PROJECT IMPLEMENTATION PLAN (PIP)

UTTARAKHAND HEALTH SYSTEMS DEVELOPMENT PROJECT

Implemented by
Uttarakhand Health & Family Welfare Society,
Department of Medical Health and Family Welfare,
Government of Uttarakhand

Funded by
The World Bank

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PROJECT BRIEF

The overall objective of the Uttarakhand Health Systems Development Project (UKHSDP) is improving the access to quality health services, particularly in the hilly and unserved areas risk protection for residents of Uttarakhand, it is envisioned to establish a well-managed health system for more effective delivery of health services through policy reform, institutional and human resource development and management and investment in health services. Specifically, the project would focus on improving access to health services for the predominantly remote population of the state, through strengthening public and private health-delivery systems; promoting greater stewardship and managerial capacity in the state directorate; improving information systems; augmenting monitoring and research; and extending coverage of RSBY/MSBY beyond hospitalization to include primary healthcare services.

Interventions under the project will support the state's plans for scaling up health system reform initiatives and making progress towards universal health coverage. The project would emphasize on strengthening the health service delivery system and increasing utilization of basic health services with special focus on improving access to quality health services for the geographically dispersed and remote populations in the state, and finding innovative ways to engage with the private sector.

A key area that the project would support is the development of innovative mechanisms for Uttarakhand to engage with private health care providers, expanding their role in meeting the unmet access needs of the state's population. A greater involvement of the private sector would create additional human resource availability for the public health system as a whole, while also providing an opportunity to redeploy existing public staff in a more efficient and effective manner.

Taking into account evidence around the shifting trends in morbidity and mortality, the Project would support the stewardship role and capacity of the state's Department of Medical Health and Family Welfare (DoMHFW) for improving health outcomes through innovations in developing and engaging the private sector; institutional strengthening; and improved management of health services. The project would also aim to reduce financial risk and make affordable, high quality healthcare available to all of the state's citizens.

The project will have two components: a) Innovations in engaging the private sector b) Stewardship and system improvement and. The total project cost is US $ 125 million, of which the IDA component is US $ 100 million and the state's share is US $ 25 million.

SITUATION ANALYSIS

Socio-Demographic Profile of the State

Carved out of Uttar Pradesh, Uttarakhand was established as an independent State in November 2000. The State is generally described as remote and hilly. 93% of the land is hilly, and 63% is covered by forest. Geographically, it is divided into three broad zones, namely, the upper reaches, the middle areas and the foothills. The districts that are categorized into these classifications are presented as under—

Social/Demographic characteristics (Census-2011)	
Geographic Area	53,484 sq. kms
Number of blocks	95
Number of villages	16,793
Number of towns	116
Total Population	10116752
• Urban	3091169
• Rural	7025583
Sex Ratio • Sex Ratio • Child Sex Ratio	 963 894
Decadal growth rate	19.17
Density- per sq. km.	189
Literacy Rate (6+ Popn.)	79.63%
• Male	88.33%
• Female	70.70%
SC Population	15.17%*
ST Population	2.56%*
* *as per Census 2001*	

Upper Himalayas: Uttarkashi, Chamoli, Pithoragarh

Mid Himalayas: Rudraprayag, Tehri, Pauri, Almora, Bageshwar, Champawat

Foot Hills: Dehradun, Nainital, US Nagar, Haridwar

Administrative Divisions: The State has two Divisions (Kumaun & Garhwal) and 13 Districts. These are further sub-divided into 78 Tehsils and 95 Blocks. As per Census 2011, there are 16793 villages. Interestingly, there has been decline in the number of villages in the State in comparison to the situation reported in Census 2001.

Population: The population of Uttarakhand stood at 10.11 million in 2011 (Census India 2011). With annual growth rate of about 1.92%, the population of the state is estimated to be around 10.31 million. Female literacy has shown a higher rate of increase than the male literacy. In five districts namely, Uttarkashi, Tehri Garhwal, Udham Singh Nagar and Haridwar, the literacy rate is below the state average.

The population size of the districts in Uttarakhand varies considerably. Four out of the 13 districts namely Dehradun, Haridwar, Udham Singh Nagar, Nainital, Tehri Garhwal, Pauri Garhwal and Almora account for 79 percent of the total population of the state of which 55 percent of the population resides in district Dehradun, Haridwar, Udham Singh Nagar and Nainital.

The density of population according to the 2011 census is 189 persons per square kilometre and this is significantly higher than the 2001 census figure of 150. The variation in the density of population is also extremely high with Haridwar having 816 persons per square km to Uttarkashi having 41 persons per square km. Uttarakhand is predominantly a rural state with 16,793 rural settlements. Out of these 81 per cent have population of less than 500. In most of the districts, more than 75-85 percent of the settlements have population of less than 500. Only 17 per cent of the rural settlements have a population ranging between 500-1999. Villages with population of greater than 2000 persons are very rare (2.7%). This clearly signifies the character of the distribution of population- scattered small size settlements. Thus,

the geographic and demographic characters point to the challenges for provision of services to a sparsely distributed population especially in the hilly terrain with difficult accessibility.

The scheduled caste population –the weaker and marginalized sections of the society form more than 20 percent of the population in the districts of Uttarkashi, Pithoragarh, Almora and Haridwar. In other districts the scheduled caste population varies between 13-17 percent.

Sex Ratio: There has been a marginal improvement in the sex ratio from 962 females per 1000 males (Census 2001) to 963 females per 1000 males (Census 2011). However, what is more disturbing is the fact that in the Child Sex Ratio (0-6 years), which was already quite alarming as per the findings of Census 2001, there has been further decline as per Census 2011. More importantly, the decline in the child sex ratio has been recorded in almost all the districts of the State, barring Haridwar. Moreover, as per Census 2011, the situation in regard to child sex ratio in rural areas is no different than that in urban areas.

District	Total Population (2011)	Sex Ratio
India	1210193422	933
Uttarakhand	10116752	963

Source: Census 2011

Literacy Rate: While 79.63% of the population is considered literate (Census India 2011), there are considerable variations between districts and substantial difference between men (88.3%) and women (70.7%). The other positive features of high literacy rate especially among the female population and improving sex ratio would be the base on which the social development and acceptance of services can be built upon. These are certain unique features that need to be taken into account while designing the strategy.

Health Infrastructure

The State of Uttarakhand is confronted with a number of challenges and the most daunting concerns the health sector. The health problems of the state have been further compounded due to tough geographical terrain and poor accessibility to health facilities (only 62% villages have all weather road connectivity). The terrain being hilly is prone to serious road accidents and incidence of falling from the hills. Besides this, earthquakes, landslides, cloudbursts, etc. are a regular feature in the state. Various secondary studies have also revealed poor health status and poor care seeking behaviour among the people of Uttarakhand, especially in hilly part of the State.
Uttarakhand has an extensive network of government health institutions of different systems of medicine. As such, this network needs to be further strengthened with adequate manpower and systemic support. The availability of various types of public healthcare facilities across the State is described below.

- **Allopathic System of Medicine (Hospitals, dispensaries, clinics):** Currently, the number of hospitals, clinics, and dispensaries in the State including blood banks is as mentioned in the table below

Health Facility Type	Position as in 2011 (Nos.)
Dist. Hosp.	12
Dist. Female Hosp.	06
Base Hosp.	03
Combined Hosp.	15
CHC (Including FRU)	55
PHC	257
Sub-centre	1848
State Allopathic Dispensary	322
Mental Hosp.	01
T.B. Clinic/Hosp./ Sanatorium	18
Total Beds	8365
Blood Bank	22 (17 Govt.+5Pvt.)

- **Mobile Health Services:** To cater to the health care needs of the population living in the remote areas, Mobile Health Van services have been introduced in the State, one in each district and equipped with modern diagnostic facilities. As of November 2016, a total of 19 Mobile Health Vans for providing primary health and RCH services have also been deployed in the remote areas under RCH programme.

- **"108" Emergency Services:** Uttarakhand is largely a difficult hilly terrain. Whenever there are emergent situations like road accidents and natural disasters, it becomes very difficult to rescue the victims and take them to requisite medical institutions for immediate treatment and trauma care. To meet with such situations and pregnancy related emergencies, State has 140 Emergency Ambulance services operational.

- **Urban Health Centre in PPP Mode:** To reduce the burden of patients on district level hospitals and to provide RCH and general healthcare services to the urban poor living in slums, 21 Urban Health Centers have been established in 4 towns of the State, functional in PPP mode.

