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IDA/R2016-0288/1

November 30, 2016

Closing Date: Monday, December 19, 2016 at 6 p.m.

FROM: Vice President and Corporate Secretary

India – Nagaland Health Project

Project Appraisal Document

Attached is the Project Appraisal Document regarding a proposed credit to India for a Nagaland Health Project (IDA/R2016-0288), which is being processed on an absence-of-objection basis.

Distribution:
Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank, IFC and MIGA

Document of
The World Bank

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Report No: PAD1153

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF US$48 MILLION

TO THE

REPUBLIC OF INDIA

FOR A

NAGALAND HEALTH PROJECT

November 28, 2016

Health, Nutrition, and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective October 31, 2016)

Currency Unit = Indian Rupees (INR)
INR 66.8 = US$1

FISCAL YEAR
April 1 – March 31

ABBREVIATIONS AND ACRONYMS

ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
BCG	Bacillus Calmette-Guerin
CAG	Comptroller and Auditor General
CES	Coverage Evaluation Survey
CPS	Country Partnership Strategy
DALY	Disability-Adjusted Life Year
DC	Direct Contracting
DLHS4	Fourth District Level Household Survey
DTP	Diphtheria, Tetanus, Pertussis
GRS	Grievance Redress Service
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HNP	Health, Nutrition, and Population
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
ICT	Information and Communication Technology
IDA	International Development Association
LIB	Limited International Bidding
NCB	National Competitive Bidding
NFHS3	Third National Family Health Survey
PAD	Project Appraisal Document
PDO	Project Development Objective
PMU	Project Management Unit
POM	Project Operational Manual
SORT	Systematic Operations Risk-Rating Tool
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Regional Vice President:	Annette Dixon
Country Director:	Junaid Kamal Ahmad
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Rekha Menon
Task Team Leader:	Patrick M. Mullen

INDIA
Nagaland Health Project

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PAD DATA SHEET

India

Nagaland Health Project (P149340)

PROJECT APPRAISAL DOCUMENT

SOUTH ASIA

GHN06

Report No.: PAD1153

Basic Information			
Project ID P149340	EA Category B - Partial Assessment		Team Leader Patrick M. Mullen
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]		
Project Implementation Start Date February 1, 2017	Project Implementation End Date March 31, 2023		
Expected Effectiveness Date February 1, 2017	Expected Closing Date March 31, 2023		
Joint IFC No			
Practice Manager Rekha Menon	Senior Global Practice Director Timothy Grant Evans	Country Director Junaid Kamal Ahmad	Regional Vice President Annette Dixon
Borrower: Republic of India			
Responsible Agency: Department of Health and Family Welfare, Government of Nagaland			
Contact: Mr. Abhijit Sinha Telephone No.: 91-370-2270565		Title: Commissioner & Secretary Email: nmhp.wb@gmail.com	

Project Financing Data (in US$, millions)					
[ ]	Loan	[ ]	IDA Grant	[ ]	Guarantee
[X]	Credit	[ ]	Grant	[ ]	Other

Total Project Cost:	60.00	Total Bank Financing:	48.00
Financing Gap:	0.00		

Financing Source	Amount
BORROWER/RECIPIENT	12.00
International Development Association (IDA)	48.00
Total	60.00

Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021	2022	2023
Annual	4.00	6.00	10.00	10.00	10.00	8.00
Cumulative	4.00	10.00	20.00	30.00	40.00	48.00

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Energy & Extractives, Environment & Natural Resources, Governance, Water

Cross Cutting Areas

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	55		
Water, sanitation and flood	Water supply	10	75	

protection				
Water, sanitation and flood protection	Sanitation	10		25
Energy and mining	Other Renewable Energy	15		75
Information and communications	General information and communications sector	10		
Total				100

☐ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Public sector governance	Decentralization	10
Social dev/gender/inclusion	Participation and civic engagement	10
Social dev/gender/inclusion	Indigenous peoples	10
Human development	Health system performance	50
Human development	Nutrition and food security	20
Total		100

Proposed Development Objective(s)

To improve health services and increase their utilization by communities in targeted locations in Nagaland.

Components

Component Name	**Cost (US$, millions)**
Community Action for Health and Nutrition	18.00
Health System Development	42.00

Systematic Operations Risk-Rating Tool (SORT)

Risk Category	**Rating**
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate

5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Low
9. Other	
OVERALL	Moderate

Compliance

Policy

Does the project depart from the CPS in content or in other significant respects?	Yes [ ] No [X]
Does the project require any waivers of Bank policies?	Yes [ ] No [X]
Have these been approved by Bank management?	Yes [ ] No [ ]
Is approval for any policy waiver sought from the Board?	Yes [ ] No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X] No [ ]

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	**X**	
Natural Habitats OP/BP 4.04		**X**
Forests OP/BP 4.36		**X**
Pest Management OP 4.09		**X**
Physical Cultural Resources OP/BP 4.11		**X**
Indigenous Peoples OP/BP 4.10	**X**	
Involuntary Resettlement OP/BP 4.12	**X**	
Safety of Dams OP/BP 4.37		**X**
Projects on International Waterways OP/BP 7.50		**X**
Projects in Disputed Areas OP/BP 7.60		**X**

Legal Covenants

Name	**Recurrent**	**Due Date**	**Frequency**
Project Reports	**X**		Continuous

Description of Covenant

The Recipient shall monitor and evaluate the progress of the Project and prepare Project Reports in

accordance with the provisions of Section 4.08 of the General Conditions and on the basis of indicators acceptable to the Association. Each Project Report shall cover the period of one calendar semester, and shall be furnished to the Association not later than one (1) month after the end of the period covered by such report.

Name	Recurrent	Due Date	Frequency
Financial Management, Financial Reports and Audits	**X**		Continuous

Description of Covenant

1. The Recipient shall maintain or cause to be maintained a financial management system in accordance with the provisions of Section 4.09 of the General Conditions.
2. Without limitation on the provisions of Part A of this Section, the Recipient shall prepare and furnish to the Association not later than forty five (45) days after the end of each calendar quarter, interim unaudited financial reports for the Project covering the quarter, in form and substance satisfactory to the Association.
3. The Recipient shall have the Project's Financial Statements audited in accordance with the provisions of Section 4.09 (b) of the General Conditions. Each audit of the Financial Statements shall cover the period of one (1) fiscal year of the Recipient. The audited Financial Statements for each such period shall be furnished to the Association not later than nine (9) months after the end of such period.

Name	Recurrent	Due Date	Frequency
Institutional Arrangements and Project Documents	**X**		Continuous

Description of Covenant

1. The Project Implementing Entity, through its Department of Health and Family Welfare shall:
(a) maintain, at all times during Project implementation, within the Department of Health and Family Welfare's regular structure, a Project Management Unit with functions and responsibilities acceptable to the Association, including, inter alia, the responsibility of said unit to coordinate and monitor the implementation of the Project in accordance with the provisions of the Project Operational Manual ;
(b) ensure that, at all times during Project implementation, the Project Management Unit shall be adequately staffed with professional and administrative staff (including procurement, financial management, environmental, social and Project related technical staff), with the necessary experience and qualifications acceptable to Association, and operating under terms of reference agreed to between the Recipient and the Association;
(c) maintain, at all times during Project implementation, a project steering committee, headed by Chief Secretary of Nagaland, which shall comprise government officials from stakeholder departments, vested with the responsibility of, inter alia, providing strategic direction to the Project; and
(d) maintain, at all times during Project implementation, an executive committee, headed by the Commissioner and Secretary of the Department of Health and Family Welfare, comprising officials from said department, and vested with the responsibility of, inter alia, ,monitoring day-to-day project implementation;
2. The Project Implementing Entity shall carry out the Project in accordance with the Project Operational Manual, the Safeguard Instruments and the Procurement Plan; and shall not amend, delete or waive any provision of the aforementioned instruments without prior written agreement between the Recipient and the Association. In the event of any conflict between the provisions of any of the POM, the Safeguard Instruments or the Procurement Plan on the one hand and the

provisions of this Agreement or the Financing Agreement on the other hand, the provisions of this Agreement or the Financing Agreement, as applicable, shall prevail.

Name	Recurrent	Due Date	Frequency
Health and Nutrition Incentives	**X**		Continuous

Description of Covenant

1. For purpose of implementing the Health and Nutrition Incentives scheme under Part 1 of the Project, the Project Implementing Entity, through the Project Management Unit, shall:
(a) publicly invite Village Health Committees to submit proposals for Health and Nutrition Action Plans in accordance with the procedures and requirements set forth in the POM;
(b) screen and select participating Village Health Committees based on the Health and Nutrition Action Plans in accordance with the protocols and eligibility criteria set forth in the POM; and
(c) make a portion of the proceeds of the Financing available on a grant basis to each selected Village Health Committee by means of an Incentive Agreement on terms and conditions acceptable to the Association and executed between the Project Implementing Entity, through the PMU, and such selected Village Health Committee, all with the terms and conditions set forth in the POM which shall include, inter alia, the following:
(i) the Project Implementing Entity's obligation (through the PMU) to make to such selected Village Health Committee a Health and Nutrition Incentive, which shall be paid in two (2) equal tranches to be paid on every calendar semester, subject to the Village Health Committee's satisfaction of the conditions set out in sub-paragraph (ii) – (viii) below;
(ii) the Village Health Committee's obligation to demonstrate on a quarterly basis, the achievement of the performance targets proposed in its respective Health and Nutrition Action Plans, in accordance with the POM;
(iii) the Village Health Committee's obligation to utilize the Health and Nutrition Incentive in accordance with sound technical, financial, environmental and social standards and practices and with the Anti-Corruption Guidelines;
(iv) the Village Health Committee's obligation to refrain from using the Health and Nutrition Incentives for the financing of any Ineligible Expenditure;
(v) the Village Health Committee's obligation to carry out all procurement related to activities to be financed by the Health and Nutrition Incentives in accordance with the provisions set forth in the POM;
(vi) the Village Health Committee's obligation to maintain cashbooks and registers recording financial transactions to demonstrate meeting the requirements of the POM, the resources, expenditures and full utilization of the Health and Nutrition Incentives by the Closing Date;
(vii) the Village Heath Committee's reporting requirements, including the obligation to prepare and provide to the Project Implementing Entity and the Association all the necessary information (as required) to enable the Recipient and the Project Implementing Entity to comply with its respective obligations under Section II. A of the Schedule to this Agreement;
(viii) the Project Implementing Entity's right to suspend or terminate at any time the right of the Village Health Committee to receive and use the Health and Nutrition Incentive or obtain refund of all or any part of the amount of the Health and Nutrition Incentive then withdrawn upon the Village Health Committee's failure to perform any of its obligations under the Incentive Agreement; and
(ix) the right of the Project Implementing Entity, the Recipient and the Association to inspect the operations related to the Health and Nutrition Incentives and the Health and Nutrition Action Plan and any relevant records and documents.
2. The Project Implementing Entity shall exercise its rights and carry out its obligations under each of the Incentive Agreements in such manner so as to protect the interest of the Recipient and the Association and to accomplish the purpose of the Financing. Except as the Association shall

otherwise agree, the Project Implementing Entity shall not assign, amend, abrogate or waive any Incentive Agreement or any of its provisions. In the event of any conflict between the provisions of an Incentive Agreement and those of this Agreement or the Financing Agreement, the provisions of this Agreement or the Financing Agreement, as applicable, shall prevail.

Name	Recurrent	Due Date	Frequency
Safeguards	**X**		Continuous

Description of Covenant

1. The Project Implementing Entity shall:
(a) ensure that the Project is carried out in accordance with the Environmental Management Plan, the Social Management Framework, Tribal Development Plan and the Resettlement Policy Framework and (if required) each Resettlement Action Plan;
(b) ensure that the Safeguards Instruments are implemented in a manner and substance satisfactory to the Association; and
(c) refrain from amending, suspending, waiving, abrogating, and/or voiding any provision of the Safeguards Instruments, in whole or in part, without the prior written mutual agreement of the Association.
2. The Project Implementing Entity shall:
(a) take all necessary actions to avoid or otherwise minimize to the extent possible, and to mitigate, any involuntary loss by persons of shelter, productive assets or access to productive assets or income or means of livelihood, temporarily or permanently, and the displacement of said people in the carrying out of the Project or any part thereof; and
(b) where the acquisition of land or assets resulting in Displaced persons is unavoidable, before initiating the implementation of any works or other activities which would result in such acquisition or displacement, develop and implement a Resettlement Action Plan in accordance with the Resettlement Policy Framework, and make available to such people compensation and, as applicable, relocate and rehabilitate the Displaced Persons in accordance with the Resettlement Action Plan and in a manner satisfactory to the Association.
3. The Project Implementing Entity shall maintain policies and procedures adequate to enable it to monitor and evaluate, in accordance with guidelines acceptable to the Association, the implementation of the Safeguards Instruments.
4. The Project Implementing Entity shall maintain throughout Project implementation, a Project grievance redress mechanism, with staffing and operating procedures acceptable to the Association, for monitoring and addressing the concerns of people affected by the Project and building public and stakeholder support for the Project.
5. Without limiting its other reporting obligations under this Agreement, the Project Implementing Entity shall, take all necessary measures to regularly collect, compile and submit to the Association, as part of the Project Reports, information on the status of compliance with the Safeguards Instruments, giving details of:
(a) measures taken in furtherance of the Safeguards Instruments;
(b) conditions, if any, which interfere or threaten to interfere with the smooth implementation of the Safeguards Instruments; and
(c) remedial measures taken or required to be taken to address such conditions.
6. In the event of any inconsistency between the provisions of any of the Safeguards Instruments and the provisions of this Agreement or the Financing Agreement, the provisions of this Agreement or the Financing Agreement, as applicable, shall prevail.

Team Composition

Bank Staff			
Name	**Role**	**Title**	**Unit**
Patrick M. Mullen	Team leader	Senior Health Specialist	GHN06
Heenaben Yatin Doshi	Procurement and Supply Chain Management	Procurement Specialist	GGO06
Arvind Prasad Mantha	Financial management	Financial Management Specialist	GGO24
Anupam Joshi	Environmental safeguards	Senior Environmental Specialist	GEN06
Bathula Amith Nagaraj	Operations	Operations Officer	GHN06
Mamata Baruah	Administration	Senior Program Assistant	SACIN
Jayati Nigam	Health systems	Consultant	GHN06
Juan Carlos Alvarez	Legal	Senior Counsel	LEGES
Amit Jain	Renewable energy	Energy Specialist	GEE06
Kanv Garg	Renewable energy	Consultant	GEE06
Ruchi Soni	Renewable energy	Consultant	GEE06
Lincoln Priyadarshi Choudhury	Operations	Consultant	GHN06
Mariappa Kullappa	Water and sanitation	Senior Water & Sanitation Specialist	GWA06
Mehul Jain	Environmental safeguards	Consultant	GEN06
Mohini Kak	Community development & nutrition	Health Specialist	GHN06
Neesha Harnam	Health system development	Health Specialist	GHN04
Ranjan B. Verma	Water & sanitation	Consultant	GHN06
Sangeeta Kumari	Social safeguards	Senior Social Development Specialist	GSU06
Satya N. Mishra	Social safeguards	Social Development Specialist	GSURR
Montserrat Meiro-Lorenzo	Peer reviewer	Senior Public Health Specialist	GCCPT
Sean Bradley	Peer reviewer	Lead Social Development Specialist	GSUGL
Christopher Juan Costain	Peer reviewer	Lead Financial Sector	GFM02

		Specialist	

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
India	Nagaland	State of Nagaland	**X**		

I. STRATEGIC CONTEXT

A. Country Context

1. The state of Nagaland, with a population of 2 million, is situated in the North-East region of India. With an area of 16,579 km^2, the state's population density is 120 per km^2 (about one-third of the national average of 312) and the state's topography is hilly with very poor roads and connectivity. The state has 11 districts, 52 blocks, and 1,500 villages. On average, per capita net state domestic product is about US$1,172 (INR 78,526), slightly lower than the national figure of US$1,297 (INR 86,879).[1] However, the socioeconomic distribution in Nagaland is more equitable—an estimated 19 percent of the population live below the official poverty line in the state, lower than the national average of 22 percent (2011-12)[2] (see also figure 5.1 in annex 5). Tribal communities make up almost 90 percent of Nagaland's population (while over 70 percent of the state's population lives in rural areas).

2. The state of Nagaland was created in 1963. The Government of India has emphasized the importance of development of the North-East and improving its linkages with the rest of India as well as internationally. Nagaland, like the other states in the North-East, is given priority by the Government of India for development investments. Although Nagaland has been included in national and regional projects, this will be the first World Bank-financed project to be directly implemented by the state government.

B. Sectoral and Institutional Context

3. Available estimates for health, nutrition, and population (HNP) outcomes in Nagaland are mixed (see table 5.1 in annex 5). In 2013-14, estimated child malnutrition (stunting) was 29.1 percent.[3] Communicable diseases, including tuberculosis, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), and malaria, remain important, while the burden of non-communicable diseases is growing. At the same time, health service utilization indicators are unambiguously poor in Nagaland (see Table 5.2 in annex 5). A 2013-14 survey in Nagaland indicated that service coverage indicators were significantly lower than national averages. Full immunization coverage was 33.2 percent, while only 3.6 percent of pregnant women received full antenatal care and 18.6 percent delivered in a health facility.[3]

4. Low utilization of basic health services reflects a number of factors, including limitations in government health service delivery combined with low availability of private sector services, particularly in rural areas. In addition, poor roads and transport links in much of the state limit access. Organization of the government health system in Nagaland is similar to other states, with 1,700 community health workers (ASHAs), 397 Sub-Centers, 124 Primary Health Centers, 21 Community Health Centers and 11 District Hospitals in the state. In 2015-16, the annual government budget for health in Nagaland was approximately US$69 million.

