-18, with expansion of benefits under the PMJAY, it covered claims totaling INR 26.9 crore (US\$4.2 million) for services delivered by the government system, and INR 58.7 crore (US\$9.1 million) for private sector services. The payments made by the scheme for services provided by government hospitals are managed at the facility level by the *Rogi Kalyan Samithis* (hospital management committees). There are state government guidelines for use of these revenues for staff incentives, medicines and consumables, and investments in repairs, infrastructure and equipment, but these are not always followed. Claims rejection rates in government hospitals are high, reflecting problems with administrative processes and medical records management.

11. Improved health systems capacity and functional health facilities improve resilience to disease outbreaks.¹⁵ An outbreak of the novel coronavirus disease (COVID-19) has been spreading rapidly across the world since December 2019. The Government of India has mounted a swift response to COVID-19 starting mid- January which continues to be calibrated to the fast-evolving situation. The national program has provided financial support to the states for diagnostics, patient, and health worker safety, contact tracing, and to fill equipment and infrastructure gaps for case management. The Meghalaya state government has also mobilized local resources for testing, quarantine, case management, and awareness-raising. There is a need for better capacity and the systems for effective planning and scale-up of services, including for decentralized testing and case management.

12. The Government of Meghalaya recognizes that improvement of the health systems is paramount for a citizen-centric fully functional service provision. The State has recently initiated several interventions and pilots to address some of these gaps. The State have signed PPP contracts for tele- radiology and pathology services, but the utilization of these services is low. Similarly, the state has signed the contract for collection of plastic waste from the health facilities which is collected once in week or more basing on the small quantity that is generated at the health facilities. However, all other waste is combined and dumped in the pits untreated. There is an urgent need to strengthen the health systems through a series of measures that can not only bring efficiency in operations but also ensure achievement of short term and long-term goals of having qualified competent staff that can sustainably provide quality service delivery. It also recognizes the role of community participation and innovations that are required to further enhance the service delivery and provide sustainability to the ecosystem.

Relationship to CPF

13. **The project will contribute to the India Country Partnership Framework (CPF) FY18–22** (Report No. 1266667-IN, July 25, 2018, discussed at the Board on September 20, 2018). By supporting improvements in public health service delivery, this project is directly aligned to the CPF focus area of “Investing in human capital.” More specifically, it directly contributes to the CPF’s key objective 3.4 which is “to improve the quality of health service

¹⁴ Government of India. 2019a.

¹⁵ Nuzzo. 2019. What makes health systems resilient against infectious disease outbreaks and natural hazards.



delivery and financing and access to quality health care.” In doing so, it primarily adopts two of the four catalytic approaches identified as being integral to the implementation of the CPF: (a) engaging a federal India and (b) strengthening public health institutions.

C. Proposed Development Objective(s)

The project development objective (PDO) is to improve utilization and quality of health services in Meghalaya.

Key Results (From PCN)

- a. Increase in number of outpatients utilizing government health services at the primary level, disaggregated by gender (utilization)
- b. Increase in number of inpatients utilizing government health services at the first-referral level, disaggregated by gender (utilization)
- c. Reduction in stockouts of essential medicines in government health facilities (quality)
- d. Increase in number of government health facilities with quality certification (quality)

D. Concept Description

14. In summary, project investments in management and accountability systems at the administrative levels (Component 1) and in improving service delivery and quality at the health facility level (Component 2) are expected to have a combined effect on improving the delivery and quality of government health services.

Component 1. Improving Management and Accountability Systems

15. This component will aim to strengthen the State Department of Health’s management and accountability systems, which will in turn contribute to improving delivery and quality of health services. In doing so, the project will help fill any gaps in the state-level response to the COVID-19 pandemic, building capacity to respond to future health crisis. This will include technical support and training for administrators at the state and district levels on planning, management and technical issues. The project will support integration of existing information systems and, where needed, development of applications to improve oversight and management of the health system, deployment of a robust data quality monitoring system to mitigate data integrity issues, and implementation of dashboards for decision-making at various management and administrative levels. Development of Human resource for health (HRH) through a multi-pronged approach to address constraints to improved availability, motivation and performance shall be prioritized. This will include building the capacity of the directorates for planning and management of human resources, developing long-term strategies for health cadre development, feasibility studies for a proposed state medical college and state health university. To help address shortages in human resources for health, especially in PHCs and CHCs, strategic planning and development of short, medium and long-term solutions to bridge gaps (including possible creation of additional health cadres).