- **Indian System of Medicine:** The Health & Population Policy of the State envisages integration of the services of different systems of medicines, such as, *Ayurveda*, Homoeopathy, and *Unani* to achieve synergy. National Rural Health Mission too seeks to revitalize local health traditions and mainstream AYUSH into the public health system. In keeping with State's policy to promote AYUSH system, AYUSH hospitals/ dispensaries have been established in various parts of the State. Funds are released from AYUSH component and under NHM from time to time to strengthen the AYUSH system in the State. Further, it is planned to integrate CHCs and PHCs with AYUSH. Considering inadequacy of allopathic manpower in the State, mainstreaming of AYUSH is seen to be a viable option to improve availability of doctors in the State, particularly, in

remote areas. In some of the states, possibilities of providing training to AYUSH doctors to enable them prescribe generic medicines are being explored. In regard to other systems of medicine, Uttarakhand has 486 Ayurvedic dispensaries, 72 Homoeopathic dispensaries and 3 Unani dispensaries.

Presently, 56% positions of doctors are vacant. Overall, the State faces shortage of over 70% specialists in various streams in the Public Health Facilities. There are certain categories of Specialists where the shortage is critically high, such as, Physicians, Anaesthetists, Pathologists, Radiologists, Cardiologists, and Neuro Surgeons. Even in other streams, the situation regarding availability of specialists is largely critical. Since, the overwhelming majority of the people in the State have to depend on Government Health Facilities for their healthcare needs, improving availability of doctors, including that of specialists, is crucial for the State.

Health Information Systems

A strong health information system is an essential component of sound programme/policy development and implementation, and is a prerequisite for strategic decision-making. For realization of any intervention goals, it is absolutely necessary to have a robust system in place. Effective and efficient management relies on routine data collection, compilation, analysis and estimation of performance indicators at regular intervals. Such a system is yet to be put in place in the State.

Presently, registers are maintained by grassroots level functionaries manually. Electronic data are generated at block level based on the reports sent by them. In the process, particularly due to lack of robust system, there is lot of duplication and inconsistencies in the data. Even at State level, for processing of data, its interpretation, and generation of desired indicators; it is required to develop capacity to gather accurate and timely data on personnel, financial resources, infrastructure, equipment, logistics, and performance of various health programs; regularly analyze those data and accordingly plan effective strategies to reach the poor and disadvantaged.

Bio-Medical Waste Management

To contain and manage bio-medical wastes, Ministry of Environment and Forest enforced the 'Bio-Medical Waste (Management and Handling) Rules 1998' under the Environment (protection), Act 1986, which was subsequently amended in the year 2000, 2002, 2003 and 2016. Considering the location of various health facilities and other aspects associated with bio-medical waste management, under UAHSDP, the State has developed a strategy and action plan for Infection Control and Bio-Medical Waste Management (IC& BMWM) to deal with the issue in an integrated manner so that all eligible health facilities are covered under the system and the provisions of bio-medical waste management rules are duly complied with. For the implementation of UKHSDP an ESMP has been developed after appropriate consultations and has been disclosed on 2nd September 2014. This ESMP lays down the environmental safeguards including BMWM practices to be followed during the implementation of UKHSDP.

Procurement and Supply Management

Development of an efficient procurement and supply chain system places a huge challenge on the State where 9 out of its 13 districts are mountainous with valleys and ridges and a result, only 5 major towns in 2 districts are connected to the railway network. The remaining 11 districts are completely dependent upon the road network which is in a variable state of functionality. At times, this poses a great difficulty in ensuring timely supplies. Moreover, at present there is no effective system for demand forecasting, stock estimation, etc. However, some steps have been initiated towards strengthening procurement system and drug distribution system in the State. Initiatives to strengthen capacity in supply chain management are envisaged under UKHSDP.

Current Challenges and Lessons Learnt from UAHSDP

Current National Health Mission (NHM) has evolved from National Rural Health Mission (NRHM) launched by Government of India in 2005. It introduces a very comprehensive and flexible approach to improving public health service delivery. NHM aims at substantial reduction in infant mortality, under-5 and maternal mortality, besides focusing on population stabilization. However, effective implementation of NHM in the state presupposes a robust institutional infrastructure and human resource capacity to meet the challenges of health service delivery in an inherited environment of systematic inadequacies and inefficiencies.

In view of the constraints and deficiencies in the public healthcare systems, the Government of Uttarakhand initiated the Uttaranchal Health Systems Development Project (UAHSDP), with the goal to meet the health needs of the people. Under this project, it was envisaged to provide high quality, responsive, affordable and integrated healthcare services. The objective of this project was to establish a well-managed health system, capable of delivering the services more effectively through policy reforms, strengthening, and renovation of the existing resources, skill development of the human resource and investment in health services. During operation of this project, various initiatives were also taken by the State Government for development of health systems. Apart from strengthening the infrastructure of healthcare facilities in the State, such as, civil works, supply of equipment, the project took some landmark initiatives. These include partnership with NGOs for better service delivery in remote areas; development of Hospital Management System; quality assurance; Bio-Medical Waste Management; integration of AYUSH with modern system of medicine; etc.

The previous project made significant contribution towards improvement of health scenario in the State. However, there exist a number of gaps in the current health system context, which are required to be addressed during the current project. Under UKHSDP, it would be endeavoured to address the following challenges by proposing to undertake strengthening systems and management capacity along with quality improvement and accountability of service delivery in the health department of the State—

- **Limited Access to Healthcare Facilities**: The aim of making healthcare accessible to the most vulnerable by addressing crucial barriers at multiple levels provides the foundation for designing innovative approaches to health care delivery. In the hilly state of Uttarakhand, among those not accessing government health facilities, 49 percent attribute the cause to lack of a nearby

government health facility (NFHS-3, 2005-06). An important reason for low health indicators in the state has been limited access to fixed health care facilities due to poor transportation infrastructure in the more remote and interior regions. In Uttarakhand, geographic and infrastructural challenges present major barriers to the population's access to basic health services. The population is constrained from reaching health facilities due to mountainous terrain, poor transportation infrastructure and geographic distance. With these challenges in mind, under UKHSDP it is planned to work for improving the health indicators of the local communities through innovative approaches that expand the reach of quality health services.

- **Out of Pocket Expenditure on Healthcare (Healthcare Financing):** Over the last decades, considerable gains in the average level of health and access to health services have been achieved in India, as also in Uttarakhand. The state has advanced towards the aim of universal coverage, so that all individuals have access to timely and appropriate health services at an affordable cost. However, not all subgroups have benefited equally from these advances. In other words, health systems have become more effective and efficient overall, but remain inequitable because the most vulnerable (e.g. poor and socially excluded) populations do not benefit equally in terms of access to health services and health outcomes. When possible, people base their choices about when and where to seek care on many socioeconomic and cultural factors that influence their perceived needs and demand. Before their perceived needs result in demand for and utilization of health services, they must interact with the reality of the health system. If health services are to be utilized they must be available, accessible and affordable. However, although financial protection has improved in the past decade but serious challenges still persist. Out of pocket (OOP) payments and informal payments are pervasive and almost universal and have not decreased following the introduction of health insurance. However, the largest share of expenditures is related to direct payments for diagnostic tests, prescribed medicines and access to a very limited package of compensated medicines. An equitable health system is one that provides its population with access to services according to needs and independent of the capacity to pay, thus safeguarding the right to health. Under UKHSDP, it is proposed to work for making health care services available, affordable, accessible and equitable to the masses.
- **Human Resource Management:** Availability of medical personnel is key to delivery of healthcare services. There has been perennial shortage of clinical staff in the State. Having been carved out from Uttar Pradesh, so far, a number of such personnel had been deployed in the health facilities from UP cadre. Most of these functionaries have now gone back to Uttar Pradesh. However, some are still continuing and their number may be taken as prospective vacancy in the sector. Moreover, being a new State, the infrastructure for production of healthcare manpower is not yet adequate. The problem has been further compounded by its topographic situation because of which people do not opt for service in the remote locations. For want of adequate manpower, many of the healthcare facilities have not been able to work fully and efficiently. The previous Project, took major initiatives in development of administrative and technical skills. A strategic support group was formed to look into Human Resource Development aspects in the State. In furtherance of the activities of this support group, following areas in Human Resource Development need attention —
    - Increasing the production of additional force of healthcare personnel