[1] Reserve Bank of India (2014–15), "Database on Indian Economy."
[2] Government of India, Planning Commission (2012).
[3] Rapid Survey on Children (2013-14), Ministry of Women and Child Development, Government of India.

5. There are significant problems related to human resources in the health sector. There is a lack of skilled health care workers, with 2.32 doctors per 10,000 population in Nagaland compared to 3.35 on average in India (2011-12). These ratios are significantly lower than internationally accepted norms. There is no medical college in the state, contributing in particular to a lack of specialist physicians. There are significant challenges in staffing rural health facilities as well as with absenteeism. An important constraint is the state government's freeze on creation of new posts in the state health services. Inadequate supply of medicines to government health services is another major factor in discouraging utilization. Conditions in health facilities also have an impact on service delivery and utilization (as well as on health worker motivation). Electricity supply in the state is unreliable, especially in rural and isolated areas. Only a few health facilities have water supply and sanitation arrangements needed for good hygienic conditions for patients and staff.

6. With regard to community-level mechanisms for accountability of health services, Nagaland has gone considerably farther than most other states in India. Under the term 'communitization', a 2002 state law transferred responsibility for local services to Village Councils and sector-specific committees. This included transfer of assets (such as buildings) as well as financial resources, notably funds for salaries. In the health sector, Village Health Committees are responsible for management of local health services, including salary payment as well as use of small funds transferred by the state government. Some 1,300 Village Health Committees have been constituted and their level of functionality varies widely. A 2014 World Bank assessment found that, at one end of the scale, with long-term support from a faith-based organization, a number of communities have made substantial investments in local health services as well as other activities with potential impact on health and nutrition. At the other end of the scale, many committees are hardly active.

C. Higher Level Objectives to which the Project Contributes

7. The World Bank's Country Partnership Strategy (CPS) for India (2013-17) (Report No. 76176) aims to contribute to the World Bank's global objectives of ending extreme poverty by 2030 and boosting shared prosperity. The strategy describes how strengthening health and nutrition service delivery systems, including developing local systems and capacities, contributes to the 'Inclusion' engagement area. The proposed project will contribute to this by making investments to improve the quality of health care services in Nagaland, by developing important components of the state's health system, improving capacities for local management and accountability, and supporting local initiatives with an impact on HNP services and outcomes. Project support at the community level will include a focus on supporting the role of women in management of health services and other HNP-related activities, contributing to the gender objectives of the Country Partnership Strategy. The CPS also emphasizes cross-sectoral initiatives, and the project will include innovation in this area, both through cross-sectoral coordination at the local level and by enlisting the energy and water/sanitation sectors to improve health service delivery.

8. Although on the scale of India, Nagaland's population is quite small, the project aims to have a broader knowledge impact through implementation and evaluation of innovative strategies, notably cross-sectoral interventions and use of incentives for community groups. The project's experience with health system development should also be useful to other states that

face similar issues. Finally, the Country Partnership Strategy includes a focus on low-income and North-East states.

9. By strengthening government health service delivery in Nagaland, the project will contribute to the objective of universal health coverage, including the HNP Global Practice goals of ensuring access to health services and financial protection for everyone by 2030 and ensuring that, by the same year, no one is pushed into or kept in poverty by paying for health care. The project's support to the community level will contribute to the 'healthy societies' aspect of these objectives, developing capacities and supporting community-level activities with HNP impacts.

II. PROJECT DEVELOPMENT OBJECTIVE

A. PDO

10. The project development objective (PDO) is to improve health services and increase their utilization by communities in targeted locations in Nagaland.

B. Project Beneficiaries

11. Communities in targeted locations will benefit from project activities at the community and health facility levels, while the population of the state as a whole will benefit from improvements in higher-level facilities as well as system-wide investments.[4] For monitoring purposes, project beneficiaries are defined as people who use health services or benefit from community-level activities supported by the project.

C. PDO Level Results Indicators

12. The following PDO indicators reflect the project's intended impact on improving health services.

(a) Community health workers (ASHAs) in targeted communities supplied with complete kits (Percentage)

(b) Targeted health facilities with at least one functional handwashing facility with running water (Percentage)

13. The following PDO indicators reflect the project's intended impact on improving utilization of health services.

(a) Children age under one year registered for immunization in targeted communities whose growth was recorded at least twice in the previous six months (total and female) (Percentage)

[4] Communities in the official catchment areas of targeted primary-level health facilities account for about 40 percent of the state population, but higher-level health facilities are used by people from wider geographic areas. In particular, the project targets all Community Health Centers and District Hospitals in the state, the services of which are accessed by people from across the state.

(b) Children ages 9-11 months registered for immunization in targeted communities who have received all recommended immunizations (total and female) (Percentage)

(c) Mothers who delivered in the previous 6 months in targeted communities who had at least 3 antenatal care visits check-ups (Percentage)

14. Intermediate outcome indicators include a Corporate Results Indicator (People who have received essential HNP services), a citizens' engagement indicator, and 9 other indicators (see annex 1).

III. PROJECT DESCRIPTION

15. Project activities at the health facility and community levels will be focused in a coordinated fashion on the same target locations to maximize impact. The Department of Health and Family Welfare has selected health facilities on the basis of clear criteria, specifically presence of relevant qualified health personnel and a minimum level of current service provision. This is intended to ensure that a basis exists on which the project can build. The target list includes all 11 District Hospitals and 21 Community Health Centers in the state, as well as 55 Primary Health Centers, 90 Sub-Centers and 500 villages (within the catchment areas of targeted health facilities). Thus, 500 Village Health Committees are potentially eligible for support on Component 1. Targeting may be adjusted during the course of implementation as documented in the Operations Manual.

16. The project will not duplicate existing activities of the state health system and National Health Mission and will not set up parallel systems. The project will support and complement existing health systems, including information and other mechanisms involving communities, under the National Health Mission. The state health system will remain responsible for the delivery of health services to the population, including ensuring key inputs such as human resources, infrastructure, equipment, medicines, and other consumables.

17. The project will adopt a phased and active learning approach, with lessons learned during the first phase informing subsequent scale-up. First-phase activities will put in place and test strategies, systems, and capacities, providing the opportunity to learn and adapt from implementation experience. First-phase activities under both Components 1 and 2 will start implementation during the first year of the project, while scale-up will start during the second year (as first-phase activities continue). Implementation at scale of new and innovative strategies to be supported by the project, particularly at the community level and involving other sectors, requires this approach. This, along with capacity constraints and the state's lack of experience with direct implementation of World Bank-financed projects, argues for an implementation period of six years.

A. Project Components

Component 1. Community Action for Health and Nutrition (estimated cost US$18 million)

18. This component is designed to empower communities to oversee, manage, and improve HNP services and their utilization. An incentive strategy will be used whereby funding will be provided to communities on the basis of progress on defined indicators of improved health and

nutrition-related services and practices. In turn, communities will use the incentives for activities and investments that are important to them and have potential impacts on health and nutrition.

19. The component will have a major focus on knowledge and skill building of Village Health Committees and other stakeholders at the community level, including women's groups and Village Councils. Village Health Committees will be supported in identifying existing gaps, determining the most suitable approaches to address these gaps, developing action plans, and operationalizing those plans. Funding will be provided to targeted committees that meet preconditions reflecting a minimum level of capacity and interest, including having a woman co-chair of the committee and a health and nutrition action plan with agreed targets. An Incentive Agreement will be signed between the Village Health Committee and the Department of Health and Family Welfare. Subsequently, financial incentives will be provided to committees on achievement of agreed targets as laid out in their action plans, following verification by the Department of Health and Family Welfare. In addition, contracted consultants will independently assess reported results as well as the use of financial incentives by the committees. Indicators chosen for the first phase of implementation relate to antenatal care, postnatal care, delivery services, birth registration, child health and nutrition services, behavior change communication efforts, and support to health service delivery. Indicators and targets will be revised based on implementation experience.

20. Committees will be empowered to use these incentives for health and nutrition-related activities that are priorities to them, including investments designed to improve performance in future rounds. Examples could include improving health facility infrastructure; incentivizing health staff; contracting additional staff; filling gaps in supplies and equipment; and encouraging behavior change in areas of health, nutrition, and hygiene. These activities will be consistent with existing policies and systems of Government of India.

21. The first phase of implementation will focus on 1 Community Health Center in each of 2 selected districts, including, in their catchment areas, 1 Primary Health Center, 3 Sub-Centers, and 17 Village Health Committees. Experience from this will inform subsequent phased scale-up to all facilities and communities targeted by the project.

Component 2. Health System Development (estimated cost US$42 million)

22. This component will support improvements in the management and delivery of health services, including both facility-specific and system-wide investments.

Subcomponent 2.1. Investments to Improve Service Delivery Conditions at Targeted Health Facilities (estimated cost US$17 million)

23. The project will finance investments to improve conditions for staff and patients in targeted health facilities, with the intention of contributing to improved staff motivation, better quality services, and greater demand for services. For example, reliable lighting and functional and clean toilets in health facilities can help reduce barriers to access to health services, in particular for women and girls. Indeed, health facilities should stand as best-practice examples to the community for safety, cleanliness, and hygiene.

24. **Reliable electricity supply.** The project will invest in off-grid electrical power solutions that will be adapted to the needs of each targeted health facility to ensure a basic level of functioning (that is, for lighting and high-priority equipment), acting as a backup when grid power is not available. In larger facilities, solar energy technology will be installed, while smaller facilities will require battery and inverter systems that can be charged by the grid when it is available. Sunlight, altitude, and temperature conditions in Nagaland make solar energy a cost-effective option. The project will also support installation of solar water pumps and water heaters in targeted health facilities. During the first phase of implementation, investments will be made in 14 health facilities for which detailed technical requirements have been assessed. The second phase will cover the approximately 160 remaining targeted facilities.

25. **Improved water supply and sanitation.** Investment in improved water supply in targeted health facilities will entail repair and upgrading of piping and storage facilities linked to existing water supplies, as well as installation of roof water harvesting systems. This work will include ensuring water supply to washbasins and toilets. Sanitation improvements will include upgrading septic tanks, including anaerobic filter installations. The first phase of implementation will involve water supply and sanitation investments in 27 health facilities for which technical requirements have been assessed. The second phase will cover the approximately 150 remaining targeted facilities. It is well understood that investment in infrastructure is not enough to ensure better hygienic conditions. The project will support behavior change communication to encourage effective maintenance and cleaning.

Subcomponent 2.2. Development of Health System Components (estimated cost US$25 million)

26. The project will support development of key components of the health system intended to improve the management and effectiveness of government health services in Nagaland.

27. **Supply chain management system.** The project will support development and implementation of systems and processes, including defining roles and responsibilities, establishing procurement procedures, putting in place a planning and ordering system, developing a quality assurance system, and developing an inventory management and distribution system. National guidelines under the National Health Mission will provide the basis for strengthening procedures and systems.

28. **Information and communication technology.** The project will support the development of an interoperable information and communication technology (ICT) platform, to which several high-priority applications will be linked, including (a) supply chain management; (b) financial management; (c) human resource management; (d) health management information system (including reducing the reporting burden on frontline health staff); and (e) mobile applications for behavior change communication. Implementation will be contracted out to a single service provider to ensure coherence of the systems and applications.

29. **Health human resource strategy.** Based on a situation analysis done during project preparation, during the first phase the project will support the development of a medium-term health human resource strategy for the state. The strategy will address key constraints, including improved human resource management systems. Once adopted by the state government, the project will finance implementation of relevant components of the strategy. In addition, the

project will provide technical support (through consultancy services) for development of a medical college in the state capital of Kohima. There is currently no medical college in the state, which has contributed in particular to a lack of specialist physicians. The state government's parallel funding in support of the project will support, for an initial period, higher-level human resources necessary for development and accreditation of the medical college, estimated to cost approximately US$3 million in state government funding over the project period. The project will not support civil works or other capital investments for development of the medical college.

30. **Other investment requirements.** Flexibility will be retained for the project to support other priority investments to improve health service delivery that cannot be met from other sources, including at the level of District Hospitals. Technical assessment and World Bank concurrence will be required for such activities to be included in the project's annual budget and work plan. During initial implementation, detailed technical assessments of health facilities to define bills of quantities for procurement of energy and water and sanitation investments under Subcomponent 2.1 will also identify other gaps in health service capacity. These will include minor repairs and rehabilitation and medical equipment and supplies necessary for effective delivery of health services necessary for achievement of the PDO. The state government's parallel funding in support of the project will be used to fill such gaps. An estimated US$9 million in state government financing will be provided over the project implementation period.

31. **Monitoring and evaluation.** Health facility and household surveys will be done at the project start, mid-project, and near the end of the project. These will provide a basis for impact evaluation of the project and will also improve knowledge of health and nutrition services and factors influencing HNP outcomes more broadly in the state. The project will support punctual evaluations and studies as needs arise.

32. **Project management.** Under this component, the project will finance the costs of the Project Management Unit, district coordinators, a contracted firm to provide technical and management support, and other consultants as needed.

B. Project Financing

Project Cost and Financing

Project Components	Project Cost (US$, millions)	IDA Financing (US$, millions)	State Government Parallel Financing (US$, millions)
1. Community Action for Health and Nutrition	18.00	18.00	0.00
2. Health System Development			
2.1 Investments to Improve Service Delivery Conditions at Targeted Health Facilities	17.00	17.00	0.00
2.2 Development of Health System Components	25.00	13.00	12.00
Total Costs	**60.00**	**48.00**	**12.00**

C. Lessons Learned and Reflected in the Project Design

33. Lessons are drawn from the World Bank's experience in financing health system development projects in ten states of India, as well as its support to a variety of central health programs. Overall, in a context where World Bank funding has become dwarfed by increased government investment in the sector, notably through the National Health Mission, World Bank financing has had the best results when it has supported and leveraged improvements in national systems, fostered innovation and new strategies, and met investment needs that could not be addressed by other sources. Poorer results can be expected when project investments and implementation are uncoordinated with national systems and when there are gaps in commitment and consensus within government (often manifested through frequent changes in project management).

34. Also informing project design is relevant international experience from projects supporting community-level capacity development and activities, such as the Third National Program for Community Empowerment in Rural Areas 'PNPM *Generasi*' in Indonesia (P115052) that supported grants to communities tied to HNP-related results, as well as the 'Community Action for Nutrition Project' (P125359) in Nepal. Evaluation of the Indonesia program demonstrated that such grants to the community level can have a significant impact on health indicators.[5]

35. Finally, the project benefits from considerable recent Nagaland-specific technical work in a number of areas. Analysis of Nagaland in 2014 as part of a global knowledge product on Influencing Multisectoral Action for Health Outcomes (P145691) identified the importance of risk factors that can be addressed through behavior change at the community level, and HNP Technical Assistance to North-East States (P146929) has involved in-depth analysis of several areas of project investment (community-level strategy, health human resources, off-grid energy, water and sanitation, supply chain management, and ICT), drawing on lessons from elsewhere in the world.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

36. The project will be implemented by the Nagaland State Department of Health and Family Welfare as well as targeted Village Health Committees (including such committees at both the village and facility levels), closely coordinated with other programs implemented at the state and local levels, notably the National Health Mission, as well as with Village Councils (figure 1).