16. The Department of Health’s procurement and supply chain management systems (PSM) will be strengthened to improve the supply of medicines and consumables. The project will support capacity-building of state and sub-state level structures involved in PSM, (like the state Procurement Board), need-based retrofitting and renovations of warehouses to improve storage capacity and monitoring capacity and PSM information systems.



A robust strategy for improving management and disposal of all biomedical waste generated by both government and private health facilities, in collaboration with the State Pollution Control Board and municipalities will be undertaken.

Component 2: Improve health service delivery and quality

17. This component will focus on investments at the service provision level to improve the utilization and quality of health services delivery, including through supporting innovations. Few key activities will include comprehensive quality assurance programs for quality certification of health facilities; investments in health service infrastructure to improve functionality; strengthening technical infrastructure like neonatal and pediatric intensive care units, engagement with private sector wherever required, strengthening forward and backward referral linkages, systems strengthening support to the Megha Health Insurance Scheme, and knowledge exchange programs.

18. It will also support the state in implementing the Ayushman Bharat strategy for strengthening Health and Wellness Centres, with capacity to provide an expanded package of services, including for primary screening, counseling, and referral for NCDs. Priority will be given for establishment of systems for effective community engagement, particularly involving women representatives at the local level, including in planning, decision-making, and monitoring. The project will support interventions to improve utilization of health services. This will involve support to re-mapping of existing ambulance services as well as innovative community-driven and public-private partnership approaches like use of information technology, telemedicine and teleradiology.

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

19. The proposed project does not envisage potential large-scale, significant or irreversible environmental and social impacts. Civil works for infrastructure repair and rehabilitation will be minor as the project will not finance construction of large hospitals or healthcare facilities. The project will invest to improve the overall ecosystem for bio-medical waste management that includes segregation, disinfection, collection and disposal that largely safeguards the environment. The major social risks of the project are the risk of exclusion and access to services to people living in remote and hard-to-reach areas. No land acquisition or involuntary resettlement is expected under the project, as the civil works is expected to be within the existing footprint of the facilities.

20. The DoHFW, the main implementing agency has not directly implemented any World Bank financed project before. However, it has been involved in implementing some of the national program supported by the World Bank. The department does not have any designated Environment & Safeguards staffs. Thus, there will be needs for training and continued capacity building assistance on ESF. Since the specific sites/health facilities where construction will take place will not be known by project appraisal stage, an Environment and Social



Management Framework (ESMF) will be prepared and disclosed prior to appraisal. During the implementation, Medical Waste Management Plan (MWMP) will be prepared as required, prior to the commencement of the specific work in accordance with the ESMF.

21. The stakeholders of the project will encompass a broad range of actors: besides the implementing agencies, they will include representatives of ethnic groups, local government stakeholders (e.g. panchayat members), civil society, NGOs, media, local/neighborhood associations/clubs, youth groups/associations, medical doctors, association, private health institutions, pharmacists association, etc. Stakeholder engagement, consultation and communication, including grievance redress and disclosure of information will be required throughout the project life. It is expected that the project activities will benefit the local population with improved health care delivery system, and it is not expected that any of the activities related to the project will have any direct or indirect negative impacts on the tribal communities. An IPPF will be prepared to assess the risks and potential impacts and recommend mitigation measures to ensure activities financed by the project will respect the dignity, aspirations, identity, culture and livelihoods of the ST population.
22. Given the COVID19 situation and related travel restrictions, most of the consultations during preparation will be conducted in a virtual manner following the relevant interim technical note on public consultation prepared by the World Bank. During the project implementation, further consultation with community will be carried out in local languages i.e. Khasi, and with rest of the stakeholders in English as that being official language in Meghalaya.

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APPROVAL

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