- Rationalizing the distribution of manpower
- Taking special efforts to retain manpower in the remote areas
- Rationalization of the selection and placement procedure to ensure availability of manpower in difficult and remote locations
- Public Private Partnership for enhancing availability of healthcare services to one and all and specialist surgeon
- Organizational strengthening of State, District and at facility level

- **Partnership with NGOs for Preventive and Curative Care:** During the previous Project, partnership was established with NGOs for providing preventive healthcare services and limited curative services. This experiment was made in the remote areas in order to reach the un-reached. These NGOs established their clinics through which they provided RCH and other services to the people in the area, apart from organizing Multi Specialty Camps. In view of the successful association with the not for profit private sector, the current project aims at building upon such partnerships with private sector for service delivery particularly in the remote areas.
- **Bio-Medical Waste Management:** Support for overseeing Public Health and Hospital Waste Management System is planned to be further augmented over the previous project. Under UAHSDP, the State Strategy for Infection Control & Bio-Medical Waste Management (IC & BMWM) was developed. This aspect would need to be addressed adequately in the current project and policy guidelines shall have to be taken for strengthening this vital aspect in the State in Healthcare Service Delivery System
- **Tourism & Trauma Care Needs:** Uttarakhand is a mountainous state with famous tourist and religious sites and draws a huge number of pilgrims and tourists from all over the country and abroad. Around 1 crore people visit Haridwar alone to take a dip in the Holy Ganges, besides additional 1 crore tourists that visit rest of the State. The tourist attraction centers are mostly situated in the mid and high mountain ranges where road accidents are common because of the sharp turns and steep climbs. The state is also susceptible to natural calamities such as earthquakes, landslides, and forest fires. Currently, the state has little backup on the health care requirements arising from these situations. In the previous project, this aspect did not receive sufficient attention. In view of the facts mentioned above it is essential to make a strategy to combat such situations on war footing by making a detailed study of the critical sites in the State for provisioning of emergency transport needs, trauma care, etc. This would involve establishment of primary & secondary trauma care needs, procurement of mobile vans and ambulance vans for referring the accident cases to higher level facilities.
- **Supplementing and Complementing the National Health Programmes:** NRHM (now NHM) was launched in the state at the fag end of the previous project. There was only limited coordination and integration of the previous project and NHM. However, in the current Project, it is envisaged to provide all possible support to supplement and complement the NHM through integrated implementation arrangements.
- **Need for Policy Frame and Strategic Planning:** Though the previous project made a significant contribution towards overall improvement in the health scenario of the State, but a lot

needs to be done. There is an urgent need to pay attention policy and strategic planning issues and district level strengthening for planning and management. In view of this the current project needs to concentrate on institutional strengthening through structural, financial, & functional reforms and governance issues. Institutional strengthening through policy reforms should include structural reforms at various levels, including convergence. It would also include functional reforms and governance issues.

PROJECT COMPONENT

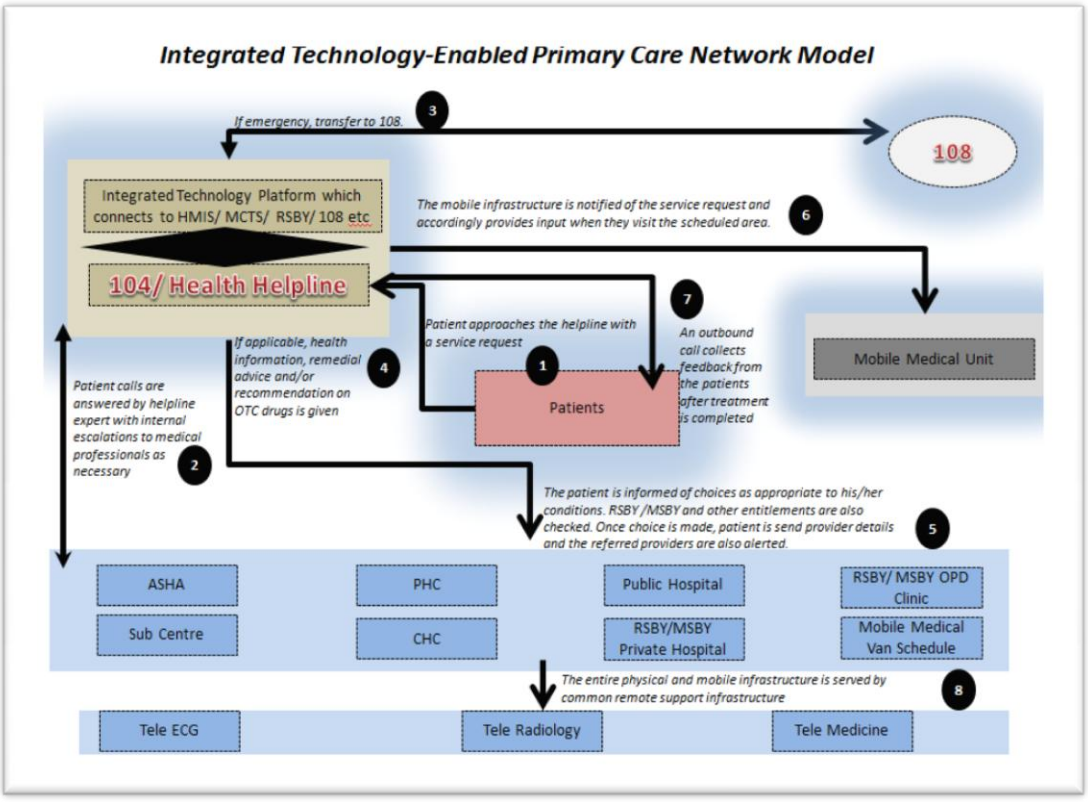
Component 1: Innovations in Engaging the Private Sector

The private sector plays a significant role in delivering healthcare to people in the State. A large part of the state's population is served by the private health care providers and non-state actors. Overall to enhance the efficacy and efficiency of the Government health interventions, it is required to capture the potential of the private sector in health and to ascertain the ways and means to involve them in efficacious implementation of various State interventions.

In view of the above, the first component under UKHSDP is "Innovations in engaging the private sector". The aim is to create a conducive policy and institutional environment to stimulate and finance innovative engagement with the private sector in delivery of healthcare services as well as in healthcare financing.

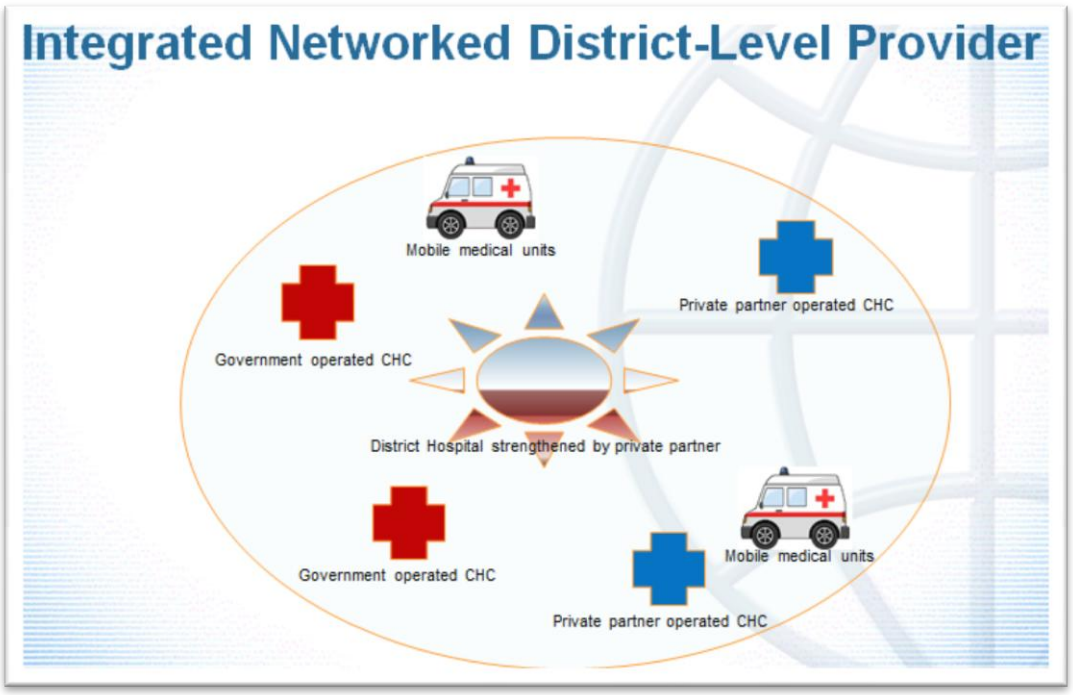
Sub-component 1.1: Innovations in integrated delivery of healthcare services (primary, referral, emergency and speciality care)

Under this component, it will be endeavoured to create integrated technology-enabled health system architecture with enhanced focus and availability of primary care, emergency care and necessary referral services.