37. The state government has created a Project Steering Committee chaired by the chief secretary, with overall responsibility for the project, including approval and monitoring of project plans and budgets, as well as approval of the Project Operational Manual (approved on February 3, 2015). A Project Executive Committee chaired by the commissioner and secretary, Department of Health and Family Welfare, will provide regular monitoring and approvals for

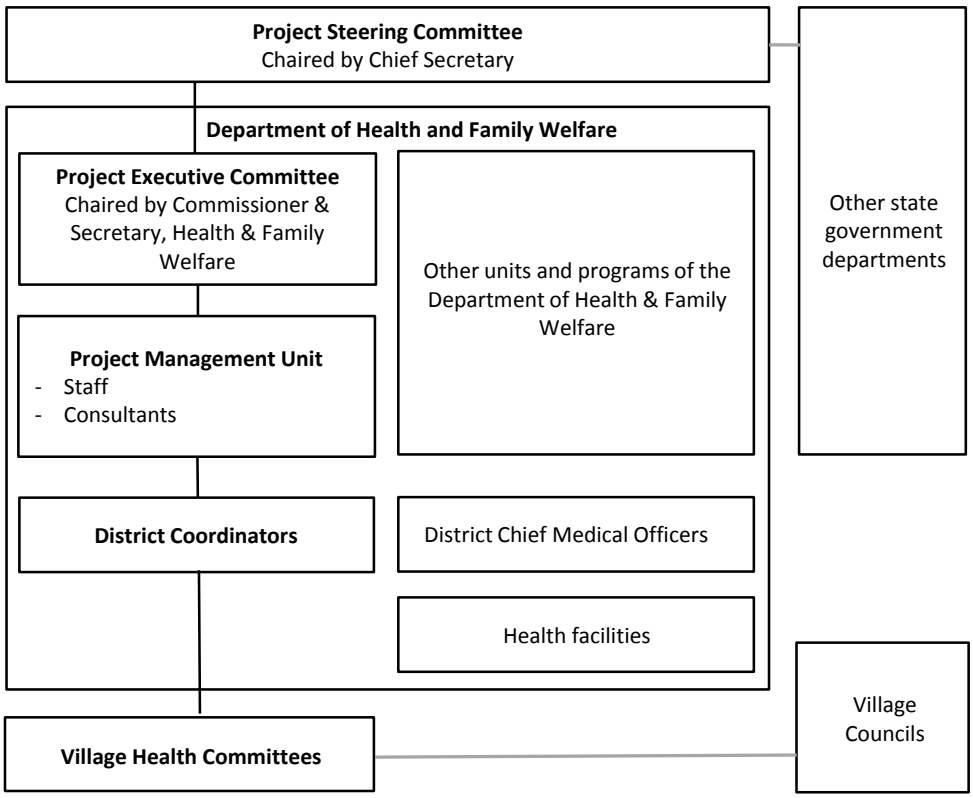
[5] World Bank. 2011. "Indonesia's PNPM *Generasi* Program: Final Impact Evaluation Report," Report No. 69142, Jakarta.

day-to-day implementation of the project. A Project Management Unit, with a senior officer of the Department of Health and Family Welfare as the project director, has been established to manage implementation of the project. Project Management Unit staff are either assigned from state government cadres or contracted. The approximately 10 staff and consultants include staff responsible for procurement and financial management, as well as technical areas including public health, community mobilization, off-grid energy, and water and sanitation. Under Component 2, a contracted consultant firm will provide technical and management support to the Project Management Unit. In addition, 11 district coordinators will be hired to support implementation.

38. Under Component 1, the Department of Health and Family Welfare will enter into Incentive Agreements with Village Health Committees for providing incentives on the basis of agreed indicators and targets. Village Health Committees will use this financing for activities with an impact on health and nutrition within guidelines set out in the Project Operational Manual.

39. To foster collaboration on the various cross-sectoral activities of the project, other state government departments are represented on the Project Steering Committee. At the local level, Village Councils are represented on Village Health Committees, while the project will also support awareness raising and capacity building of important stakeholders, including women's groups.

Figure 1. Implementation Arrangements



B. Results Monitoring and Evaluation

40. Monitoring and evaluation of project indicators will focus on targeted health facilities and the communities they serve. Baseline values for project indicators derive from data collected in these locations by the Department of Health and Family Welfare during project preparation. Subsequent regular reporting on project indicators will rely on the department's reporting and information systems. The project's support to an ICT platform and applications will include improvements to these systems. In addition, the project will support a series of health facility and household surveys. Project indicator targets will be evaluated and revised at project mid-term consistent with national strategies.

C. Sustainability

41. Commitment-related risk is mitigated by the strong consensus within the state government and among other stakeholders that has been evident during preparation, as well as by the fact that community-level involvement and commitment to the project is built into the strategy supported under Component 1. The current poor fiscal situation of the state government indicates substantial risk to financial sustainability of activities initiated by the project. Community support to operations and maintenance of investments at the local level will be fostered. The usefulness to communities of the incentive strategy under Component 1 will determine the extent to which this is continued by the government after the project period. At the same time, in a context of continued economic growth, government health spending is expected to continue to grow, so that the amount allocated to these incentives (planned at less than 5 percent of current annual government health spending in the state) should be fiscally sustainable. Upon project completion, activities will be sustained by the state government through the existing framework.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

42. **Political and governance.** There is a risk that project resources could be used for purposes other than intended. The state government has created a Project Steering Committee, chaired by the chief secretary, to provide high-level ownership of the project. Consultation during preparation has fostered broad consensus across the state government on the objectives and activities of the project. Consultants providing technical and management support will reduce outside pressures on state government officials implementing the project. Procurement and financial procedures have been agreed in detail in the Project Operational Manual. Political and governance risk is rated Moderate.

43. **Macroeconomic.** Although the fiscal situation of the state government presents risks, annual average project expenditure represents less than 10 percent of government health spending in the state, so risks related to fiscal sustainability are rated Moderate.

44. **Sector strategies and policies.** Health sector strategies and policies in Nagaland are in line with national policies, supported in particular by the National Health Mission, with modifications appropriate to the context. Overall, national strategies and policies in the sector are

technically sound. At the same time, flexibility for state-specific adaptations is increasing. The risk in this area is rated Moderate.

45. **Technical design of project or program.** Some parts of the project, notably community-level and cross-sectoral activities, may be sufficiently complex to pose design and implementation risks. To manage this risk, project activities are well-defined and limited to clearly feasible activities. Several new strategies (such as community action and alternative energy) will be implemented in a phased manner, with learning from the first phase applied to subsequent scale-up. Design of project-supported activities was substantially supported by World Bank-executed non-lending technical assistance. The project will contract necessary technical expertise during implementation. The risk in this area is rated Moderate.

46. **Institutional capacity for implementation and sustainability.** While there is strong commitment to and ownership of the project by the Nagaland state government, full responsibility for implementation of a World Bank-financed project is new for the state. There is an important risk that insufficient systems and capacity may hinder implementation. The state's fiscal situation may reduce its ability to provide counterpart funding. Cumbersome procedures may delay funds flow from the state treasury to the project. To mitigate this risk, the state government has created the necessary project implementation structures and is using a Project Preparation Advance to support preparatory and start-up activities. Consultants will provide technical and management support. Moreover, streamlined procedures are agreed in the Project Operational Manual. The state treasury will provide an advance to the project account. Institutional strengthening of the Health and Family Welfare Department, especially the Project Management Unit, will be undertaken. Additional consultant support in operational and technical areas will be supported by the project. In addition, the risk will be mitigated by intensive project support and monitoring by the World Bank team to ensure achievement of desired results. The risk in this area is rated Substantial.

47. **Fiduciary.** Risks stem largely from currently insufficient systems, experience, and capacities for implementation, as well as governance-related risks. These risks will be mitigated by contracting necessary capacity to support the Project Management Unit, as well as ensuring clarity on implementation procedures. A Project Preparation Advance of US$1 million has been used to put in place essential implementation capacities, including Project Management Unit consultants. The risk in this area is rated Substantial.

48. **Environment and social.** As the majority of Nagaland’s population is part of tribal communities, OP 4.10 (Indigenous Peoples) is triggered, requiring the project to take proactive steps to ensure that its benefits accrue to members of tribal groups. Project support to components of the health system may entail risks related to medical waste management, while there may be risks related to disposal of wastes produced by any civil works. The project is classified as Environmental Assessment Category B under OP 4.01. Planned civil works will be limited to the existing footprint of health facilities. However, observed encroachment on health facility land in some locations raises the small risk of the need for land acquisition and resettlement, so OP 4.12 is triggered. The risk in this area is rated Moderate.

49. **Stakeholders.** There is broad support for the project within the state government administration. Preparation of the project included substantial consultation with community

leaders and stakeholders, while community-level implementation of project activities during implementation will entail ongoing consultation, ownership, and commitment. The risk in this area is rated Low.

50. The overall risk is rated Moderate.

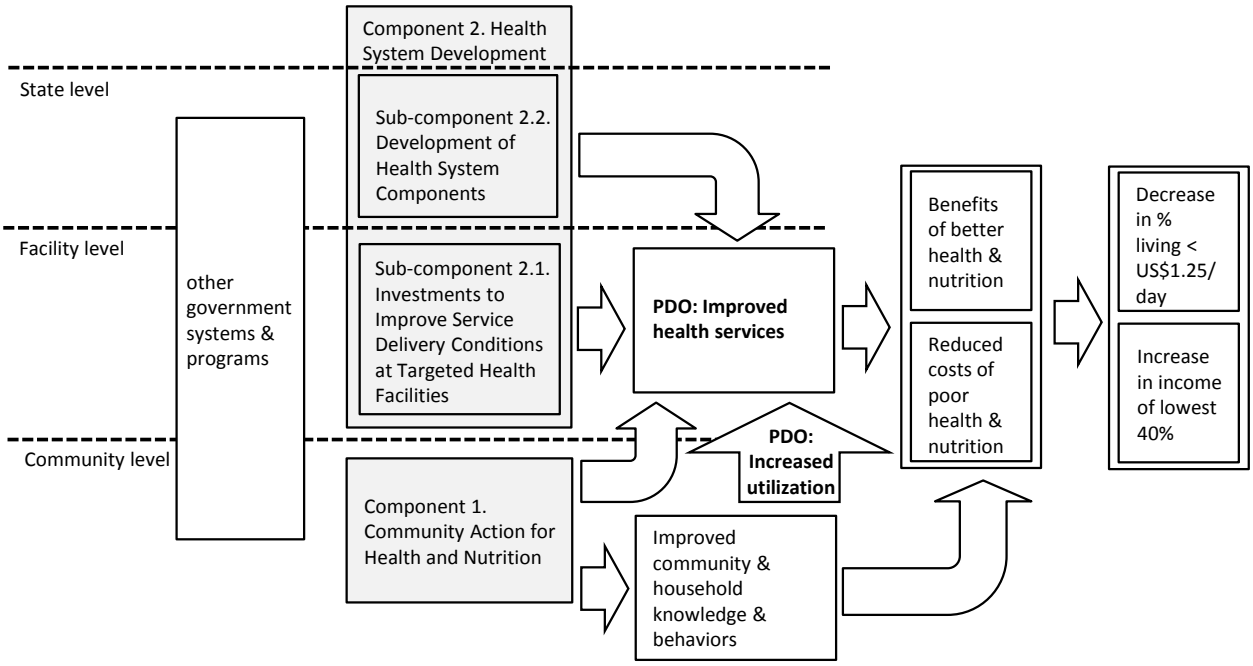
VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

51. **Development impact.** Figure 2 provides an illustration of the anticipated causal chain between project activities, the PDO, and development impact with regard to the World Bank group's global objectives to end extreme poverty and boost shared prosperity (see annex 5).

52. **Rationale for public sector action.** There are a variety of market failures in the HNP sector that argue for government intervention, including positive and negative externalities that are not fully captured by the private market, adverse selection and moral hazard, and information asymmetries. These do not necessarily require direct provision of health services by the Government, but in the case of Nagaland, strengthening the government health services, as well as community structures for their management and accountability, is the best option in the absence of a strong private sector for health care delivery. Equity considerations also point to the need to strengthen public sector health services to reduce impoverishing health expenditures.

Figure 2. Causal Chain to Development Impact



53. **Value added of World Bank support.** The value added of World Bank support to the proposed project stems from its expertise and experience in health system development in India, as well as its experience in other sectors, notably community development, renewable energy, and water and sanitation. The World Bank is also well positioned to apply elsewhere lessons

from this project in implementing community-level and cross-sectoral interventions to improve health and nutrition.

B. Technical

54. The project will focus on improving government health services and their utilization in the context of a lack of significant private sector services, particularly in rural areas of the state. The project will join with central and state government resources to improve management and delivery of health services. The project will aim to develop components of the health system (that is, human resource and supply chain management systems, community-level management) that will increase the effectiveness of these existing government inputs. At the same time, the project will invest in areas (that is, community-level investments, health facility power, water and sanitation) that have been identified as important to health service delivery and utilization but are insufficiently addressed by existing programs.

55. The project will have a strong focus on strengthening community engagement, management, and accountability mechanisms, building on a uniquely promising basis in Nagaland. The project will also include cross-sectoral interventions (notably in the areas of energy and water and sanitation) at both the facility and community levels.

56. Fostering the participation of women in oversight and management of health services at the community level is an explicit goal, while project activities, including community mobilization and investments in health services, are designed to improve utilization of health services by women and girls. Monitoring and evaluation of the project will include gender-disaggregated indicators as well as examine gender-related factors influencing health and nutrition.

C. Financial Management

57. The Department of Health and Family Welfare has deputed a senior finance officer to the Project Management Unit. A financial management consultant provides support. The annual funding requirements of the project will be determined based on approved work plans and will be included in the budget of the Department of Health and Family Welfare as a separate budget line for an externally aided project. Funds will be drawn from the budget into a separate bank account opened by the Project Management Unit. The procurement, payment, and accounting functions for activities under Component 2, as well as consultancies under Component 1, will be centralized at the Project Management Unit. Separate books of accounts will be maintained for the project. Additionally, an off-the-shelf accounting system will be used for project accounting and financial reporting. Disbursements will be based on submission of interim financial reports. Internal audit of the Project Management Unit will be carried out by the Directorate of Accounts and Treasury while external audit will be done by the comptroller and auditor general (CAG).

58. With regard to community-level activities under Component 1, incentives will be released by the Project Management Unit into separate bank accounts opened for this purpose by each eligible Village Health Committee. The committees will maintain cash books and registers to record financial transactions, and expenditure reports will be periodically submitted to the Project Management Unit. Results will be verified by project's district coordinators with support

from contracted consultants, who will also assess the use of the incentives by the committees. Financial management procedures are described in the Project Operational Manual, providing guidance on accounting, internal control, and financial reporting.

59. Parallel co-financing of the project by the state government (US$12 million) is to be implemented by the Department of Health and Family Welfare, with monitoring and reporting by the Project Management Unit.

60. The financial management arrangements proposed under this project are considered to be adequate, to account for and report on project expenditures. These arrangements will satisfy the fiduciary requirements of OP/BP 10.00 (refer to annex 3 for details).

D. Procurement

61. The project will involve contracting of services, purchase of goods and equipment, and minor civil works. The Project Management Unit will include staff responsible for procurement. In addition, a contracted consultant firm will provide support to procurement and contract management. Procurement for activities under Component 2, as well as consultancies under Component 1, will be handled by the Project Management Unit.

62. Component 1 will involve incentives to Village Health Committees, the use of which will be governed by procedures described in the Project Operational Manual. Procurement procedures may include shopping; local competitive bidding inviting prospective bidders for goods and works located in and around the local community; direct contracting (DC) for small value goods, works, and non-consulting services; and the use of community labor and resources. The Project Operational Manual describes in detail procurement arrangements, methods and procedures for this component. Contracted consultants will assess the use of the incentives by committees.

63. Main risks are related to capacity limitations and weaknesses in current procurement practices, delays in decision making, and potential for external interference in the procurement process. These risks will be mitigated by close monitoring, internal and external audits (by the government), disclosure of procurement information, and post review of contracts by the World Bank. Under Component 2, contracted support to procurement and contract management will further reduce this risk. The project will also assist the government in strengthening procurement and supply chain management systems for the Department of Health and Family Welfare as a whole. Based on this, the residual procurement risk is assessed as Substantial.

E. Social (including Safeguards)

64. Article 371A of the Constitution of India provides special status to Naga customary law. Scheduled tribes form a majority of the state's population (86.5 percent of the total and 93 percent of the rural population). A Social Assessment has concluded that the project carries no risk of major adverse social impacts. The Social Assessment and Social Management Framework (including the Resettlement Policy Framework, Tribal Development Plan, and Gender and Social Inclusion Guidelines) were adopted and publicly disclosed by the state government on November 22, 2014.

65. **Resettlement Policy Framework.** Planned limited civil works for improving existing health facilities may carry a small risk of involving resettlement; therefore, the World Bank's Operational Policy on Involuntary Resettlement (OP 4.12) has been triggered. In Nagaland, 93 percent of the land is privately owned, governed by local customary laws. The Resettlement Policy Framework provides for (a) purchase of private land required for the project through transparent and community-based processes on a willing-buyer, willing-seller basis and (b) assistance to displaced squatters. The framework provides for preparation and execution of site-specific resettlement action plans by the Department of Health and Family Welfare through the deputy commissioners concerned (Revenue Department).

66. **Tribal Development Plan.** Given that most project beneficiaries belong to tribal communities, the Operational Policy on Indigenous Peoples (OP 4.10) has been mainstreamed into project design, emphasizing (a) free, prior, and informed consultation; (b) sensitivity to the sociocultural traditions of the tribal communities of Nagaland; (c) community-based implementation; (d) culturally appropriate information, education, and communication strategies; and (e) special attention to the needs of poorer tribal communities.

67. **Gender and social inclusion.** Naga tribes have women's organizations and most villages have traditional women's organizations. Women are represented on Village Development Boards and Village Health Committees and thus empowered to participate in the project. The Gender and Social Inclusion Guidelines in the Social Management Framework will foster participation of women and socially vulnerable people in the project. The project's results matrix is informed by gender and social inclusion considerations, including gender disaggregation of service delivery indicators as well as monitoring of the proportion of Village Health Committees with female co-chairs.

68. **Citizens' engagement.** Citizens' engagement is integral to the project, particularly through implementation of Component 1. A project indicator is included in the results framework on planning, implementation and evaluation of project supported activities by Village Health Committees, which include male and female representation from the community.

69. The social safeguards documents adopted and disclosed in 2014 remain valid and relevant. Social safeguards requirements will apply to activities supported by state government parallel financing in support of the project.