Under the integrated district-level network approach, it is envisaged that the management contracts for a District-level Hospital, the CHCs and the Mobile Health Vans (MHVs) would be combined (within a geographical area), to one private provider in order to optimize the service delivery channels. It is suggested that the MHVs (under PPP) could act as the primary care community level gateway, in which out-patient consultation, basic lab services, ANCs and supply of medicines could take place.

If the patient needs additional clinical services or diagnosis, the CHCs could act as the first referral



unit.

However, if the CHCs are managed by the same private provider who operates the MHV, the referral linkage could help optimize the primary care service delivery system. In case, patients need advanced diagnostics (e.g. CT) and (specific) specialty care services (e.g. surgical wards), the CHCs could refer the patients to district hospitals where such services could be managed and operated by the same operator.

In order to operationalize this approach, the current MHV, CHC and DH contracts could be integrated in to one contract with in a geographical contiguity (ideally a district, but can club unserved areas of two districts in a cluster for better logistic convenience of services). This allows better coordination, management control, and monitoring as well as a complete chain of services to the patients. This would also optimize the 104 health network gateway. PPP for advanced diagnostics and specialty services in district hospitals could be based on demand analysis (case load) and morbidity conditions.

Overall, as part of the initiative for engaging private sector in government health interventions, the following activities would be undertaken under UKHSDP—

- Supporting development of a conducive regulatory, policy and institutional environment to support on-going and new PPPs as well as new investments in the state, especially in the remote areas
- Reviewing and restructuring on going PPP contracts
- Undertaking a private sector mapping for the health sector in the state, including analysis on the demand for various service delivery gaps in the state
- Mapping investment opportunities and conducting a public private dialogue with respect to investor and provider interest in service delivery opportunities in the state
- Developing an information network that supports a patient centric health system that would help patients navigate across different levels of care, public and private providers as well as create linkages to financing entities such as RSBY/MSBY.

Designing financing options for PPPs with the broader financing approach and design.

Contract Design and Key Components of Integrated District-level PPP Model for Service Delivery

a) Contract Structure:

The contract will be based on BOT model (Build, Operate and Transfer). The bid will include both capital expenditure as well as operational expenditure, inbuilt into the quoted price structure by the bidder, as the assets will be transferred to the GOUK at the end of the contract period. Beyond what is already available in the government facility on an as-is basis, all capital expenditure will be borne by the private provider. Two-stage bid system (technical and commercial) would be followed as per Bank procurement procedures. The total investment requirements related to procurement of MHVs, any capital expenditure on the buildings, equipment, and other requirements shall be according to the service delivery cluster and the existing condition of the facilities in each cluster. The private provider shall be asked to conduct a detailed survey of the facilities and affirm his knowledge of the conditions before signing the bid documents. Ownership of the assets including equipment shall remain with the GOUK, and the operational management rights shall be transferred to the private provider through the contract/MoU. The private provider shall handover all the assets created for the execution of the contract for which the prices have been incorporated in the bid value, in working order, to GOUK at the time of termination of the contract to ensure continuity of services. The total bid value should include all costs (capital and operational) in summary, and details (of break-up of cost/ tariffs) may be enclosed as annexure. The contract design will be performance based and shall contain three essential components: a) Core contract (that assures minimum service delivery at various facilities); b) Volume based payments (payments based on a range of volume of services) that encourages greater performance (quantum of services); c) Incentives for adherence to quality of services and other performance parameters. The quotes should be modular and include separate quotes for the MHV, CHC and DH services so that the price implication for any future change in the cluster composition can be determined on that basis.

b) Scope of Services:

The defined (standard) services and specialties that ought to be provided at the CHCs, DHs and MHVs shall be provided by the private provider. However, the private provider may submit a detailed

plan for any expanded scope of services (and details of how the doctors and specialists will be deployed) based on the demand- supply analysis (for services) and the epidemiological profile in the district. Service delivery (and performance) shall be the primary focus of the contract and the private provider will be given sufficient flexibility to determine the input conditions such as deployment of (specialist) human resources. Facility-based activities under national health programs (such as disease control, vector control, preventive and health promotion activities, health camps, etc.) shall be part of the scope of services and bids should reflect cost of such activities.

The private provider shall treat all patients who visit the health service delivery points and shall not be charging any additional fee except as provided in the contract. Beneficiaries of RSBY and MSBY shall also receive treatment from the health facilities, but the billing and reimbursement modalities and the revenue share will be determined and specified in the bidding documents and under the contract. The private provider (facilities under its management) shall be a key component of the ICT based referral network (and help desk) for the primary care service network that is being envisaged. Some specific issues such as the need for full time radiologist vis-à-vis a female medical officer licensed for antenatal USGs under the PNDT act, and the use of USG in the MHVs, were carefully reviewed while determining the scope of services under MHV. Similarly, it was agreed that the number of specialists to be deployed in the DH should be based on the case load factor rather than the just the staffing norm.

c) Institutional Framework: In order to sustain health sector PPPs in the state, over long term horizon beyond the project period, it was agreed that the state's health sector PPP cell should be a single one, and located in the Directorate of health services, though strengthened by the project. The organizational framework, operational and administrative responsibilities including financial powers of the PPP cell and their reporting relationship vis-à-vis UKHSDP will need to be worked out accordingly. It was agreed that the PPP cell (staffed with consultants) will be responsible for the developing PPP concept cases, and shall be involved in the design, 'procurement', supervision and monitoring, and overall management of health sector PPPs in the state. It was also suggested that all the existing PPP contracts (under NRHM, UKHFWS, etc.) should be gradually brought under the overall responsibility of the unified health sector PPP cell.

d) Financing mechanism and payment:

The principal source of funding for the PPP projects will be from the GOUK (including project funds, as applicable). In addition, RSBY and MSBY earnings shall augment these resources. The private provider is expected to estimate the case mix, case load, volume of services, bed occupancy, average length of stay and other performance/ productivity parameters, while estimating the bid value. It was agreed that the government shall pay / reimburse the private provider broadly on three categories: a) Base contract (minimum contract value for ensuring availability of earmarked clinical and support services including emergency services); b) Volume based service contract (Payments based on delivering a volume of services- volumes to be categorized into slabs beyond the minimal volume); c) Incentives for quality (incentive for adherence to clinical quality indicators) and other performance indicators. The KPIs for each of the above three payment categories have been developed by the technical advisory team in consultation with the state. It was suggested that the case mix / volume

based fee should constitute the bulk of payment so that service delivery is the focus of the contract rather than just maintaining a service delivery readiness. The team would also undertake further consultation & discussion to understand the issues related to nature of payment under RSBY and the revenue share from reimbursements. The institutional mechanism for payment under PPP contracts would be one unified source of payment for services and incentives. Any user charges collected from patients (APL patients or registration fee from all patients, donations, etc.) as agreed under the contract may be deposited as specified in the bidding documents.

e) Contract period, handover clauses and renewal:

The initial contract shall be for a period of 4 years with a provision to extend the contract to the same provider for another 2 years. After 6 years the contract shall be rebid or renegotiated. Therefore the bid estimate should contain the capital expenditure amortized over only 4 years. In case of equipment, annual depreciation rate shall be used to subtract the final settlement of dues with the private provider, as applicable. Any outstanding reimbursement/ payment to the private provider from the government shall be released only after the private provider vacates the premises; and after all dues / penalties have been duly settled. It was agreed that before the renewal or termination of the contract, sufficient time period should be allowed in order to plan for smooth transition of service provider without disrupting the service delivery. Once the contract is awarded, the private provider is responsible for upkeep and maintenance of all the assets (building, equipment etc.).

f) Communication and institutional coordination at the district level:

The private provider assumes the service delivery responsibilities (contract for MHV, CHC and DH), intense efforts must be made to create awareness (about service delivery points run by the private provider) to the community through publicity campaigns and outreach camps. This is planned to be carried out in conjunction with the government health officials in the district. The contract should make a clear mention of the institutional arrangements for coordination, decision making, supervision, monitoring, and accountability systems between the local authorities, field health workers and the private partners.

Implementation Arrangements:

Private sector component would be implemented by PPP cell headed by One Joint Director level official, who will be supported by two Assistant Director level officials (one for Contract Management and another for Program management). Under each Assistant Director, there would be expert and support staff as required. Under Assistant Director (Contract Management), there would be two consultants one for MIS and another for M & E, further supported by program assistant, Under Assistant Director (Program Management), there would be two consultants one for Planning & Transaction and another for Legal, also PPP cell is equipped with Accounts manager. The structure of PPP Cell is presented in (Implementation Arrangement). The PPP cell will be headed by Joint Director level official, who will be a full time staff on deputation from DoMHFW to UKHSDP. Further, Both the Assistant Director level person under PPP Cell (Contract Management & Program management) will be a full time staff on deputation from DoMHFW to UKHSDP. These officials will for all purposes report to Joint Director (PPP), who will further report to Project Director UKHSDP

through Additional Project Director. The roles and responsibilities of the respective Consultants are presented separately as annexure to this document.

In addition, the PPP Cell in consultation with other cells will also strive and devise a strategy for upgrading the CHC which is farthest from the district hospital as a sub-district hospital with visiting specialists and referral transport facility (in each district).

The PPP Cell will hire a transaction advisor to conduct with due diligence the structural transaction for the integrated network and for designing financing options for PPPs with the broader financing approach and design wherever needed.

The PPP Cell will also commission a status paper on regulation related to quality initiatives – Clinical Establishments Act, RSBY, MSBY and NABH accreditation etc.

Sub-component 1.2: Innovations in Healthcare Financing

This sub-component aims to support expansion of primary care coverage into the state's health insurance programs (RSBY and MSBY), as also addresses the bottlenecks that these programs have been facing. This sub-component will focus on designing, implementing and evaluating benefit packages around childhood and adolescent health as well as case management of non-communicable diseases in primary care settings. In February, 2014, the state announced initiative similar to RSBY called Mukhamantri Swasthya Bima Yojana (MSBY) for BPL as well as non income tax payee APL families for inpatient services. First phase of MSBY was launched in April 2015 to July 2016. Subsequently second phase of the scheme with enhanced financial cover was launched in August 2016. The objective of this sub-component is to identify key elements of current Mukhamantri Swasthya Bima Yojana (MSBY) implementation that need to be strengthened and the contours of program expansion into primary care.

Implementation challenges facing current RSBY/ MSBY implementation: Following significant state pressure on the single RSBY insurance provider in the state, there have been large improvements in recent months in claims settlements. However, here are still some challenges that the state faces—

- There is a great need to include RSBY data base management and information flows in the existing implementation mechanism. There is also a need for improved monitoring and tenure criteria oriented towards quality with respect to insurance providers.
- Moreover, the state intends to expand RSBY into primary care, in a phased manner. Expanded packages as a pilot would be implemented in a small number of districts. First-phase coverage expansion may start with child health services, with the potential to expand in the next phase to non-communicable diseases.
- The state needs to act quickly to begin integration of outpatient services coverage in pilot districts.
- Key decisions regarding specifics of expanded benefit packages, provider payment mechanisms, rates, empanelment criteria (including the balance between access and other provider characteristics), and interface with the existing hospital coverage need to be taken soon and communicated in detail to the insurance provider.

- No link between RSBY and Mobile Medical Vans

In view of the aforesaid, under UKHSDP, specifically the following activities are to be implemented—

- The project will support constitution of an expert group to guide the development of clinical content and guidelines for promotive, preventive and curative care for children in the age group of 0-18 years. In addition, the group will also guide the development of clinical pathways on triage, emergency care management and referral guidelines (for primary care settings) focused on the common health needs of children (0-18 years), as well as the essential elements of an age-appropriate annual assessment.
- Designing and implementing a proper system for managing and using RSBY data and information flow
- Devising and implementing improved monitoring and tenure criteria oriented towards quality with respect to insurance providers.
- Expanding RSBY/MSBY into primary care in a phased manner. In this activity, expanded packages will be piloted in a selected number of districts. The first-phase coverage expansion would start with child health services, with the potential to expand in the next phase to non-communicable diseases. Further, integrating outpatient services coverage in pilot districts is also planned. For the first phase, since the design of the primary care expansion will not be ready right away, it is proposed to obtain the insurer's commitment to a clause in the new insurance contract to include administration of primary care packages at no cost with reimbursement of claims paid for primary care packages being made to the insurer by the state on a no-loss-no-profit basis.
- Designing and finalizing the specifics of expanded benefit packages, provider payment mechanisms, rates, empanelment criteria (including the balance between access and other provider characteristics), and interface with the existing hospital coverage and communicating the same to the insurance providers.
- Including RSBY/MSBY card readers in mobile medical vans, at the very least for enabling beneficiaries to check as to whether their cards

Implementation Arrangements:

The PIT of UKHSDP in coordination and consultation with the RSBY/MSBY Cell of DGHS and RSBY and other cells under UKHSDP will start by designing a proper system for managing and using RSBY data and information flow, improved monitoring and tenure criteria oriented towards quality with respect to insurance providers. Thereafter, the RSBY and PPP cells/PIT will devise and design the strategy for expanding RSBY/MSBY into primary care in a phased manner, which would involve— (a) Designing and finalizing the specifics of expanded benefit packages of primary care for child care and non-communicable diseases, (b) provider payment mechanisms, (c) rates, (d) empanelment criteria (including the balance between access and other provider characteristics), and (e) interface with the existing hospital coverage. The strategy development would also involve devising mechanism for including RSBY card readers in mobile medical vans, so that the larger public may make use of the facility through RSBY/MSBY. Further, the RSBY Cell will also develop an information network that supports a patient centric health system that would help patients navigate across different levels of care, public and private providers as well as create linkages to financing

entities such as RSBY/MSBY. Once the aforesaid steps have been implemented, the private players will be identified and invited to be part of the integrated system.

Monitoring Indicators: Innovations in Engaging the Private Sector

In view of the activities planned under this component, the following would be the proposed key output indicators to assess the impact made by the project interventions over a period of time-

Sub-component 1.1: Innovations in integrated delivery of healthcare services

1) **Covered children who receive an annual assessment**: One of the key focus areas of the project is to create integrated technology-enabled health system architecture with enhanced focus and availability of primary care, emergency care and necessary referral services, especially for the women & children in the state. In view of the same, over the period of six years of the project implementation, effort will be made to increase the number of children who receive assessment . The annual assessment of children would include assessment of the services, vaccinations and screening tests listed in the protocols and will be divided in age bands. The Numerator would be the number of children who receive an annual assessment by mobile vans or CHCs and the Denominator would be the total number of children covered by RSBY/MSBY

   The assessment would be done on an annual basis and the responsibility of data collection would lie with the CHCs for their concerned area of coverage. Further, the data would be collected from the routine reporting system of primary services.

2) **Cumulative number of patients who use outpatient services provided by the PHCs, CHCs and MHVs (by districts):** Under the integrated district-level network approach, it is envisaged that the management contracts for the CHCs and the Mobile Health Vans (MHVs) would be combined (within a geographical area), to one private provider in order to optimize the service delivery channels. For assessing the impact made by such an intervention, especially on primary care,it would be required to assess as to how many patients have availed outpatient services at PHCs, CHCs and MHVs.. Over the period of six years of the project implementation, efforts will be made to increase the number of people availing these services from 7.74 lakhs to 11 lakhs per year.. Further, as the project endeavours to make accessing healthcare facilities and services more convenient and easy for the state's populace, especially the women & children; it will be endeavoured to collect, compile and analyse gender-wise.

   The assessment would be done on an annual basis and the responsibility of data collection would lie with the outsourced CHCs for their concerned area of coverage. Further, the data would be collected from the routine reporting system of the CHCs.

3) **Cumulative number of patients who use the services provided by the mobile health vans (by gender):** As mentioned in point no. 2 above, under the integrated district-level network approach, it is envisaged that the management contracts for the CHCs and the Mobile Health Vans (MHVs) would be combined (within a geographical area), to one private provider in order to optimize the service delivery channels. It will be endeavoured to explore the possibilities of

integrating the current MHV and CHC contracts into one contract with in a geographical contiguity (i.e. a district), designing the implementation mechanism, and implementing the same. In view of this, for assessing the impact made by such an intervention, it would be required to assess as to how many patients have availed the facilities and services being delivered by the MHVs. Thus, it is proposed to measure the number of patients availing the services of MHVs. Over the period of six years of the project implementation, efforts will be made to increase the number of people availing services of MHVs to 50,000 from the baseline status. Further, as the project endeavours to make accessing healthcare facilities and services more convenient and easy for the state's populace, especially the women & children; it will be endeavoured to collect, compile and analyse gender-wise (Female v/s Male) data of the patients availing services from outsourced CHCs.