F. Environment (including Safeguards)

70. The project has been classified as Category B under the World Bank's Operational Policy on Environmental Assessment (OP 4.01). An Environmental Assessment was undertaken, including secondary information review, field visits to health services, and stakeholder consultations. The primary finding was that there is a need to improve biomedical waste management practices. This has been addressed under the Environment Management Plan developed for the project. Another finding of the assessment was that most health facilities have poor access to sanitation facilities and are dependent on natural water springs for their water requirements. These springs are typically seasonal, resulting in water shortages. These issues will be addressed by project investments under Component 2. The Environmental Assessment and

Management Plan were adopted by the state government and publicly disclosed on November 22, 2014. These safeguards documents remain valid and relevant.

71. The project has also been screened for climate and disaster risks and adaptation mitigation co-benefits have been estimated, stemming from its renewable energy as well as water and sanitation investments.

72. Health care waste management is governed by the Government of India's biomedical rules. The project's Environmental Management Plan includes management measures and associated guidelines in line with these rules, along with plans for training, communication, and monitoring. A budget is provided by the project for implementation. To ensure effective implementation of the Environmental Management Plan, the Department of Health and Family Welfare will designate a state-level nodal officer and define related responsibilities of selected officials at the district and facility levels. A state-level working group will be established with representation from the Department of Health and Family Welfare, municipal corporations, Village Health Committees, and the Nagaland Pollution Control Board. The Environmental Management Plan includes half-yearly internal and annual external monitoring.

73. The environmental safeguards documents adopted and disclosed in 2014 remain valid and relevant. Environmental safeguards requirements will apply to activities supported by state government parallel financing in support of the project.

G. World Bank Grievance Redress

74. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

Annex 1: Results Framework and Monitoring

Country: India

Project Name: Nagaland Health Project (P149340)

Results Framework

Project Development Objective			
PDO Statement			
To improve health services and increase their utilization by communities in targeted locations in Nagaland.			
These results are at	Project Level		
Project Development Objective Indicators			
		Target Values	
Indicator Name	Baseline (2015)	Mid-project	End Target
1. Community health workers (ASHAs) in targeted communities supplied with complete kits (Percentage)	0	30	70
2. Targeted health facilities with at least one functional handwashing facility with running water (Percentage)	31	40	70
3. Children age under one year registered for immunization in targeted communities whose growth was recorded at least twice in the previous six months (Percentage)	6	20	40
3.a. Female children age under one year registered for immunization in targeted communities whose growth was recorded at least twice in the previous six months (Percentage)	6	20	40
4. Children ages 9-11 months registered for immunization in targeted communities who have received all recommended immunizations (Percentage)	40	50	60
4.a. Female children ages 9-11 months registered for immunization in targeted communities who have received all recommended immunizations (annual rate) (Percentage)	40	50	60
5. Mothers who delivered in the previous 6 months in targeted communities who had at least 3 antenatal care check-ups (Percentage)	55	65	75
Intermediate Results Indicators			
		Target Values	

Indicator Name	Baseline (2015)	Mid-project	End Target
1. People who have received essential HNP services (Cumulative number)	0		
2. Target villages where a village health and nutrition day was organized in the previous month (Percentage)	14	30	50
3. Births in targeted communities in the previous year for which birth certificates were issued (Percentage)	0	20	30
3.a. Female births in targeted communities in the previous year for which birth certificates were issued (Percentage)	0	20	30
4. Targeted Village Health Committees that have received training (Percentage)	0	30	70
5. Targeted Village Health Committees that received Health and Nutrition Incentives in the previous year (Percentage)	0	20	70
6. Targeted Village Health Committees with a female co-chair (Percentage)	0	20	70
7. Targeted health facilities with at least one functional flush or pour-flush toilet (Percentage)	46	60	70
8. Targeted health facilities with electricity supply improved by the project (Cumulative number)	0	20	100
9. A procurement manual based on National Health Mission guidelines is adopted by the Department of Health and Family Welfare and staff are trained on its use (Yes/No)	No	Yes	Yes
10. A common database, integrated with the Health Management Information System, records all service delivery data reported by health facilities (Yes/No)	No	No	Yes
11. Citizens and/or communities involved in planning/implementation/evaluation of development programs (Yes/No)	No	Yes	Yes

Indicator Description

Project Development Objective Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
1. Community health workers (ASHAs) in targeted communities supplied with complete kits (Percentage)	Numerator: number of community health workers (ASHAs) in targeted communities supplied with complete kits; denominator: all community health workers (ASHAs) in communities targeted by the project	Biannual	Routine reporting	Department of Health and Family Welfare
2. Targeted health facilities with at least one functional handwashing facility with running water (Percentage)	Numerator: number of targeted health facilities with at least one functional handwashing facility with running water; denominator: total number of health facilities targeted by the project	Biannual	Routine reporting	Department of Health and Family Welfare
3. Children age under one year registered for immunization in targeted communities whose growth was recorded at least twice in the previous six months (Percentage)	Numerator: number of children age under one year registered for immunization in targeted communities whose growth was recorded at least twice in the previous six months; denominator: total number of children age under one year registered for immunization in communities targeted by the project	Biannual	Routine reporting	Department of Health and Family Welfare
3.a. Female children age under one year registered for immunization in targeted communities whose growth was recorded at least twice in the previous six months (Percentage)	Numerator: number of female children age under one year registered for immunization in targeted communities whose growth was recorded at least twice in the previous six months; denominator: total number of female children age under one year registered for immunization in communities targeted by the project	Biannual	Routine reporting	Department of Health and Family Welfare
4. Children ages 9-11 months registered for immunization in targeted communities who have received all recommended immunizations (Percentage)	Numerator: number of children ages 9-11 months registered for immunization in targeted communities who have received all recommended immunizations; denominator: total number of children ages 9-11 months registered for immunization in targeted communities (calculated as an annual rate)	Annual	Routine reporting	Department of Health and Family Welfare
4.a. Female children ages 9-11 months registered for immunization in targeted communities who have received all recommended immunizations (Percentage)	Numerator: number of female children ages 9-11 months registered for immunization in targeted communities who have received all recommended immunizations; denominator: total number of female children ages 9-11 months registered for immunization in communities targeted by the project (calculated as an annual rate)	Annual	Routine reporting	Department of Health and Family Welfare

5. Mothers who delivered in the previous 6 months in targeted communities who had at least 3 antenatal care check-ups (Percentage)	Numerator: number of mothers who delivered in the previous 6 months in targeted communities who had at least 3 antenatal care check-ups; denominator: total number of mothers who delivered in the previous 6 months in targeted communities	Biannual	Routine reporting	Department of Health and Family Welfare

Intermediate Results Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
1. People who have received essential HNP services (Cumulative number)	Cumulative number of people who have received HNP services delivered by targeted health facilities	Annual	Routine reporting	Department of Health and Family Welfare
2. Target villages where a village health and nutrition day was organized in the previous month (Percentage)	Numerator: number of targeted villages where a village health and nutrition day was organized in the previous month; denominator: total number of targeted villages	Biannual	Routine reporting	Department of Health and Family Welfare
3. Births in targeted communities in the previous year for which birth certificates were issued (Percentage)	Numerator: number of births in targeted communities in the previous year for which birth certificates were issued; denominator: total number of births in communities targeted by the project	Annual	Routine reporting	Department of Health and Family Welfare
3.a. Female births in targeted communities in the previous year for which birth certificates were issued (Percentage)	Numerator: number of female births in targeted communities in the previous year for which birth certificates were issued; denominator: total number of female births in communities targeted by the project	Annual	Routine reporting	Department of Health and Family Welfare
4. Targeted Village Health Committees that have received training (Percentage)	Numerator: number of targeted Village Health Committees (and Sub-Center and Health Center Management Committees) that received training (cumulative since the start of the project); denominator: total number of Village Health Committees (and Sub-Center and Health Center Management Committees) targeted by the project	Quarterly	Routine reporting	Department of Health and Family Welfare
5. Targeted Village Health Committees that received Health and Nutrition Incentives in the previous year (Percentage)	Numerator: number of targeted Village Health Committees (and Sub-Center and Health Center Management Committees) that received Health and Nutrition Incentives in the previous year; denominator: total number of Village Health Committees (and Sub-Center and Health Center Management Committees) targeted by the project	Annual	Routine reporting	Department of Health and Family Welfare

6. Targeted Village Health Committees with a female co-chair (Percentage)	Numerator: number of targeted Village Health Committees (and Sub-Center and Health Center Management Committees) with a female co-chair; denominator: total number of Village Health Committees (and Sub-Center and Health Center Management Committees) targeted by the project	Biannual	Routine reporting and monitoring	Department of Health and Family Welfare
7. Targeted health facilities with at least one functional flush or pour flush toilet facility (Percentage)	Numerator: current number of targeted health facilities with at least one functional flush or pour flush toilet facility; denominator: total number of health facilities targeted by the project	Biannual	Routine reporting	Department of Health and Family Welfare
8. Targeted health facilities with electricity supply improved by the project (Cumulative Number)	Number of targeted health facilities for which the project has improved electricity supply	Biannual	Routine reporting	Department of Health and Family Welfare
9. A procurement manual based on National Health Mission guidelines is adopted by the Department of Health and Family Welfare and staff are trained on its use (Yes/No)	Adoption of a procurement manual and training on its use	Biannual	Routine reporting	Department of Health and Family Welfare
10. Common database, integrated with the Health Management Information System, recording all service delivery data reported by health facilities (Yes/No)	Existence of a common database, as part of the Health Management Information System, recording all service delivery data reported by health facilities	Biannual	Routine reporting	Department of Health and Family Welfare
11. Citizens and/or communities involved in planning/implementation/ evaluation of development programs (Yes/No)	This is a recommended indicator of citizen engagement. It will reflect planning and implementation by Village Health Committees that include male and female community members.	Biannual	Routine reporting	Department of Health and Family Welfare

Annex 2: Detailed Project Description

INDIA: Nagaland Health Project

Objectives

1. The PDO is to improve health services and increase their utilization by communities in targeted locations in Nagaland.

Component 1. Community Action for Health and Nutrition (estimated cost US$18 million)

2. A 2014 World Bank assessment found that the communitization policy holds significant potential to improve local management and accountability of health services. The assessment found that a number of issues will need to be addressed, starting with improving the knowledge and capacities of the committees, as well as ensuring that mandated representation by women is implemented. This component is designed to empower communities to oversee, manage, and improve health services as well as undertake health and nutrition-related activities that are priorities for them. An incentive strategy will be used whereby funding will be provided to communities on the basis of progress on defined indicators of improved health and nutrition-related services and practices. In turn, communities will use the incentives for activities and investments that are important to them and have potential impacts on health and nutrition.

3. The component will have a major focus on knowledge and skill building of Village Health Committees and other stakeholders at the community level, including women's groups and Village Councils. Village Health Committees will be supported in identifying existing gaps, determining the most suitable approaches to address these gaps, developing action plans, and operationalizing those plans. Toward this end, facilitators will be placed in each district to work closely with the Village Health Committees in the facility catchment area. The capacity of the Department of Health and Family Welfare to implement and institutionalize this strategy will be developed, by ensuring that district-level staff are closely engaged in implementation of this component.

4. Funding will be provided to targeted committees that meet preconditions reflecting a minimum level of capacity and interest, including constitution of the committee according to government guidelines,[6] having a woman co-chair of the committee, developing a village health and nutrition action plan endorsed by the Village Council, and opening a dedicated bank account. On attainment of the preconditions, an Incentive Agreement will be signed between the Village Health Committee and the Department of Health and Family Welfare, formalizing the community's participation in this program.[7]

[6] Notably, in the case of committees managing health facilities, this would include having representation from villages other than the one in which the facilities are located (which currently rarely happens).

[7] Committees responsible for health facilities are termed 'Sub-Center Management Committees (for Sub-Centers) and 'Health Center Management Committees' (for Primary Health Centers and Community Health Centers). The term 'Village Health Committee' will be used here to encompass the various types of committees.

5. Subsequent biannual incentives will be determined by progress on a set of indicators relating to health and nutrition services and practices. Indicators are adapted for the level targeted (village, Sub-Center, Primary Health Center, or Community Health Center). Indicators chosen for the first phase of implementation relate to antenatal care, postnatal care, delivery services, birth registration, child health and nutrition services, behavior change communication efforts, and support to health service delivery (table 2.1). As part of development of their health and nutrition action plans, Village Health Committees will determine targets for relevant indicators and achievement of targets will be tied to incentives received under the program. Indicators and targets will be revised based on implementation experience.

Table 2.1. Indicative Indicators Linked to incentives

1	Number of community awareness-building activities on health, nutrition, sanitation, or related issues
2	ASHA worker kit is complete
3	Monthly village health and nutrition days held by *Asha* and *Anganwadi* workers and including growth monitoring
4	% births in the village in the last six months for which a birth certificate was issued
5	% pregnant women who received at least 3 antenatal care checkups
6	% pregnant women whose pregnancy was registered and who received a Mother Child Tracking card
7	% new mothers who received a conditional cash transfer (*Janani Suraksha Yojana*)
8	% of newborn who were weighed by an ASHA or other health staff within first 24 hours of birth
9	% of children under 1 year who have received all recommended vaccinations

6. Tools and training will be provided to Village Health Committees to enable them to monitor and track progress. Committees will record progress along the set of indicators on a monthly basis to enable them to keep track of their achievements and take required corrective action. The monthly reports will also be shared with the department to enable timely feedback and support to the committees. Committees will also prepare biannual reports, reporting on the status of indicators in relation to the agreed biannual targets according to the action plan. The reports, submitted to the department, will be verified by the district facilitators before incentives are released to the committee. Progress of key indicators will also be shared with Village Councils. Incentive amounts earned by committees may vary depending on the extent to which indicators have shown improvement and targets achieved. Committees that do not show progress will be encouraged and supported to earn incentives in the subsequent six months.

7. The project's district coordinators will be responsible for verifying biannual progress reports submitted by the Village Health Committees, before sending them to the Project Management Unit for action. Verification will take the form of spot-checks of records at the village and facility levels. The Project Management Unit will release funds directly into the bank accounts of Village Health Committees if results have been achieved. In addition, contracted consultants will independently assess reported results, including through periodic sampling of beneficiaries, as well as the use of financial incentives by the committees.

8. Average funds to be received by committees need to be significant enough to attract their interest and commitment as well as to finance initiatives with potential impact. However, the program also needs to retain the potential for sustained financing at scale by the state government after the end of the project. Taking these factors into account, on average annual incentives are anticipated to range from US$2,600 (INR 164,000) for a Village Health Committee not responsible for a health facility to US$16,000 (INR 1 million) for a committee

responsible for a Community Health Center. Incentive amounts will be regularly reviewed and revised based on implementation experience. Committees will be empowered to use this financing for health and nutrition-related activities that are priorities to them, including investments designed to improve performance in future rounds. The committees will be provided a broad positive list and a specific negative list of potential activities. Examples of activities that could be funded by incentives include improving health facility infrastructure; incentivizing health staff; contracting additional staff; filling gaps in supplies and equipment; and encouraging behavior change in areas of health, nutrition, and hygiene. Committees will be encouraged to leverage resources from other potential sources, such as village development funds.

9. The first phase will focus on 1 Community Health Center in each of two districts, including, in their catchment areas, 1 Primary Health Center, 3 Sub-Centers and 17 villages. Experience from setup and implementation of the necessary systems will inform subsequent phased scale-up to all facilities and communities targeted by the project. Scale-up will start on a strict time frame of 12 months after the start of the first phase, a period that should be sufficient to obtain the necessary experience with implementation systems and processes.

Component 2. Health System Development (estimated cost US$42 million)

10. This component will support improvements in the management and delivery of health services, including both facility-specific and system-wide investments.

Subcomponent 2.1. Investments to Improve Service Delivery Conditions at Targeted Health Facilities (estimated cost US$17 million)

11. The project will finance investments to improve conditions for staff and patients in targeted health facilities, with the intention of contributing to improved staff motivation, better quality services, and greater demand for services.

12. **Reliable electricity supply.** Uninterrupted electricity at targeted health facilities will contribute to improved working conditions and better quality services that are more attractive and accessible to the population. A 2014 World Bank assessment of 24 health facilities found that 18 experienced power cuts of 12–18 hours per day, while 1 had power cuts of more than 18 hours. None of the facilities had grid power supply for more than 18 hours. A 2012 government report indicated that 44 percent of Sub-Centers and 14 percent of Primary Health Centers in Nagaland do not have electricity supply, significantly higher than the national figures of 25 percent and 8 percent, respectively.[8] In this situation, basic lighting is not reliable, while electrical equipment often cannot be operated. Indeed, in comparison with equipment standards outlined by the Indian Public Health Standards, there is a lack of medical equipment and lighting infrastructure in health facilities across Nagaland. This can partly be attributed to the lack of reliable electric power supply. In one District Hospital that was assessed, a medical imaging machine had been installed five years previously but never used due to the lack of power. Similarly, refrigerators, water purifiers, and other equipment are underutilized. Although some facilities have diesel generator sets, they are for the most part not used due to lack (and cost) of

[8] Ministry of Health and Family Welfare. 2012. "Rural Health Statistics in India 2012."

fuel. Lack of electrical power undermines working conditions for staff, service quality, and the attractiveness and accessibility of health services to the population.