The assessment would be done on an annual basis and the responsibility of data collection would lie with the MHVs for their concerned area of coverage. Further, the data would be collected from the routine reporting system of the MHVs.

4) **Number of mobile medical units complying with requirements of having at least one female doctor with sonology certification (>90% compliance on day to day basis) (Number)** The project endeavours to make accessing healthcare facilities and services more convenient and easy for the state's populace, especially the women & children. The focus of the state has also been the same. In view of this, the state had mandated the MHV operators to deploy at least one female doctor with each MHV. However, there have been instances where the MHVs were fund to be operating without female doctor. Such instances on one hand hamper the availing of MHV services by the female populace, on other hand it is also a breach of contract conditions. Thus, under the project, it is proposed to monitor and assess this indicator.

   This exercise would be carried out annually and the corresponding data would be culled out from the data available with PPP Cell and with the financial reports submitted by MHV operators. The responsibility of collecting and analysing this data will lie with the PPP Cell.

5) **Patients utilizing the emergency services of the outsourced CHCs per year:** Under the integrated district-level network approach, it is envisaged that the management contracts for the CHCs and the Mobile Health Vans (MHVs) would be combined (within a geographical area), to one private provider in order to optimize the service delivery channels. It is suggested that the MHVs (under PPP) could act as the primary care community level gateway, in which out-patient consultation, basic lab services, ANCs and supply of medicines could take place. If the patient needs additional clinical services or diagnosis, the CHCs could act as the first referral unit. In case, patients need advanced diagnostics (e.g. CT/MRI) and (specific) specialty care services (e.g. surgical wards), the CHCs could refer the patients to district hospitals where such services could be managed and operated by the same (or alternate private provider) under collocation or BOT models of PPP. This would also include delivery of emergency services to the patients. However, to assess the functioning of the outsourced CHCs as regards the delivery of emergency services to patients, it would be required to measure the number of patients who

availed emergency services at the outsourced CHCs. Over the period of six years of the project implementation, earnest efforts will be made to increase the number of people availing emergency services at the outsourced CHCs to 2,000 from the baseline status.

The assessment would be done on an annual basis and the responsibility of data collection would lie with the outsourced CHCs for their concerned area of coverage. Further, the data would be collected from the routine reporting system of the CHCs.

6) **Cumulative number of emergency Cesarean sections (C-section) performed in the outsourced CHCs:** as envisioned in the project, the very purpose of outsourcing the CHCs to private operators is to ensure that all required medical (specialist and general physicians) and paramedical staff are available at the CHCs for delivering required services. This includes the services of a Gynaecologist. The key advantage of having a gynaecologist at the CHC is that, in case required the C-section operations can be undertaken at the CHC level itself. This would also greatly reduce the load of conducting C-section deliveries at the District level hospitals. However, to ascertain that whether or not the deployment of a Gynaecologist at CHCs has aide in the purpose, it is required to make an assessment of the number emergency of C-section deliveries being conducted at the outsourced CHCs. Over the six year period of the project implementation, it is targeted to increase the number of emergency C-section deliveries being conducted at CHCs by 2000 from the baseline status.

   The assessment would be done on an annual basis and the responsibility of data collection would lie with the outsourced CHCs for their concerned area of coverage. Further, the data would be collected from the routine reporting system of the CHCs.

Sub-component 1.2: Innovations in Healthcare Financing

1) **Benefit package of child health services finalized and piloted:** As part of the activities under the 'Innovations in healthcare financing' of the project, one of the key activities is to design, finalize and pilot the package of child health services under the RSBY and MSBY. This would be very crucial in order to achieve the objectives envisioned under the project. However, to keep track of the progress of the activity with a view to ensure its contribution in achieving desired outcomes from the implementation of the project; would be an important measure. Under the project, it is envisioned that delivery of child health services package would start from the second year of project implementation.

   Thus, it is to assess on an annual basis the status of the progress of designing, finalizing and piloting of the package of child health services under the RSBY and MSBY. The responsibility of undertaking this assessment would be of the UKHFWs and the source of data for the same would be the appropriate administrative records.

2) **Benefit package of NCDs services finalized and piloted:** As part of the activities under the 'Innovations in healthcare financing' of the project, one of the other key activities is to finalize and pilot the package of NCD services under the RSBY and MSBY. This also would be very crucial in order to achieve the objectives envisioned under the project. However, with a view to ensure its contribution in achieving desired outcomes from the implementation of the project;

keeping track of the progress of the activity; would be an important measure. Under the project, it is envisioned that delivery of NCD services would start from the fourth year of project implementation.

Thus, it is proposed to assess on an annual basis the status of the progress of finalizing and piloting of the package of NCD under the RSBY and MSBY. The responsibility of undertaking this assessment would be of the UKHFWs and the source of data for the same would be the appropriate administrative records.

3) **Eligible households enrolled under RSBY/MSBY during the year:** RSBY and MSBY are specific schemes intended to assist the poor households of the state in availing quality healthcare services at Government as well as at private healthcare facilities. However, for wider distribution of the benefits of these schemes, it is mandated that the maximum number of households are enrolled for the purpose. As per the available data, currently 46% of the eligible households are enrolled under the schemes. Under the project, it is targeted to increase the enrolment proportion by u to 55% from the baseline status, that is, up to 100%. The year-wie target for increasing the enrolment are presented in the box below—

Baseline	**Household Enrolment Increase Target**					
	Project Year					
	Y1	**Y2**	**Y3**	**Y4**	**Y5**	**Y6**
46%	**46% (46%)**	**50% (96%)**	**50% (96%)**	**50% (96%)**	**50% (96%)**	**55% (100%)**

The assessment of the enrolment target achievement would be done on an annual basis and the source of data for the purpose would be RSBY & MSBY administrative reports. For assessing the target achievement, the Numerator would be the number of households enrolled under RSBY/MSBY in the year and the Denominator would be the total number of households eligible for RSBY/MSBY coverage in the year. The responsibility of data collection and its assessment would lie jointly with the RSBY unit and the implementing agencies.

For details regarding years-wise monitoring indicators of for sub-components and sub-component activities (frequency of monitoring, data source/methodology for monitoring, responsibility of monitoring/data collection, description of indicators, etc.), please refer to the chapter on 'Results Framework and Monitoring System' at Page No. 57

Budgetary Requirement
Component 1.Innovations in engaging the private sector component

Sr.No.	PROJECT COMPONNENT & ACTIVITIES IN DETAIL	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Total	% Cost
	Componnent - 1: Innovations in engaging the private sector component									
	A. Innovations in integrated delivery of healthcare services (primary, referral and emergency care) (USD 47.5 m)									
1	**Distt operator- MHV+ CHC + DH strengthening (Integrated Model)**	**0.25**	**5.50**	**6.00**	**9.00**	**9.50**	**9.50**	**2.75**	**42.50**	**34.00**
1.1	Package 1 (Integrated Model for District A)	0.25	3.00	3.50	3.50	3.50	3.50	1.25	18.50	14.8
1.2	Package 2 (Integrated Model for Small/ Sub-District B)	0.00	2.50	2.50	2.50	3.00	3.00	0.50	14.00	11.2
1.3	Package 3 (Integrated Model for District C)	NA	NA	NA	3.00	3.00	3.00	1.00	10.00	8.0
2	**Health Triage + Telemedicine**	**0.00**	**0.67**	**1.00**	**1.00**	**1.00**	**1.00**	**0.33**	**5.00**	**4.00**
	B. Innovations in Healthcare Financing (USD 32.33 m)									
3	**RSBY/MSBY child health**	**0.00**	**1.50**	**3.50**	**4.00**	**5.00**	**5.00**	**1.33**	**20.33**	**16.26**
4	**RSBY/MSBY NCD**	**0.00**	**0.00**	**1.00**	**2.00**	**4.00**	**4.00**	**1.00**	**12.00**	**9.60**
	Total	0.25	7.67	11.50	16.00	19.50	19.50	5.41	79.83	64

Implementation Plan (Time Frame): Innovations in Engaging the Private Sector

Sl.	Activity	Time Frame						
		Y1	Y2	Y3	Y4	Y5	Y6	Y7
A	**Innovations in integrated delivery of healthcare services (primary, referral and emergency care)**							
1	Supporting development of a conducive regulatory, policy and institutional environment to support on-going and new PPPs as well as new investments in the state, especially in the remote areas							
2	Reviewing and restructuring on-going PPPs for community health centres (CHCs) and mobile health vans							
3	Supporting development of new PPPs as integrated network of mobile health vans, outsourced and government runs CHCs and specialized services and diagnostic services at the district hospitals in selected districts, with outreach services from the district hospital to the CHCs under its jurisdiction.							
4	Implementation of district-level integrated model							
B	**Innovations in Healthcare Financing**							
5	Developing an information network that supports a patient centric health system that would help patients navigate across different levels of care, public and private providers as well as create linkages to financing entities such as RSBY/MSBY							
6	Expanding RSBY/MSBY into primary care (Child care and NCD) in a phased manner - Designing and finalizing the specifics of expanded benefit packages, provider payment mechanisms, rates, empanelment criteria (including the balance between access and other provider characteristics), and interface with the existing hospital coverage							
7	Implementation of specific primary care component under RSBY/MSBY interventions							

Component 2: Stewardship and System Improvement Component

This component aims to strengthen the government's ability to effectively implement the first component of the project and thus, enable them to provide effective stewardship to the entire health system and particularly in its capacity to effectively pursue the innovations being planned under this project. This component will also finance the project implementation costs. The component will build upon the foundations of the previous Bank project in the state. It will work closely with the present structure of the National Health Mission (NHM), which is the flagship initiative of the national government, providing additional financial resources to strengthen the state's health delivery infrastructure, with a focus on public health, maternal and immunization services, and disease control programs. One of the aims of this component is to strengthen the program management capacity for the health system as a whole, and not just the activities under the project.

The focus of this component will be on strengthening the institutional structures for stewardship and service delivery under the project, as well as augmenting the state's own human resource capacity, with the intention that the necessary skills required for efficacious implementation of the project and the other health programs of the State are ensured.

The capacity of the department as well as that of staff, as strengthened under this component, will not only serve the activities of this project, but also contribute to the leadership role of the government for the health system as a whole.

Under this component, it will also be endeavoured to promote the establishment of a governance structure and regulatory system for improving delivery of quality services at all levels, with a view to ensure that services provided by public and private providers are of good, equitable, and comparable quality. The activities under this component will also support research and evidence generation, with a view to generate relevant information and evidence for strategic planning, improved information systems, and for data generation & management for assisting the department in taking informed and appropriate decisions, including timely feedback to service providers. Moreover, the activities under this component the component are also envisioned to promote a multi-disciplinary approach for strengthening the ability of the State's health system to respond to seasonal and context-specific needs. Couple of key areas under this component are mentioned below.

Disaster Preparedness: Under UKHSDP, for strengthening the disaster response, activities under this project will be designed to coordinate and complement on-going activities and investments under Bank-supported Uttarakhand Disaster and Recovery Project. The overall aim is to develop a trauma-resilient health system which is prepared to attend to such eventualities could prevent considerable loss of life and contribute to favourable health outcomes through timely and appropriate treatment of trauma victims.

It is aimed at supporting development of a comprehensive disaster response plan for the health system, which is regularly updated and fully integrated with the broader state disaster management plan. This plan will take account of relevant human resource needs and available expertise, and the ability to mobilize the resources in disaster situations to where it may be needed. Long-term goal of

this sub-component will be to have the health sector prepared to respond to any disaster in a way that is fully coordinated with other sectors.

Quality Improvement

Various activities under quality improvement are already taking place in the state. The state has defined Quality Assurance implementation framework and formed State and District Quality Assurance committees. State is committed to improve quality of health care delivery in the state and project will play major role in its implementation. Under this component steps will be taken to bring all public health facilities under NABH accreditation, implementation of same will be in phase-wise manner. Initially, efforts will be directed in bringing 5 public health facilities under NABH accreditation which are identified (Dharchula, Kapkot, Joshimath, Guptkashi and Bhatwadi). Under the project, support will be provided for facilities assessment and contracting of turnkey services for identified public health facilities for attaining NABH quality standards and attaining NABH certification.

Implementation Mechanism:

The Joint Director level official will head this component, he will be supported by One Assistant Director level official and one health communication and multisectoral coordination officer from DoMHFW to UKHSDP on full time deputation. Also this component is further supported with five full time experts on contractual basis (Expert HMIS, Expert Monitoring and Evaluation, Expert Environment & Social safeguard, Research Expert and Health Communication Expert), supported by five program assistants. The Contractual Experts and Program Assistant for all purposes will report to Joint Director Health System Strengthening , who will in turn report to the Project Director (UKHSDP) through Additional Project Director (UKHSDP).

The said two cells will undertake various activities required for efficacious implementation of various interventions planned under UKHSDP

Monitoring Indicators: Stewardship and System Improvement Component

1) **Number of Specialists working in the outsourced health facilities (and augmenting the positions functionally vacant in the public system) (Number) :** In order to provide equitable and quality healthcare services to the populace of the state, one of the pre-requisites is having appropriate and proper staff at all levels of healthcare facilities. Out the various health facilities, upwards from grassroots (SHC) level; CHC is the first level of healthcare facility where the patients can avails the services of specialist doctors. However, as per the Government records, currently 75% of post of specialist are lying vacant at the CHC level. Under the project, dedicated efforts will be made to bridge this gap and reduce the number of vacancies of specialist at CHC level. Under the six year project implementation period, it is targeted to bring down the proportion of vacant specialist positions at CHC level by 50% from the baseline status of 75%, that is, up to 25% at the end of project period.

2) **Development and periodical update of a comprehensive disaster response plan at the state level:** As part of the project, it is also planned to assist the state in preparing and updating its comprehensive disaster response plan (health focussed). However, as it involves detailed planning, assessing available and required resources, making sector specific plans, etc.; it is required to carefully design and update the disaster plan (as per needs). Thus, it is proposed that after making careful and detailed assessments for the first year, the process of preparing the disaster response plan would be initiated from the second year of project execution. All other relevant details regarding state specific needs would be compiled for the plan from the third to fifth year of project execution; and at the end of the sixth year an updated 'Comprehensive State Disaster Response Plan' would be available.

   The monitoring of the 'Comprehensive State Disaster Response Plan' activity would be done on an annual basis using the administrative records of UKHFWS and the overall responsibility of monitoring would also lie with UKHFWS.

3) Number of governmental and non-governmental healthcare facilities issued with an entry (or higher) level certification by NABH (Number)
4) Health personnel receiving training financed by the project- cumulative (number)

For details regarding years-wise monitoring indicators of for sub-components and sub-component activities (frequency of monitoring, data source/methodology for monitoring, responsibility of monitoring/data collection, description of indicators, etc.), please refer to the chapter on 'Results Framework and Monitoring System' at Page No. 58

Budgetary Requirement: Stewardship and System Improvement Component

Sr.No (Continued numbering from budget Table of Component 1)	PROJECT COMPONNENT & ACTIVITIES IN DETAIL	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Total	% Cost
	Componnent - 2: Stewardship and system improvement component (USD 45.17 m)									
5	**Project Core Team And Office Expenses**									
5.1	Government staff on deputation to project	0.34	0.37	0.41	0.45	0.50	0.55	0.60	3.23	**2.58**
5.2	National Consultant MIS	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.3	National Consultant Supervision Monitoring & Evaluation	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.4	National Consultant Transaction Management & Planning	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.5	National Consultant Procurment	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.6	National Consultant Finance	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.7	National Consultant Enviornment & Social	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.8	National Consultant Primarycare & Child Health	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.9	National Consultant Health Research	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.1	National Consultant Multisectorial Coordination	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.11	Hiring of internal auditor	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.12	Hiring of external auditor	0.03	0.03	0.04	0.04	0.04	0.05	0.05	0.28	**0.23**
5.13	Future Consultants & Support Staff (Approx. 25)	0.30	0.33	0.36	0.40	0.44	0.48	0.53	2.85	**2.28**
Total 5.	**Project core team and office expenses**	**0.97**	**1.07**	**1.17**	**1.29**	**1.42**	**1.56**	**1.72**	**9.20**	**7.36**
6	**Office Expences Office Equipment &** Maintenance**, Transport Expenses**									
6.1	Office Equipment	0.35	0.10	0.10	0.10	0.10	0.10	0.10	0.95	**0.76**