13. The project will invest in off-grid power solutions that will be adapted to the needs of each facility to ensure a basic level of functioning (that is, for lighting and high-priority equipment), acting as a backup when grid power is not available. In larger facilities, (Primary Health Centers, Community Health Centers and District Hospitals), solar energy technology will be installed, while smaller facilities, particularly Sub-Centers, will require battery and inverter systems that can be charged by the grid when it is available. Peak energy needs (such as for some types of equipment with high power demand such as x-ray machines) cannot be met by off-grid solutions alone and so a combination of electricity from the grid and existing diesel generation sets will be used. Analysis of solar energy potential in Nagaland concludes that it is a cost-effective option, with only 20 percent lower potential than locations receiving high solar energy such as Gujarat or Rajasthan. At the same time, considering the low cost to the user (that is, the health facility) of grid power, solar energy investments are cost-effective as a backup but not as a replacement to the power grid. The project will also support installation of solar water pumps and water heaters in targeted health facilities. In Sub-Centers, the project will invest in backup power capacity to ensure operation of, along with lighting and water heaters, infant warmers (in Sub-Centers where deliveries are done) and freezers or refrigerators (for the vaccine cold chain). In Primary Health Centers, solar power systems will ensure backup electricity for the equipment necessary for a labor ward and operating theater. In Community Health Centers and District Hospitals, in addition to labor ward and operating theater equipment, backup power will be needed for x-ray machines.

14. During the first phase of implementation, investments will be made in 14 health facilities for which detailed technical requirements were assessed under World Bank technical assistance. On the basis of planned technical assessment of the remaining target facilities (around 160), the second phase of investment will be supported by the project, benefiting from implementation experience and lessons learned during the first phase. In each phase, the project will procure, through a competitive process, suppliers who will ensure supply and installation of equipment, repairs and maintenance, as well as necessary training. Training of health workers and Village Health Committees will foster their support to the ongoing operations and maintenance.

15. **Improved water supply and sanitation.** Better water and sanitation facilities in health facilities will similarly contribute to improved working conditions, service quality, and patient demand—for example, clean and accessible toilets can help reduce barriers to access to health services, in particular for women and girls. Indeed, health facilities should stand as best-practice examples to the community for cleanliness and hygiene. Despite the apparent abundance of water, particularly during the monsoon season, the settlement pattern in the state, with villages perched on hilltops, constrains accessibility of water sources, so that most households are dependent on water piped varying distances from upland surface sources (such as streams and springs) fed by constrained rainfall catchment areas. A 2014 World Bank assessment of 33 health facilities found that only 4 had adequate running water for washbasins and only 3 had water connections for toilets. Most (27) facilities relied on water piped from streams, while 11 facilities experienced seasonal water shortages. Only a few facilities had water supply arrangements needed for good hygienic conditions for patients and staff (that is, functional water connections to washbasins and toilets). A 2012 government report indicated that 51 percent of

Sub-Centers and 16 percent of Primary Health Centers in Nagaland did not have regular water supply, compared to the national figures of 26 percent and 11 percent, respectively.[9] With regard to sanitation, the assessment found that only a few facilities had toilets with running water connections; at the same time, although many toilets were clean and functional, a good number were poorly maintained or not in use. In all facilities, toilets are connected with buried septic tanks or pits, although these are not emptied and there are no evident arrangements for waste treatment or filtering. It should be noted that unlike other types of public facilities (such as schools), there are no specific provisions for health facilities in national water and sanitation development programs.

16. The project will invest in improved water supply in targeted health facilities. This will entail repair and upgrading of piping and storage facilities linked to existing water supplies, as well as installation of roof water harvesting systems (which may act as the main water source for small facilities such as Sub-Centers and as a backup for larger facilities). This work will include ensuring water supply to washbasins and toilets. Improvements to sanitation facilities will also include upgrading septic tanks, such as anaerobic filter installations, and putting in place the necessary plumbing connections to discharge wastewater from sinks, toilets, and drains to the improved septic tanks.

17. The first phase of implementation will involve water supply and sanitation investments in 27 health facilities that were assessed under World Bank technical assistance. Technical assessment of the remaining facilities (around 150) will be followed by a subsequent phase of investment that will be informed by the first phase. Along with repair, upgrading, and installation work, the project will support capacity building of health staff and facility committees for them to take up their responsibilities for ongoing operations and maintenance. It is well understood that investment in infrastructure is not enough to ensure better hygienic conditions. The project will support behavior change communication, targeting committee members and health staff, as well as patients and their families, to encourage effective maintenance, cleaning, and use of handwashing and toilet facilities.

Subcomponent 2.2. Development of Health System Components (estimated cost US$25 million)

18. The project will support development of key components of the health system intended to improve the management and effectiveness of government health services in Nagaland.

19. **Supply chain management system.** Currently, procurement and supply chain management in the government health system in Nagaland is characterized by manual processes, lack of trained staff, poor storage infrastructure, insufficient procedures, and resulting irregular supply of medicines and consumables. The project will support development and implementation of systems and processes, including defining roles and responsibilities, establishing procurement procedures, putting in place a planning and ordering system, developing a quality assurance system, and developing an inventory management and distribution system. This will include support to operationalization of relevant policy, notably the Nagaland Medicines and Diagnostics Policy (2013). The project will support establishment of a centralized unit within the Department

[9] Ministry of Health and Family Welfare. 2012. "Rural Health Statistics in India 2012."

of Health and Family Welfare with responsibility for procurement and supply chain management. The organizational structure, with job descriptions for all staff involved in supply chain management, will be clearly defined. The project will support training programs to develop the capacities of staff at the various levels. The project will finance improvements in storage infrastructure as well as equipment for inventory management. Procedures will be developed and training conducted for warehouse management.

20. **ICT.** The project will finance ICT investments to support improvements in several aspects of management of the government health system in Nagaland. This work will reflect lessons from initiatives in India and elsewhere that emphasize the importance of establishing a single interoperable platform on which priority applications can be developed, avoiding discrete and uncoordinated investments. The project will therefore support development of such a platform, to which several high-priority applications will be linked. Technical assistance during project preparation identified the following areas for ICT investment: (a) supply chain management, including planning, ordering, monitoring, and management of medicines, consumables, and equipment; (b) financial management, enabling faster approvals and improved budgetary processes and expenditure tracking; (c) human resource management, including career progression, posting, and training management, as well as payroll and leave processing; (d) health management information system, including reducing the reporting burden on frontline health staff through the use of mobile applications for program data collection and beneficiary tracking; and (e) mobile applications to enhance the reach of health behavior change communication initiatives. Implementation will be contracted out to a single service provider to ensure coherence of the different systems and applications.

21. **Health human resource strategy.** As part of technical assistance to the state, the health human resource situation in Nagaland was examined, with a focus on retention of skilled staff in rural areas. An important constraint that became clearly evident is the state government's freeze on creation of new posts in the state health services. This has limited the number of regular staff positions and increased reliance on contractual health workers. Interviews with a variety of health workers and students revealed that motivations for rural service are often personal and family related. Challenges include difficult working and living conditions, irregular pay or lack of pay parity (such as between regular and contractual staff), lack of job security for contractual staff, limited career trajectories, and irrational or unclear posting and transfer practices. Suggestions from health workers include improvements in living and working conditions, clearer career paths, regular and timely payments to health workers, creation of more regular posts, and a transparent posting and transfer policy. In particular, a policy of regularly rotating health workers between hardship and non-hardship postings was recommended to improve rural retention in the state. In Nagaland, financial incentive policies are in place for rural workers, although not uniformly across cadres. Based on this situation analysis, during the first phase the project will support development of a medium-term health human resource strategy for the state, including necessary technical work. The strategy will address key constraints mentioned earlier, including improved human resource management systems. Once adopted by the state government, the project will then finance implementation of relevant components of the strategy.

22. In addition, the project will provide technical support (through consultancy services) for development of a medical college in the state capital of Kohima. There is currently no medical college in the state, which has contributed in particular to a lack of specialist physicians. In 2014,

the World Bank provided non-lending technical support to development of a plan to establish the state's first medical college. The state government's parallel funding in support of the project will focus on supporting higher-level human resources necessary for development of the medical college, estimated to cost approximately US$3 million in state government financing over the project implementation period. The project will not support civil works or other capital investments for development of the medical college.

23. **Other investment requirements.** Flexibility will be retained for the project to support other priority investment requirements that cannot be met from other sources. Technical assessment and World Bank concurrence will be required for such activities to be included in the project's annual budget and work plan. During initial implementation, detailed technical assessments of health facilities to define bills of quantities for procurement of energy and water and sanitation investments under Subcomponent 2.1 will also identify other gaps in health service capacity. These will include minor repairs and rehabilitation, as well as medical equipment and supplies, necessary for effective delivery of health services necessary for achievement of the PDO. The state government's parallel funding in support of the project will also be used to fill such gaps, estimated at around US$9 million in state government financing over the project implementation period.

24. **Monitoring and evaluation.** Health facility and household surveys will be done at the start of the project, mid-project, and near the end of the project. These will provide a basis for impact evaluation of the project and will also improve knowledge of health and nutrition services and factors influencing HNP outcomes more broadly in the state. The project will also support punctual evaluations and studies as needs arise.

25. **Project management.** The project will finance under this component the costs of the Project Management Unit (excluding salaries of state government employees), a consultant firm to provide technical and management support, and other consultants.

Annex 3: Implementation Arrangements

INDIA: Nagaland Health Project

Project Institutional and Implementation Arrangements

1. The project will be implemented by the Department of Health and Family Welfare, Government of Nagaland. Through Notifications dated April 14 and 23, 2014, the state government created the Project Steering Committee, Project Executive Committee, and Project Management Unit.

2. The Project Steering Committee is chaired by the chief secretary, with members including commissioners and secretaries from relevant state government departments, including the Departments of Health and Family Welfare, Finance, Planning, Administration, Forests and Environment, New and Renewable Energy, Rural Development, and Social Welfare. The Project Steering Committee has overall responsibility for the project, acting as authorizing authority for project activities, budgets, and procedures. It will approve annual project plans and budgets, review regular reports on implementation progress, take necessary measures to ensure timely implementation, including necessary financial and legal approvals, and ensure coordination and consultation with state government departments, local authorities, and other stakeholders. The Project Steering Committee approves any modifications to the Project Operational Manual and is responsible for ensuring that all fiduciary, technical, and safeguards requirements specified in the Project Agreement and Project Operational Manual are fulfilled, including implementation and review of annual audits.

3. The Project Executive Committee is chaired by the commissioner and secretary, Department of Health and Family Welfare, with membership composed of the senior leadership of the Department of Health and Family Welfare. The committee is responsible for routine and timely reviews and approvals of project activities, including approvals of staffing, consultants, contracts, and payments, in accordance with the procedures specified in the Project Operational Manual. The Project Executive Committee will ensure coordination across the Department of Health and Family Welfare, including at the district, health facility, and village levels, as well as regularly monitor implementation of the project, including technical, fiduciary, and safeguards aspects.

4. The Project Management Unit, with a senior officer of the Department of Health and Family Welfare as the project director, will implement the project, including developing work plans and budgets; ensuring the technical design and quality of project-supported activities (including developing and reviewing technical specifications, terms of reference, technical proposals, and other relevant documents); reporting on project implementation; and coordinating and consulting across the Department of Health and Family Welfare and other departments as well as with local authorities, community groups, and other stakeholders. The Project Management Unit will be responsible for implementation of financial management, procurement, and safeguards requirements and procedures as set out in the Project Operational Manual. The Project Management Unit will have approximately 10 staff, including a project director, deputy project director, and state government officials (on deputation or additional charge) and consultants responsible for financial management, procurement, safeguards, monitoring and

evaluation, and technical areas including public health, community mobilization, information technology, and others. Under Component 2, a contracted consultant firm will provide technical and management support to the Project Management Unit. It is expected to contribute to scaled-up activities under phase 2 of the project.

5. In addition, when required, the Department of Health and Family Welfare will set up working groups involving technical-level members from relevant state government departments, to provide support on project activities that require coordination across sectors. Initially, the following working groups will be constituted: (a) community mobilization; (b) water and sanitation; (c) off-grid energy; and (d) environmental management. The areas of focus and constitution of working groups may be modified during the course of project implementation as needs change.

6. At the district level, chief medical officers will contribute to implementation and monitoring of the project, supported by 11 district coordinators who will have full-time responsibilities related to the project. At the health facility level, staff of the Department of Health and Family Welfare will similarly contribute to relevant project activities under the direction of chief medical officers and the hierarchy of the Department of Health and Family Welfare.

7. Under the Nagaland Communitization of Public Institutions and Services Act, 2002, Village Councils were empowered to constitute Village Health Committees "to protect and promote the health and well-being of the people," by exercising responsibilities in four main areas: (a) management of health centers (including administrative, technical, and financial matters); (b) preventive health care; (c) promotion of indigenous medicine; and (d) mobilization of local resources. In villages where Sub-Centers are located, Common Health Sub-Center Committees were constituted, including representation from Village Health Committees in the Sub-Center catchment area (although in practice this representation is not in place in many cases). For Primary Health Centers and Community Health Centers, Health Center Management Committees were constituted, also with the intention that villages in the facility catchment area are represented. The committees are composed of a chairperson (selected by the Village Council), three members of the Village Council, the secretary of the Village Development Board, members of the village women's group (*Mahila Sangh*), health workers, the local *Anganwadi* worker, and one or more co-opted members.[10] In the case of Common Health Sub-Center Committees and Health Center Management Committees, the medical officer or senior nurse working at the local health facility is the member-secretary. Guidelines indicate that the committees are to have a three-year tenure and meet at least once every quarter. These committees will receive incentives and implement activities under Component 1.

8. The project will contract consultants to support implementation of Component 1 at the local level. This will involve capacity building, facilitation, and monitoring of the incentive strategy at the community level. The facility-level committees and Village Health Committees in

[10] Village Councils have been constituted under the Nagaland Village and Area Council Act, 1978, in every recognized village, with overall authority and responsibility to, among others, formulate village development plans and support implementation government development programs at the village level.

their catchment areas will receive support, including for preparation of health and nutrition action plans, which is one of the pre-conditions for participation in the program.

Financial Management and Disbursement

9. The project will be implemented by the Department of Health and Family Welfare, Government of Nagaland. Under the administration of the project director, a Project Management Unit has been established for carrying out project activities. The finance wing of the Project Management Unit is headed by an experienced finance officer, deputed from the Department of Health and Family Welfare, and will be responsible for all financial management functions. A financial management consultant will provide support on financial management functions. The Project Management Unit will have the overall responsibility of maintaining the financial management system and ensuring that these functions are carried out in accordance with the project's legal agreements. These activities will include (a) adequate annual budgetary provision and effective utilization; (b) sufficient and timely flow of funds for project activities; (c) maintenance of adequate and competent financial management staff; (d) appropriate accounting of project expenditures; (e) preparation and timely submission of interim financial reports; and (f) timely submission of audit reports and project financial statements to the World Bank.

10. **Budgeting.** The project's funding requirements will be provided within the state budget of the Department of Health and Family Welfare as a separate budget line under Externally Aided Project. A separate budget head has been opened for the project and, based on the annual work plans developed by the Project Management Unit and approved by the Project Steering Committee, yearly budget provisions will be approved by the state Finance Department. The Project Management Unit will ensure the adequacy of budget provision throughout project implementation.

11. **Funds flow and disbursement.** Given the weak financial position of the state, significant delays are currently experienced in processing payments through the state treasury. It has therefore been agreed to ring-fence the funds flow arrangement from the state treasury to the Department of Health and Family Welfare. The Project Management Unit has opened a separate bank account for the project. The applicable disbursement method will be 'reimbursement'. The state government will use its budgetary resources to finance project expenditures. The project will submit quarterly interim financial reports to the Aid, Accounts, and Audit Division (Controller of Aid, Accounts, and Audit) of the Department of Economic Affairs, Ministry of Finance, Government of India. These financial reports will be submitted by the Controller of Aid, Accounts, and Audit to the World Bank for seeking reimbursement of project expenditures.

12. **Finance staffing and training.** The Finance wing of the Department of Health and Family Welfare is presently headed by a senior finance officer deputed to the project who has rich experience in handling government accounting and financial management matters. In addition to administering financial management for the state government health system, this officer supervises financial management of national programs (such as National Health Mission and National AIDS Control Program). The finance officer will report to the project director and will ensure that agreed financial management arrangements are carried out. The Project Management Unit has hired an additional financial management consultant on a contract basis to

support financial management functions. Additionally, under Component 2, a consultant firm will be contracted to provide support to the Project Management Unit on technical, procurement, and financial management issues. Sufficient training will be provided to the finance staff on financial management and the World Bank's disbursement policies and procedures.

13. **Accounting and internal controls.** The project will follow cash-basis accounting for recording project expenditures. The accounting and procurement function will be centralized at the Project Management Unit. Payments will be made by the Project Management Unit for activities relating to (a) construction of works; (b) procurement of goods; (c) consulting services and nongovernmental organization activities; (d) training and capacity-building programs; and (e) incentives to Village Health Committees and Sub-Center and Health Center Management Committees under Component 1. Receipts and payments will be periodically reconciled with the state treasury and bank account statements. Separate books of accounts will be maintained for the project. The Project Management Unit will purchase an off-the-shelf accounting system for recording financial transactions. The chart of accounts will be appropriately developed to classify project expenditures based on project components/major activities.

14. Incentives to Village Health Committees (including Sub-Center and Health Center Management Committees) under Component 1 will be directly deposited by the Project Management Unit into separate bank accounts created for this purpose by the committees. Incentive Agreements will be signed between the Project Management Unit and eligible Village Health Committees to govern the provision of incentives and their use. Village Health Committees will be identified and selected in accordance with criteria described in the Project Operational Manual approved by Project Executive Committee and World Bank. Village Health Committees will use this financing for activities with an impact on health and nutrition within guidelines set out in the Project Operational Manual. The committees will maintain cash books and registers to record financial transactions. At the district level, the office of the chief medical officer and the project's district coordinators will monitor activities and ensure that expenditure reports are periodically submitted to Project Management Unit.

15. After initial start-up funding, incentives to community-level committees will be conditional on achievement of certain agreed indicators and targets. Results will be verified by the project's district coordinators. In addition, contracted consultants will independently assess reported results, including through periodic sampling of beneficiaries, as well as the use of financial incentives by the committees.

16. **Financial reporting.** Interim financial reports (format attached to the Disbursement Letter) will be prepared by the Project Management Unit from information generated by an off-the-shelf accounting software. Interim financial reports will be submitted to the World Bank within 45 days from the end of each calendar quarter and will provide information on the sources and uses of funds according to disbursement categories and project components.

17. Interim financial reports will form the basis of disbursement. Eligible expenditures under Component 2 will be expenditures incurred by the Project Management Unit for civil works, goods, consultant services, training, and operating costs. Eligible expenditures under Component 1 will be incurred by the Project Management Unit for consultant services and incentives released by the Project Management Unit to Village Health Committees (including Sub-Center

and Health Center Management Committees). At the end of the project, incentive proceeds that have remained unspent in the bank accounts of committees will be either refunded to the World Bank or adjusted by the Project Management Unit from the final eligible claims to be submitted to the World Bank.

18. **Internal audit.** The internal audit for the project will be conducted by the Directorate of Treasuries and Accounts, Government of Nagaland. The terms of reference for internal audit will be agreed in the first year of project implementation. The audit will review accounting and internal control processes adopted by the Project Management Unit in executing payments. Additionally, it will provide comments on procurement and contract management functions adopted by the Project Management Unit in awarding contracts. Audits will be conducted annually and will provide feedback to management on control weaknesses and issues that require management attention. The internal audit reports along with the corrective actions taken by the project to address control weaknesses (if any) will be shared with the World Bank.

19. **External audit.** The CAG will be the external auditor for the project. The CAG's office will conduct an annual audit of project financial statements covering sources and uses of funds. The audit will be conducted according to terms of reference agreed with the World Bank, and the audit report will be submitted within nine months from the close of each financial year. The audit report for expenditures incurred under the Project Preparation Advance and retroactive financing will be combined with the first year audit report. The annual audit report will consist of (a) audit opinion; (b) project financial statements; and (c) management letter highlighting weaknesses, if any. Table 3.1 lists the audit reports that will be monitored.

Table 3.1. Audit Reports

Implementing Agency	Audit Report	Auditor	Due Date
Project Management Unit, Department of Health and Family Welfare, Government of Nagaland	Audit report and project financial statements	CAG of India	December 31 of each year

20. **Supervision plan.** Given the innovative nature of project activities such as incentives to communities and the fact this is the first World Bank-financed project to be directly implemented by the state government, the financial management risk of the project is assessed as Substantial. The state government is putting in place essential implementation capacities, that is, contracting necessary individuals, firms, and nongovernmental organizations, to support project activities using the Project Preparation Advance. During the first year of project implementation, the World Bank will undertake semiannual implementation support missions, including field visits, to ensure that agreed financial management arrangements, accounting processes, and procedures are appropriately followed. As implementation progresses, it will involve review of financial reports and audit reports.

21. **Retroactive financing.** Payments made by the Project Management Unit on or after November 1, 2015, for contracts awarded following World Bank procurement procedures will be eligible for retroactive financing up to a limit of US$5 million. The Project Management Unit will submit a separate interim financial report to claim such expenditures.

22. **Public disclosure.** Annual audit reports and project financial statements will be disclosed by the Project Management Unit on the website of the Department of Health and Family Welfare.

23. **Disbursement schedule.** IDA funds will be disbursed against eligible expenditures under the following categories subject to allocated amount and disbursement percentages as indicated in table 3.2.

Table 3.2. Disbursement Categories

Category	Amount of the Financing Allocated (US$, millions)	Percentage of Expenditures to Be Financed (Inclusive of Taxes)
(1) Goods, works, non-consulting services, consultants' services, training, and incremental operating costs for the project	32	100%
(2) Health and Nutrition Incentives	15	100% of disbursed amounts
(3) Refund of preparation advance	1	Amount payable pursuant to Section 2.07 of the General Conditions
TOTAL AMOUNT	**48**	

Procurement

24. Procurement for the project will be carried out in accordance with the World Bank's 'Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers', dated January 2011 and revised in July 2014 (Procurement Guidelines) and 'Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers', dated January 2011 (revised in July 2014) (Consultant Guidelines).

25. Component 1 will involve incentives to Village Health Committees, the use of which will be governed by procedures set out in the Project Operational Manual. The Project Operational Manual describes in sufficient detail all procurement arrangements, methods, and procedures including roles and responsibilities of the Village Health Committees.

26. **Procurement capacity.** The Project Management Unit of the Department of Health and Family Welfare will handle all procurement under Component 2, involving procurement of goods, equipment, civil works, and services, as well as procurement of services under Component 1. A procurement consultant has been hired by the Project Management Unit. For scaled-up activities under phase 2 of the project, a contracted firm will provide support to procurement management. The project will also assist the government in strengthening the procurement and supply chain management system for the Department of Health and Family Welfare as a whole.

27. **Procurement arrangements.** For activities under Component 2 (and consultant procurement under Component 1), day-to-day procurement functions (procurement planning and monitoring, coordination with technical staff, reporting and coordination with the World Bank, implementation of procurement risk mitigation plan, and so on) will be filled by the Project Management Unit, headed by a director and including a procurement consultant.

Table 3.3. Perceived Procurement Risks and Mitigation Measures

Risk Factor	Initial Risk	Mitigation Measure	Completion Date	Residual Risk
Limited capacity and inefficiencies resulting in delays in procurement processes	High	Monitoring by the Department of Health and Family Welfare for community-level procurement Use of skilled procurement staff for handling procurement of services Monitoring through the Procurement Plan and quarterly reports (by the Department of Health and Family Welfare and the World Bank) Consultant support to procurement	Continuous from year 1	Substantial
Noncompliance with agreed procurement arrangements (particularly for decentralized procurement)	High	Monitoring by the Department of Health and Family Welfare for community-level procurement Review by independent consultants of the utilization of incentives by Village Health Committees. External/internal procurement audits	Continuous from year 1 (during early phase of incentive cycle)	Substantial
External interference in the procurement process	Substantial	External/internal procurement audits Development and adoption of a code of ethics Disclosure of procurement-related information Appropriate handling of complaints	Continuous from year 1	Substantial
Overall risk	High			Substantial

28. **E-procurement**. An e-procurement system is not currently used by the Department of Health and Family Welfare. However, if needed in the future, e-procurement may be permitted up to the threshold for National Competitive Bidding (NCB) provided the proposed system is assessed and found acceptable by the World Bank.

29. **Monitoring and supervision of procurement.** The Project Management Unit will act as a single point of contact for the World Bank for the purpose of implementing/monitoring the agreed procurement arrangements under the project. The Project Management Unit will prepare a consolidated summary report containing important information on procurement progress. The format for the consolidated report on prior review contracts (which will be submitted to the World Bank on a quarterly basis as part of the interim financial reports) will be agreed with the World Bank. The information received by the Department of Health and Family Welfare (through audit reports or otherwise) and the World Bank's implementation support missions (including post reviews) will be analyzed by the Department of Health and Family Welfare, which will prepare an action plan and take any required corrective measures.

30. **Procurement risk assessment.** Table 3.3 lists major procurement-related risks and the mitigation plan. The risk ratings have been decided based on both the probability of occurrence of various events (including fraud and corruption risks related to procurement) as well as their likely impact. Based on the risk factors and mitigation measures, the overall residual

procurement risk rating for the project is determined as Substantial. The residual rating on procurement will be reviewed and updated periodically by the World Bank.

31. **Methods of procurement.** Table 3.4 lists the procurement methods and thresholds to be used for this project. These methods and thresholds are reproduced in the Procurement Plan. The thresholds provided in the table are for the initial 18 months of implementation; based on the procurement performance of the project, the thresholds may be modified as required. Domestic preference will be applicable for International Competitive Bidding (ICB) procurement of goods according to Appendix 2 of the World Bank's Procurement Guidelines.

Table 3.4. Procurement Methods

Category	Method of Procurement	Threshold (US$ Equivalent)
Goods and non-consultant services	ICB	> 3,000,000
	Limited International Bidding	Wherever agreed by the World Bank
	NCB	Up to 3,000,000 (with NCB conditions)
	Shopping	Up to 100,000
	DC	According to para 3.7 of the Procurement Guidelines
	Force account	According to para 3.9 of the Procurement Guidelines
	Framework agreements	According to para 3.6 of the Procurement Guidelines
	Procurement from United Nations agencies	According to para 3.10 of the Procurement Guidelines
Works	ICB	> 40,000,000
	NCB	Up to 40,000,000 (with NCB conditions)
	Shopping	Up to 100,000
	DC	According to para 3.7 of the Procurement Guidelines
	Force account	According to para 3.9 of the Procurement Guidelines
Consultants' services	Selection based on Consultants' Qualifications/Least-Cost Selection	Up to 300,000
	Single-Source Selection	According to para 3.9–3.11 of the Procurement Guidelines
	Individuals	According to Section V of the Procurement Guidelines
	Selection of Particular Types of Consultants	According to para 3.15–3.21 of the Procurement Guidelines
	Quality- and Cost-Based Selection/Quality-Based Selection/Selection under a Fixed Budget	For all other cases
	(a) International short list	> 800,000
	(b) Short list may comprise national consultants only	Up to 800,000

32. **Incentives to communities (Village Health Committees**). For the use of incentives to support community-level activities under Component 1, procurement at the community level will be done using methods and procedures specified in detail in the Project Operational Manual prepared by the Department of Health and Family Welfare.

33. **Review by the World Bank**. Prior review by the World Bank will be done for the following contracts:

(a) Works: All contracts more than US$10.0 million equivalent

(b) Goods: All contracts more than US$2.0 million equivalent

(c) Services (other than consultancy): All contracts more than US$2.0 million equivalent

(d) Consultancy services: > US$1.0 million equivalent for firms

(e) Consultancy services: > US$300,000 equivalent for individuals

34. In addition, the justifications for all contracts to be issued on Limited International Bidding, Single-Source, or DC basis will be subject to prior review (except those less than US$50,000). In the case of the selection of individuals above the prior review threshold, the qualifications, experience, terms of reference, and terms of employment will be subject to prior review. These thresholds are for the initial 18 months of project implementation; based on the procurement performance of the project, these thresholds may be modified. The prior review thresholds are indicated in the Procurement Plan. The Procurement Plan will be subsequently updated annually (or as required) and will reflect changes in prior review thresholds, if any. The World Bank will carry out an annual ex post procurement review of the procurements falling below the prior review thresholds mentioned earlier. Independent consultants will be contracted by the project to review utilization of incentives by Village Health Committees under Component 1. The terms of reference for this review will be agreed by the World Bank and the Department of Health and Family Welfare.

35. **Frequency of procurement supervision.** The World Bank will normally carry out implementation support mission on a semiannual basis. Mission frequency may be increased or decreased based on the procurement performance of the project.

36. **Use of government institutions and enterprises.** Government-owned enterprises or institutions in India may be hired for tasks of unique and exceptional nature if their participation is considered critical to project implementation. In such cases, the conditions described in clause 1.13 of the World Bank's Consultant Guidelines shall be satisfied and each case will be subject to prior review by the World Bank.

Social (including Safeguards)

37. **Social Assessment.** The assessment for the project underlines (a) the unique sociocultural tradition of Nagaland marked by a large majority of indigenous (tribal) people; (b) a legal-institutional system favorable to community participation; (c) gender and social inclusion needs in the context of a patriarchal social order; (d) varying socioeconomic status of tribal groups; and (e) management of limited involuntary resettlement risks in the context of a unique land tenure system. The Social Assessment concludes that the project carries no risk of major adverse social impacts. The project will largely benefit the tribal population and hence will be aligned with the World Bank's OP 4.10 on Indigenous Peoples. Likely benefits include better health care services

across different parts of the state and across different tiers of health care facilities. This will, in turn, help reduce the burden of illness and the risk of impoverishment due to out-of-pocket payments for health services. A few civil works for improving existing health facilities may involve a low risk of involuntary resettlement, and therefore, OP 4.12 (Involuntary Resettlement) has been triggered. Based on the Social Assessment carried out through stakeholder consultations, a Social Management Framework has been prepared, which includes (a) a Resettlement Policy Framework compliant with OP 4.12; (b) a Tribal Development Plan compliant with OP 4.10; and (c) Gender and Social Inclusion Guidelines.

38. **Resettlement Policy Framework.** Nagaland has a complex land tenure system where 93 percent of the land is privately owned and customary laws govern. The Resettlement Policy Framework provides for (a) purchase of private land required for the project through transparent community-based processes on a willing buyer-willing seller basis and (b) extending rehabilitation assistance to any displaced squatters. The Resettlement Policy Framework provides for preparation and execution of site-specific resettlement action plans by the Department of Health and Family Welfare through the concerned deputy commissioners (Revenue Department).

39. **Tribal Development Plan**. Given that overwhelming majority of the beneficiaries are tribals, OP 4.10 has been mainstreamed into the project design, emphasizing (a) free, prior, and informed consultation; (b) sensitivity to the sociocultural traditions of the tribal communities of Nagaland; (c) community-based implementation; (d) culturally appropriate information, education, and communication strategies; and (d) special attention to the needs of poorer tribal communities.

40. **Gender and social inclusion.** Women in Nagaland play a significant role in the economy, constituting 44 percent of the workforce. Within a patriarchal social context, Naga women are gaining space in the public sphere. Almost every Naga tribe has a women's organization and most villages have traditional women's organizations. Naga women's organizations have evolved from being solely sociocultural organizations into political entities, capable of negotiating for space in the political process, including through calls for peace and efforts to stop violence in the society. Each village has a Village Council and a Village Development Board. Village Councils have special powers to maintain law and order and administer justice in accordance with customary laws. Women are represented on Village Development Boards and Village Health Committees and thus empowered to participate in the project through its support to the communitization policy. The Gender and Social Inclusion Guidelines in the Social Management Framework emphasize participation of women and socially vulnerable people in the project.

41. **Participation.** The project envisages active involvement of primary stakeholders through involvement of Village Health Committees. Under Component 1, the project will incentivize and work through Village Health Committees in improving service delivery. To address the issues of gender and active community participation, the project will conduct (a) training and sensitization of community groups; (b) capacity building of beneficiary groups; and (c) involve community-based and nongovernmental organizations in the process of mobilization and providing hand-holding support to community groups in implementation of the project.

42. **Stakeholder risks, consultations, and grievance redress.** Potential project beneficiaries and community groups along with different cadres of health staff and officials, nongovernmental organizations, and representatives from other state departments and institutions have been consulted through a number of consultation workshops and visits to towns and villages across the state. They have been consulted in detailing of technical studies that contributed to the project design. The outcomes of technical assistance studies were further shared with all stakeholders in a dissemination workshop in July 2014 to provide input to the project design.

43. **Implementation strategy.** Implementation mechanisms have been established by the state government for the project. A detailed Project Operational Manual has been developed to guide the systems and procedures to be followed at all levels of project implementation. Capacity-building requirements in specific areas have been highlighted by various technical assistance studies, based on which the project will plan and implement training and awareness programs for stakeholders having key roles to play in implementation. The Social Management Framework will be implemented by the Department of Health and Family Welfare. In the case of any land acquisition for the project, the Resettlement Policy Framework will be implemented by the Department of Health and Family Welfare with support from the Revenue Department, which will carry out any land purchases where private land is required. Social screening will be carried out by the chief medical officers at the district level and Resettlement Action Plans will be prepared based on land surveys carried out by the Revenue Department. Chief medical officers will prepare and implement Resettlement Action Plans to relocate any affected squatters as necessary. At the health facility level, Village Health Committees will include representatives from Village Councils, health staff, women's organizations, and faith-based organizations. The Project Management Unit will designate staff responsible for planning and monitoring implementation of the Social Management Framework. The Department of Health and Family Welfare has limited exposure to management of social and environment safeguards and will be supported with capacity building and implementation support by the World Bank.

44. Social safeguards requirements will apply to activities supported by state government parallel financing in support of the project.

Environment (including Safeguards)

45. The primary environmental risks associated with the project relate to the handling and disposal of infectious wastes generated from health care facilities. The overall framework for health care waste management in India is provided by the Government's biomedical rules (prepared in 1998 and amended in 2000 and 2011). The rules, which apply to all persons and institutions that generate, handle, treat, and dispose infectious waste, are based on the principles of segregation at generation, followed by adequate treatment and disposal to prevent recycling of such infectious waste and reduce adverse impacts on public health and the environment.

46. In compliance with the national policy, rules, and regulations, the Ministry of Health and Family Welfare, Government of India, developed an Infection Management and Environment Policy Framework in 2007 along with a set of operational guidelines for each level of primary health care facilities, that is, Sub-Centers, Primary Health Centers, and Community Health Centers. These guidelines are in the form of simple pictorial presentations of the various steps

needed to manage infectious waste in a hygienic, safe, and environmentally sound manner and are recommended for use by the health facilities supported by this project.

47. The project has been classified as Category B according to the World Bank's OP 4.01 on Environmental Assessment. The project's Environmental Assessment reviewed the national and state legislative requirements, reviewed the World Bank's policy requirements, and conducted a rapid assessment of current practices of biomedical waste management at different tiers of health care services in Nagaland. On this basis, an Environmental Management Plan was developed. The Environmental Assessment and Environmental Management Plan were shared with stakeholders through consultation meetings and workshops and incorporated their views and suggestions.

48. The Environmental Management Plan proposes a study to determine suitable mechanisms for biomedical waste management at different levels of health care facilities (suitable to the local situation and volume of biomedical waste generated by different tiers of health care facilities). The Environmental Management Plan also includes management measures and associated guidelines in line with the abovementioned rules and regulations along with training and capacity-building plans, a communication plan, a monitoring plan, and a budget for implementation.

49. To ensure effective implementation of the Environmental Management Plan, the Department of Health and Family Welfare will designate a state-level nodal officer and assign environmental management responsibilities to selected officials at the district and facility levels. To further guide and monitor the implementation of biomedical waste management in the state, a working group will be established with representation from the Department of Health and Family Welfare, municipal corporations, and the Nagaland Pollution Control Board. To ensure the effective implementation of project interventions in water and sanitation, a state-level nodal officer will be designated. The officer will work in tandem with officers at the district and sub-district levels to ensure effective delivery by contracted technical consultants and suppliers.

50. The Environmental Management Plan includes half-yearly internal and annual external monitoring of environmental performance. Adherence to the management measures and associated guidelines will be verified periodically. Based on the periodic monitoring reports, suitable follow-up action will be taken.

51. Environmental safeguards requirements will apply to activities supported by state government parallel financing in support of the project.

Monitoring and Evaluation

52. Monitoring and evaluation of project indicators will focus on targeted health facilities and the communities they serve. Currently, 177 health facilities and 500 villages in their catchment areas are targeted, chosen on the basis of defined criteria. Targeting will be reviewed and revised as needed during the course of project implementation. Baseline values for project indicators are based on data collected in these locations by the Department of Health and Family Welfare during project preparation. Subsequent regular reporting on project indicators will rely on the

department's reporting and information systems. The project's support to an ICT platform and applications will include improvements to these systems.

53. In addition, the project will support a series of health facility and household surveys—at project start, midway through implementation, and at the end of the project. These will provide a basis for impact evaluation of the project as well as collect data on a range of issues to deepen knowledge of health services, their utilization, and community- and household-level factors and behaviors affecting health and nutrition.

Annex 4: Implementation Support Plan

INDIA: Nagaland Health Project

1. The implementation support plan for the project has been developed based on the nature of the project activities, lessons learned from past operations in the country and sector, and the project's risk profile in section V (Key Risks).

2. **Approach to implementation support**. Implementation support will include (a) intensive supervision and hand-holding in the first two years of implementation; (b) regular technical meetings and field visits by the World Bank team; (c) technical monitoring and support by the Department of Health and Family Welfare with support from technical staff of other departments; and (d) internal audit, procurement, and financial management reporting from various sources used to assess and monitor progress of the project through its implementation. Data for performance monitoring to inform implementation support will be collected through the Department of Health and Family Welfare's reporting and monitoring systems, feedback from Village Health Committees and other community-level stakeholders, and health facility and household surveys.

Focus	Skills Needed	Resource Estimate (Staff Weeks)	
		First 12 Months	12-72 Months (per Year)
Team leadership and coordination	Task team leader	9	6
Technical reviews and support, including data analysis and health systems	Health specialists	9	6
Institutional and implementation arrangement and coordination	Operations specialist	12	8
Financial management training and review	Financial management specialist	8	4
Procurement training and review	Procurement specialist	8	4
Social development	Social specialist	6	4
Water, sanitation, and medical waste management	Environment specialist	6	4
Health system development (supply chain management, ICT, human resources)	Health system development specialist	6	6
Solar power	Renewable energy specialist	4	4

3. The first year of implementation will be critical in ensuring that project human resources and technical capacity are in place to improve organizational performance and enable implementation of project activities. The focus in the first year will need to be on the following issues: consolidating the Project Management Unit; recruiting consultants to support the Project Management Unit; establishing coordination mechanisms with other departments; contracting organizations to support the community-level strategy under Component 1; contracting suppliers for phase-one investments in off-grid electrical power solutions and water and sanitation systems; setting up mechanisms to improve accountability and monitoring; and conducting a first health facility and household survey.

4. The World Bank's financial management, procurement, social, and environmental specialists, who are based in the country office, will play a vital role in successful project

implementation support, given that the project includes capacity building in these areas for the department and communities.

5. **Implementation support plan.** During the first year, the World Bank will undertake semiannual implementation support missions, including field visits. The semiannual missions will focus on review of project performance against the Results Framework, progress toward targets, and agreement on planned actions. Implementation support missions will also include monitoring compliance with financial management, procurement, and safeguards requirements. One month before the formal review mission, the Project Management Unit will provide to the World Bank a progress report on project activities. In addition to these formal missions, punctual technical missions to Nagaland by the World Bank team will be undertaken to provide focused support to start-up and implementation.

6. The first implementation support mission will take place by March 2017, with a midterm review in mid-2020 and project closure on March 31, 2023.

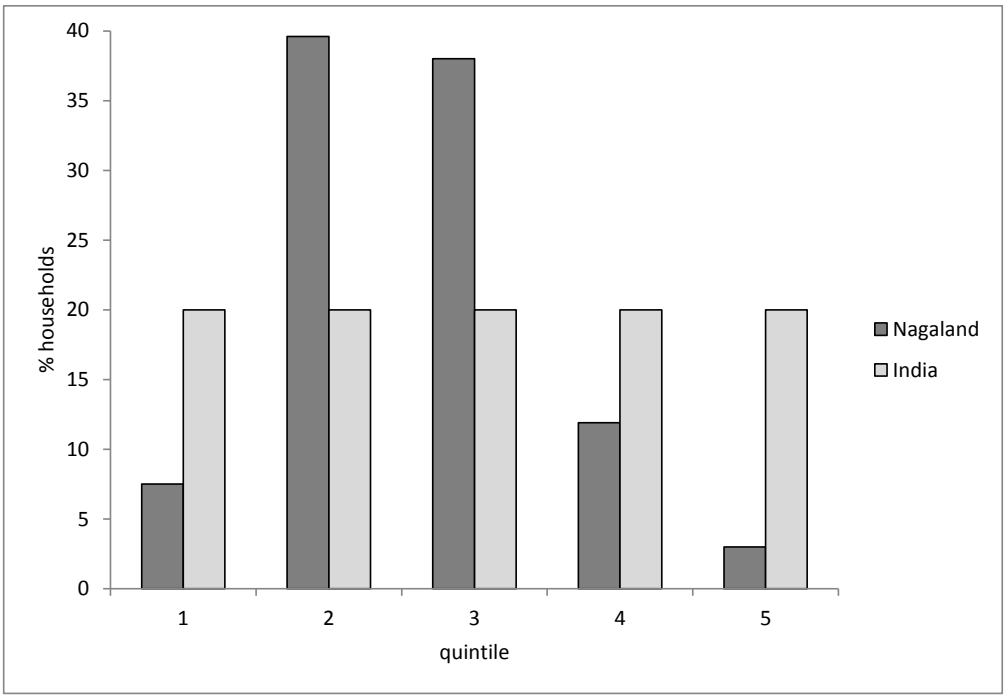
Annex 5: Economic Analysis

INDIA: Nagaland Health Project

Background

1. Although on average Nagaland, with a lower per capita income, is poorer than India as a whole, the socioeconomic distribution in the state is somewhat more equitable. Figure 5.1 illustrates that, in comparison with India as a whole, households in Nagaland are concentrated in the second and third quintiles (ranked on a relative indicator of socioeconomic status), with lower numbers in the poorest and richest quintiles. Nonetheless, the distribution in Nagaland is clearly skewed toward the lower end of the scale, with 47 percent of households situated in the lowest two quintiles (compared to 40 percent nationally).[11] This pattern may be linked with strong social structures in the state, as tribal communities make up almost 90 percent of Nagaland's population. For example, the egalitarian nature of the society may be supported by the fact that ownership rights for almost all land in the state are vested with tribal communities.

Figure 5.1. Distribution of Households by Asset Index Quintiles (2009)



Source: 2009 United Nations Children's Fund (UNICEF) Coverage Evaluation Survey (CES).

2. Available estimates for HNP outcomes in Nagaland are mixed (table 5.1). Communicable diseases, including tuberculosis and HIV/AIDS, remain important, while the burden of non-communicable diseases is growing: a recent study estimated age-standardized mortality due to

[11] A relative index is estimated from data on socioeconomic status (such as asset ownership) collected by a household survey. Households are ranked in quintiles on the basis of the index. The index (and quintiles) are formed from the full national sample, so that, overall, 20 percent of households are in each quintile. The positions of households in Nagaland are thus relative to the national distribution.

cancer at 237.4 per 100,000 annually in the North-East region, compared to the national estimate of 97.6 per 100,000.[12] A 2012–13 household survey in Nagaland found that 10.6 percent reported that they had suffered from chronic illness during the past year.

Table 5.1. HNP Outcome Indicators

	Nagaland	India
2005–06 NFHS3		
Under-5 mortality (per 1,000)	64.7	74.3
Infant mortality (per 1,000)	38.3	57.0
Chronic child malnutrition (stunting) (% children under 5 years)	38.8	48.0
Total fertility rate	3.74	2.68
Body mass index < 17.0 (% women 15–49 years)	4.4	15.5
2012–13 DLHS4 and 2013–14 Rapid Survey on Children		
Chronic child malnutrition (stunting) (% children under 5 years)	29.1	38.7
Anemia (% children 6–59 months)	31.3	-
Anemia (% women 15–49 years)	54.4	-
Reported illness or injury (%)	12.7	-
Reported chronic illness in previous year (%)	10.6	-

Sources: 2005–06 Third National Family Health Survey (NFHS3), 2012–13 Fourth District Level Household and Facility Survey (DLHS4), and 2013–14 Rapid Survey on Children.

Table 5.2. HNP Service Utilization, Energy, and Water/Sanitation Indicators

	Nagaland	India
2009 CES		
Received all basic vaccinations (% children 12–23 months)	27.8	61.0
At least 3 antenatal care visits (% women who delivered in previous 12 months)	29.4	68.7
Full antenatal care (% women who delivered in previous 12 months)	3.5	26.5
Delivered in a health facility (% births in previous 12 months)	30.4	72.9
• Delivered in a government health facility (% of births in previous 12 months)	25.9	47.0
• Delivered in a private health facility (% of births in previous 12 months)	4.5	25.9
Taken to see health provider (% under-2 children with acute respiratory infection (ARI) symptoms in previous 2 weeks)	50.6	82.6
2013-14 Rapid Survey on Children		
Received all basic vaccinations (% children 12-23 months)	33.2	65.3
At least 3 antenatal care visits (% women who delivered in previous 12 months)	14.5	63.4
Full antenatal care (% women who delivered in previous 12 months)	3.6	19.7
Delivered in a health facility (% births in previous 12 months)	18.6	78.7
2011 Census		
Household's main source of lighting is electricity	81.6	67.2
Household's main source of water is tap, well, hand pump, tube well, or bore well	79.6	96.5
Household has a toilet or latrine on the premises	76.5	46.9

Sources: 2009 UNICEF CES, 2011 Census, and 2013–14 Rapid Survey on Children.

[12] Dikshit, R., *et al*. 2012. "Cancer Mortality in India: A Nationally Representative Survey." *Lancet* 379 (9828): 1807–1816.

3. At the same time, health service utilization indicators are unambiguously poor in Nagaland (table 5.2).

4. In contrast with other parts of India, in Nagaland utilization of government health facilities is higher compared to utilization of private health providers. For example, of childbirths that occur in a health facility in Nagaland, seven out of ten are in a government facility, compared to about half in India as a whole. The 2015 baseline survey of communities targeted by the project indicated that when people were sick, 34 per cent sought care at the nearest government primary health care facility or hospital, while 17 percent sought care from a private provider. Those in the lowest socio-economic status quintile were more likely to seek care from traditional healers or government providers as compared to those in higher wealth quintiles. The main reasons cited for not seeking care outside the home even when sick was because they felt the illness or injury was not severe enough (59 percent), or because the cost of seeking health care was too high (11 percent) or due to lack of transport (6 percent). Those in the lowest wealth quintile were less likely to seek care due to lack of transport, high costs and lack of good health providers in the area.[13]

5. In 2011–12, estimated private out-of-pocket spending on health services in Nagaland was about US$3 (INR 184) per capita annually in rural areas and US$4 (INR 243) in urban areas, dramatically lower than the national estimates of US$21 (INR 1,142) and US$32 (INR 1,749) respectively.[14] However, the 2015 project baseline survey found that the average cost of treatment for those who sought care outside of the home within 14 days prior to the survey was US$87 (INR 5,825). In addition, there was a large standard deviation of US$441 (INR 29,534), meaning while some households incurred low costs, a number incurred much higher costs than the average. In 2012–13, annual government spending on health in Nagaland, including about US$11 million under the National Health Mission, totaled approximately US$47 million, or about US$23 per capita, comparable to the national figure of US$20 per capita in 2012. In 2015–16, the government health budget was about US$69 million.

6. The government's main nutrition-focused program is the Integrated Child Development Services, under the responsibility of the state Department of Social Welfare, delivering services at the village level through a network of *Anganwadi* centers and *Anganwadi* workers. ASHAs and *Anganwadi* workers cooperate to deliver health and nutrition services to mothers and children.

7. There are significant problems related to human resources in the health sector. There is a lack of skilled health care workers, with 2.32 doctors per 10,000 population in Nagaland compared to 3.35 on average in India (2011–12). While there is a larger number of nurses and midwives per capita in Nagaland (3.56 per 10,000) than in India as a whole (1.47 per 10,000), these figures are an order of magnitude lower than accepted international benchmarks. A 2014 qualitative study by the World Bank found that doctors and nurses in training and in government service are often very motivated by family and community factors to work in rural areas of

[13] Government of Nagaland. 2016. *Baseline Survey of District Hospitals, Health Facilities, Households and Village Health Committees*. Kohima: Department of Health and Family Welfare.
[14] 2011–12 68th National Sample Survey.

Nagaland. However, they face significant challenges, including poor living and working conditions; insufficient support in staffing, equipment, and medicines; as well as irregular and inconsistent remuneration, lack of job security, and lack of clear career progression and transfer policies.

8. Inadequate supply of medicines to government health services is another major factor in discouraging utilization. A 2014 World Bank assessment found severe shortcomings in the state government's health supply chain management system. This was corroborated by the 2015 project baseline survey that found that none of the health Sub-Centers surveyed had all 5 basic medicines (paracetamol, chloroquine phosphate, zinc sulphate, oral rehydration salt and tetanus toxoid vaccine) available together on the day of the survey, while in only 5 percent of Primary Health Centers and Community Health Centers were all 5 medicines available. Other management systems also require improvement, including financial management, reporting, and information systems.

9. Conditions in health facilities also have an impact on service delivery and utilization (as well as on health worker motivation). Power supply in the state is unreliable, especially in rural and isolated areas. A 2014 World Bank assessment of 24 health facilities in Nagaland found that 19 experienced power cuts of 12-18 hours or more per day. Even District Hospitals situated in urban and peri-urban settings face this problem. The 2015 project baseline survey found that all 11 district hospitals, while connected to main electrical connections, had on average, only 15 hours of electricity each day, severely limiting their ability to provide health services.

10. Similarly, a 2014 World Bank assessment of water and sanitation in 33 health facilities in the state found that only 4 had adequate running water for washbasins and only 3 had water connections for toilets. Only a few facilities had water supply arrangements needed for good hygienic conditions for patients and staff (that is, functional water connections to washbasins and toilets). Additionally, findings from the 2015 project baseline survey indicated that only three district hospitals (Kohima, Mon and Tuensang) had piped water connections while the remaining eight district hospitals accessed water from boreholes. This was true for all sub-district health facilities (Community Health Centers, Primary Health Centers and Sub-Centers) as well. Only about half these facilities had access to piped water, while the remaining used boreholes or wells as their main source of water. In fact about 26 percent Sub-Centers and 8 percent of Primary Health Centers did not have water from any source. The limited availability of water in health facilities was evident from the lack of hand washing facilities and functional toilets which are basic minimum requirements for ensuring hygienic practices in health facilities. Hand washing facilities for staff were observed only in 17 percent of Sub-Centers, 53 percent of Primary Health Centers and 81 percent of Community Health Centers. Separate functional pour or flush toilets were available, in only 9 percent of Sub-Centers, 30 percent of Primary Health Centers and 60 percent of Community Health Centers. It should be noted that unlike other types of public facilities, there are no specific provisions for health facilities in national water and sanitation development programs.

11. Problems with the government health service delivery system can partly be attributed to accountability deficits. Top-down supervision is hampered by poor reporting systems and lack of capacity, as well as political economy issues (for example, relating to posting and transfers of staff). With regard to bottom-up—or community-level—accountability mechanisms, Nagaland

has gone considerably farther than most other states in India. Under the term ‘communitization’, a 2002 state law transferred responsibility for local health, education, water, sanitation, forests, roads, and power services to Village Councils and sector-specific committees. This included transfer of assets (such as buildings) as well as financial resources, notably funds for salaries. Village Development Boards manage funds provided under rural development programs, while in the health sector, Village Health Committees are responsible for management of local health services, including salary payment as well as use of block grants transferred by the state government.

12. Some 1,300 Village Health Committees have been constituted and their level of functionality varies widely. A 2014 World Bank assessment found that, at one end of the scale, with long-term support from a faith-based organization, a number of communities have made substantial investments in local health services as well as other activities with potential impact on health and nutrition. At the other end of the scale, many committees are hardly active. Health system weaknesses described earlier constrain the effectiveness of Village Health Committees, as the committees often use available financial resources to address medicine stock-outs while they have no control over posting and transfers of health staff. There is often a focus on curative care and investments in health facilities, with little work on illness prevention through raising community awareness of good health, nutrition, and hygiene practices.

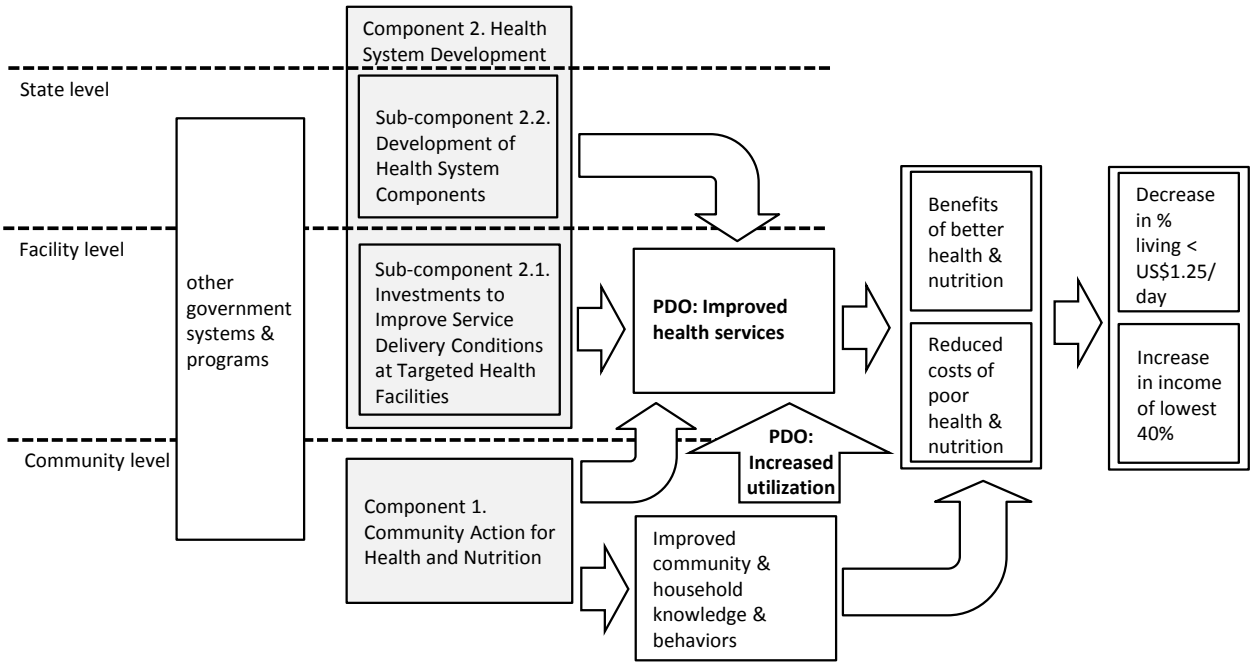
Development Impact

13. The intended development impact of the project as described by the PDO is to improve health services and increase their utilization by communities in targeted locations in Nagaland. The causal chain in figure 5.2 illustrates how the proposed project will contribute to achieving this objective by addressing the above-described challenges to service delivery and their utilization. At the community level, Component 1 will act on both the supply and demand sides. The component will support improvements in service delivery through enhancing the capacities of Village Health Committees to effectively meet their responsibilities for oversight and support to local health and nutrition services. Component 1 will also contribute to increased service utilization through enhancing community and household knowledge and behaviors.

14. Investments made by Sub-component 2.1 are focused on targeted health facilities, particularly through improving power, water and sanitation, as well as through filling gaps that are not addressed by other government systems and programs outside of the project, such as in the areas of repair and maintenance and medical equipment and supplies. Currently, conditions in health facilities are poor, affecting service delivery and utilization. While there are no specific provisions for health facilities in sectoral power and water and sanitation development programs in India, the importance of such investments has been emphasized at a global level, most recently in 2012 as part of the Sustainable Energy For All Initiative. This initiative emphasizes the importance of electricity for delivery of vital primary health care services, particularly where maternal and child health are concerned. In particular, electricity is required for lighting, vaccination, clean water access, equipment sterilization, and powering other essential

equipment.[15] The World Health Organization (WHO) and the World Bank review a wide range of impacts on health service delivery of lack of reliable energy supply, including on the operation of equipment necessary for immunization, sterilization, delivery, surgery and diagnostics, as well as on communication and referral, opening hours, staff and patient safety, staff morale and retention, and information management.[16]

Figure 5.2. Causal Chain to Development Impact



15. Studies on the absence of water, sanitation and hygiene facilities in health services suggest substantial negative consequences to health. The WHO and UNICEF note that the absence of adequate water, sanitation and hygiene severely compromises the ability of health facilities to provide safe and people-centered care and presents serious health risks to both health care providers and those seeking treatment.[17] At a global level, health care-associated infections affect hundreds of millions of patients a year with 15 percent estimated to develop one or more infections during a hospital stay.[18] Among newborns, the risk of death associated with sepsis is

[15] See the Sustainable Energy For All webpage on "Energy and Women's Health" at http://www.se4all.org/hio_energy-and-womens-health

[16] World Health Organization and World Bank. 2014. *Access to Modern Energy Services for Health Facilities in Resource-Constrained Settings: A Review of Status, Significance, Challenges and Measurement*. World Health Organization: Geneva.

[17] WHO (World Health Organization) and UNICEF. 2015. *Water, Sanitation and Hygiene in Health Care Facilities: Status in Low-and Middle-Income Countries and Way Forward*. Geneva: World Health Organization.

[18] Allegranzi, Benedetta, *et al*. 2011. "Burden of Endemic Health-care-associated Infection in Developing Countries: Systematic Review and Meta-analysis." *Lancet* 377 (9761): 228-241.

34 times greater in low-resource settings, while the risk of death due to preterm births and intrapartum birth complications are 10 and 36 times greater, respectively.[19]

16. At the state level, Sub-component 2.2 focuses on development of key health system components that will contribute to state-wide improvements in health service delivery through better management of information, medicine supply and human resources. The bulk of cost-effectiveness research in the health sector focuses on specific technical interventions but the delivery of those interventions depends on the effective functioning of such health system components. A review by the Disease Control Priorities Project concludes that while there is a need for more evidence on the effectiveness of specific system development interventions, it is clear that health system development is an essential basis for sustained improvements in health services and outcomes in low-income countries.[20]

Table 5.3. Cost-Effectiveness of Selected Maternal and Child Health and Nutrition Services

	Estimated Cost per DALY Averted (2012 US$)
Treatment of severe malaria	20-40
Management of obstructed labor	60-80
Behavior change communication (BCC) on nutrition and water, sanitation and hygiene	80-100
BCC on handwashing	80-200
BCG, DTP, polio, measles and hepatitis B vaccinations*	100
Pneumococcus and rotavirus vaccinations	100
Oral rehydration therapy	150
Mothers' groups to improve maternal and neonatal health	150-1,000
Access to modern contraceptives	150-300
Intrapartum care	175-200
Treatment of pneumonia	200-500
Quality improvement protocol for hospital newborn care	300
Cesarean-section	1,500-2,500

* BCG: Bacillus Calmette-Guerin; DTP: Diphtheria, Tetanus, Pertussis

Source: Horton, Susan and Carol Levin. 2016. "Cost-Effectiveness of Interventions for Reproductive, Maternal, Neonatal, and Child Health." In *Reproductive, Maternal, Newborn, and Child Health. Disease Control Priorities, Third Edition, Volume 2*, edited by Black, R.E. *et al*., 319-334. Washington, DC: World Bank.

17. As illustrated in figure 5.2, the project's interventions will join with other government systems and programs, including the National Health Mission, to improve delivery of health services and increase their utilization by targeted communities. There is a substantial literature on the cost-effectiveness of these services. Along with general curative outpatient and inpatient care, many of these services focus on maternal and child health and nutrition. It has been

[19] Oza, Shefali, *et al*. 2015. "Neonatal Cause-of-death Estimates for the Early and Late Neonatal Periods for 194 Countries: 2000–2013." *Bulletin of the World Health Organization* 93 (1): 19-28.

[20] Mills, Anne, Fawzia Rasheed and Stephen Tollman. 2006. "Strengthening Health Systems." In *Disease Control Priorities in Developing Countries, Second Edition*, edited by Jamison, Dean T. *et al*., 87-102. New York: Oxford University Press and World Bank.

suggested that interventions with a cost per disability-adjusted life year (DALY) averted[21] of less than the country's annual per capita gross national income can be considered "very cost-effective," while those with a cost per DALY less than three times annual per capital gross national income can be considered "cost-effective."[22] In 2015, India's per capita gross national income was US$1,590.[23] Table 5.2 provides estimates of cost-effectiveness of a number of health and nutrition interventions that are among the standard services to be delivered through the government system at the community and facility levels in Nagaland. All are considered cost-effective and most are very cost-effective.

18. Project-supported activities will join with the government's ongoing financing and investments in government health services in order to improve health service delivery. A total of 500 communities, encompassing a population of 800,000, and 177 health facilities are targeted by the project,[24] including all 11 District Hospitals and 21 Community Health Centers which provide first-referral services to the entire state population of 2 million. In addition, the project will support state-wide system improvements that will benefit the entire state population. The impact of the project's contribution will be reflected by the project indicators. (Annex 1) Achievement of project indicator targets will mean that at least 350 communities will benefit from improved services from community health workers, at least 125 health facilities will have improved water and sanitation, and at least 100 health facilities will possess reliable electrical power supply. These improvements are intended to contribute to achievement of service delivery-related targets in communities supported by the project, including an increase from 6 to 40 percent in the proportion of children under age 1 year who receive preventive nutrition services, an increase from 40 to 60 percent in the proportion of children age 9-11 months who are fully immunized, and an increase from 55 to 75 percent in the proportion of mothers who receive antenatal care. In addition, health system development supported by the project will improve, across the state, medicine supply, health information systems, and health human resource management. This, plus project-supported investments in all District Hospitals and Community Health Centers in the state, can be expected to contribute to improvements in the range of services provided by the government health system.

19. A simple model provided in table 5.4 provides estimates of the impact of total government health spending (including project financing) in the state over the six year project implementation period. A projected increase of 10 percent annually in general outpatient as well as maternal and child service coverage would result in a total (cumulative) number of beneficiaries of those services of about 1.2 million over the six year period, at an average cost per capita of US$42. (This level of improvement is conservative compared to the project indicator targets that focus on the 500 target communities). Alternatively (not shown) an annual increase in service coverage of 15 percent would result in total beneficiaries of 1.4 million.

20. With regard to the monetary benefits of health and nutrition interventions, a report by the Lancet Commission on Investing in Health estimates that a quarter of India's growth in full

[21] A DALY averted is a measure of gains in years of life due to averted mortality combined with gains in years of full health due to averted illness and disability.
[22] WHO. 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: WHO.
[23] World Development Indicators.
[24] Project targeting is subject to revision as needed during implementation.

income (economic growth plus the value of life years gained) over 2007-12 was the result of the decline in mortality experienced by the country during the same period, translating to 3 percent of India's 2007 gross domestic product.[25] The commission also notes that investing in health in India is expected to provide a tenfold return over the period 2015-35; that is, for every US$1 invested in health, the returns will be US$10. The commission emphasizes that about half of the investments made in India should be in the area of health system strengthening in order to develop capacity to scale up priority interventions. In 2015-16, the government spending on health in Nagaland was approximately US$ 69 million. This project would provide an additional US$10 million annually, for a total of US$60 million. If the commission's figure is used, a possible return on investment would be US$600 million.

Rationale for Public Sector Intervention

21. There are a variety of market failures in the HNP sector that argue for government intervention, including positive and negative externalities that are not fully captured by the private market, adverse selection and moral hazard, and information asymmetries.[26] These do not necessarily require direct provision of health services by government, but in the case of Nagaland, strengthening the government health services, as well as community structures for their management and accountability, is the best option in the absence of a strong private sector for health care delivery. Equity considerations also point to the need to strengthen public sector health services to reduce impoverishing health expenditures.

World Bank Value Added

22. There are several aspects to the value added of World Bank support to the project. Part of the value added of World Bank support to the proposed project stems from its expertise and experience in health system development in India, as well as its experience in other sectors, notably community development, renewable energy, and water and sanitation. The World Bank is also well positioned to apply elsewhere lessons from this project in implementing community-level and cross-sectoral interventions to improve health and nutrition. In addition, the World Bank will also be able to provide implementation and evaluation support, which will be vital to making this project a success. The World Bank has off-grid electrification programs in countries such as Kenya and Niger that are looking at health facility electrification; experiences from such programs will provide useful guidance for the successful implementation of this project. In addition, in this context, the involvement of the World Bank will add value through its ability to convene stakeholders in support of global initiatives such as universal health coverage, universal access to electricity, and sustainable energy.

[25] The Lancet Commission for Investing in Health. 2013. "Returns on investing in health in India." Available at http://globalhealth2035.org/sites/default/files/policy-briefs/india.pdf.
[26] Musgrove, Philip. 1999. "Public Spending on Health Care: How Are Different Criteria Related?" *Health Policy* 47 (3): 207–223.

Table 5.4. Model of Development Impact

	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	*Total*
Service coverage								
Projected % improvement from previous year		10	10	10	10	10	10	
Outpatient consultation rate (per 100 population)	0.05	0.05	0.06	0.06	0.07	0.07	0.08	
Mothers receiving at least 3 antenatal care check-ups (%)	14.5	16.0	17.5	19.3	21.2	23.4	25.7	
Mothers delivering in a health facility (%)	18.6	20.5	22.5	24.8	27.2	30.0	33.0	
Newborns receiving check-up within 24 hours	5.2	5.7	6.3	6.9	7.6	8.4	9.2	
Children under 1 year receiving nutritional services (%)	6.0	6.6	7.3	8.0	8.8	9.7	10.6	
Children under 1 year fully immunized (%)	33.2	36.5	40.2	44.2	48.6	53.5	58.8	
Population numbers								
State population	2,087,291	2,112,338	2,137,687	2,163,339	2,189,299	2,215,570	2,242,157	
New mothers	47,590	48,161	48,739	49,324	49,916	50,515	51,121	
Children under 1 year	46,781	47,343	47,911	48,486	49,067	49,656	50,252	
Beneficiary numbers								
Persons receiving outpatient care	96,433	107,349	119,501	133,028	148,087	164,851	183,512	*856,328*
Mothers receiving at least 3 antenatal care check-ups	6,901	7,682	8,551	9,519	10,597	11,796	13,132	*61,278*
Mothers delivering in a health facility	8,852	9,854	10,969	12,211	13,593	15,132	16,845	*78,604*
Newborns receiving neonatal care	2,475	2,755	3,067	3,414	3,800	4,230	4,709	*21,975*
Children under 1 year receiving nutritional services	2,807	3,125	3,478	3,872	4,310	4,798	5,341	*24,925*
Children under 1 year fully immunized	15,531	17,290	19,247	21,425	23,851	26,551	29,556	*137,919*
Total	132,998	148,054	164,813	183,470	204,239	227,359	253,096	*1,181,030*
Cost								
Assumed annual increase in government health spending (%)		5	5	5	5	5	5	
Government health spending (US$ millions)	69	72	76	80	84	88	92	*493*
Nagaland Health Project (US$ millions)	0	10	10	10	10	10	10	*60*
Total (US$ millions)	69	82	86	90	94	98	102	*553*
Total per capita (US$)	33	39	40	42	43	44	46	*42*

Baseline service coverage estimates and population numbers are based on the 2011 Census, 2013-14 Rapid Survey on Children and 2015 Nagaland Health Project Baseline Survey.