6.2	Vehicle rental	0.06	0.07	0.07	0.08	0.09	0.10	0.11	0.57	**0.46**
6.3	Office Supplies & maintenance	0.20	0.20	0.15	0.20	0.22	0.24	0.27	1.48	**1.18**
6.4	Travel Allownce Domestic	0.15	0.17	0.18	0.20	0.22	0.24	0.27	1.42	**1.14**
6.5	Travel Allownce International	0.08	0.08	0.09	0.10	0.11	0.12	0.13	0.71	**0.57**
Total 6.	**Office Expences Office Equipments & Maintance, Transport Expences**	**0.84**	**0.61**	**0.59**	**0.68**	**0.74**	**0.80**	**0.87**	**5.13**	**4.11**
7	**Training Capacity building and consultation workshop**									
7.1	Training on Primary care	0.10	0.10	0.10	0.10	0.03	0.03	0.03	0.48	0.38
7.2	Training on Quality of care	0.03	0.10	0.10	0.10	0.03	0.03	0.03	0.41	0.33
7.3	Training on integrated model of care	0.02	0.15	0.15	0.15	0.15	0.03	0.03	0.67	0.54
7.4	Training on Trauma & NCD care	0.03	0.10	0.10	0.10	0.03	0.03	0.03	0.41	0.33
7.5	Training to SDRF on health response at disaster situation	0.03	0.10	0.10	0.10	0.01	0.03	0.01	0.37	0.30
7.6	Training on Infection control & Bio-medical waste management	0.03	0.10	0.10	0.10	0.03	0.03	0.03	0.41	0.33
7.7	Participation in National & International training programs	0.06	0.10	0.10	0.10	0.10	0.06	0.03	0.55	0.44
7.8	Other Training Activities	0.10	0.15	0.20	0.20	0.10	0.05	0.05	0.85	0.68
Total 7.	**Training Capacity building and consultation workshop**	**0.39**	**0.90**	**0.95**	**0.95**	**0.47**	**0.27**	**0.22**	**4.15**	**3.32**
8	**Consultation Workshop & communication**									
8.1	Health Information system	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.2	104 health helpline	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.3	UHC through RSBY/MSBY	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.4	Social Issues	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.5	Referral mechanism using IT system	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.6	Human Resource Management	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.7	Emergency response in disaster situations	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**

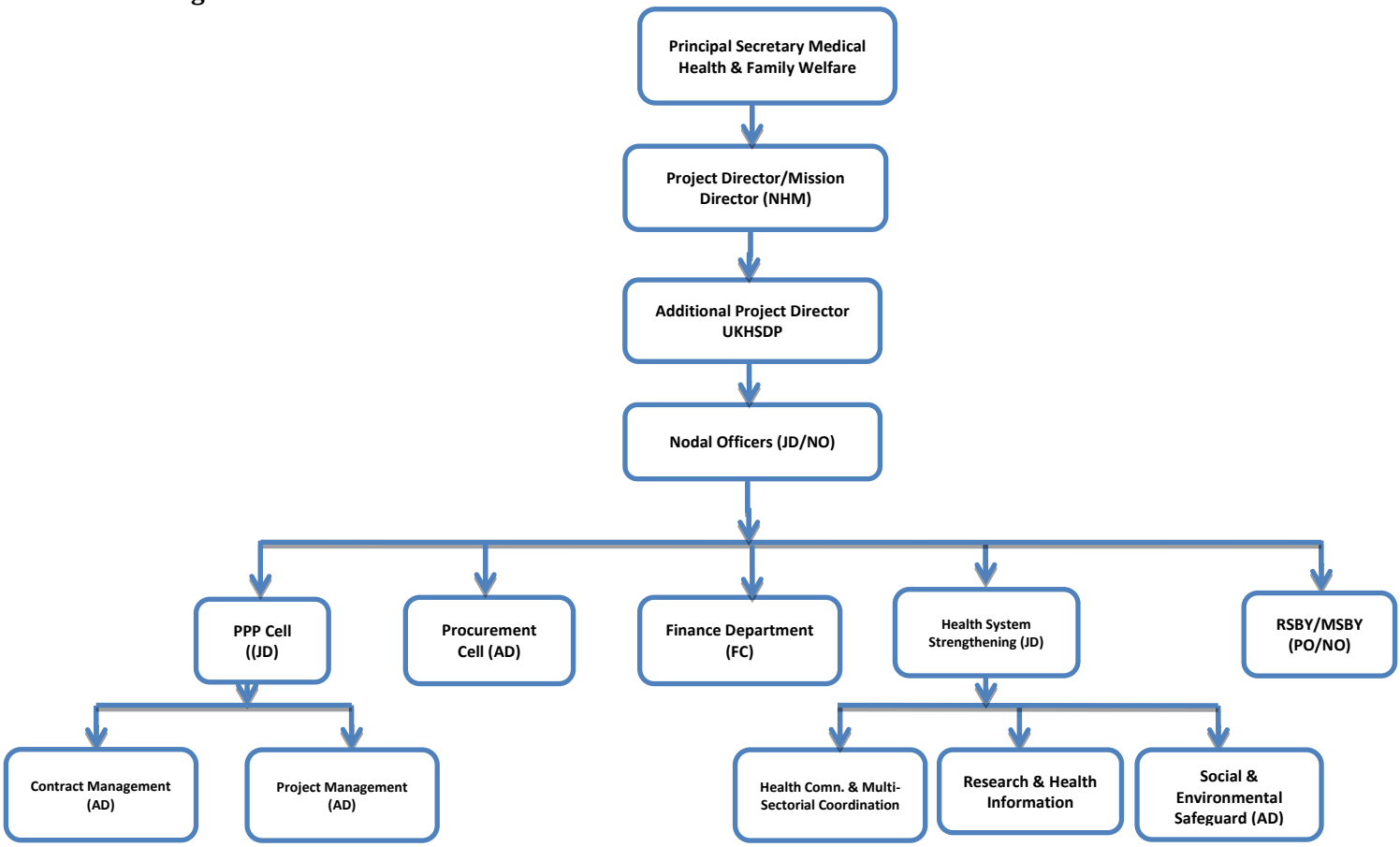
8.8	Provision of healthcare in Yatra route	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.9	Effective multisectorial coordination	0.05	0.03	0.03	0.01	0.01	0.01	0.01	0.16	**0.13**
8.10	Other CW related to Project activity	0.10	0.15	0.20	0.20	0.10	0.05	0.01	0.81	**0.65**
Total 8.	**Consultation Workshop & communication**	**0.55**	**0.45**	**0.50**	**0.29**	**0.19**	**0.14**	**0.10**	**2.22**	**1.78**
9	**Sector Strengthning, Research, Monitoring and Evaluation**									
9.1	Accreditation of public health facilities-feasibility study	0.50	1.00	0.00	0.00	0.00	0.00	0.00	1.50	**1.20**
9.2	Accreditation of public health facilities-turnkey contracts	0.00	2.00	3.00	4.00	4.00	4.00	1.50	18.50	**14.80**
9.3	Household Survey study 1	0.00	0.05	0.10	0.00	0.00	0.00	0.00	0.15	**0.12**
9.4	Household Survey study 2	0.00	0.00	0.00	0.05	0.10	0.00	0.00	0.15	**0.12**
9.5	Information system design	0.03	0.07	0.10	0.00	0.00	0.00	0.00	0.19	**0.15**
9.6	Information system development and implementation	0.00	0.00	0.00	0.20	0.50	1.00	0.40	2.10	**1.68**
9.7	M & E by independent agency	0.12	0.15	0.15	0.20	0.15	0.10	0.05	0.92	**0.74**
9.8	Research grants and other studies	0.20	0.20	0.15	0.15	0.15	0.10	0.00	0.95	**0.76**
Total 9.	**Sector Strengthning, Research, Monitoring and Evaluation**	**0.85**	**3.47**	**3.50**	**4.60**	**4.90**	**5.20**	**1.95**	**24.46**	**19.57**
	Total Component 1	0.25	7.67	11.50	16.00	19.50	19.50	5.41	79.83	64
	Total Component 2	**1.81**	**1.68**	**1.77**	**1.97**	**2.16**	**2.36**	**2.59**	**45.17**	**36**
	Total Component 1 + Component 2	**3.31**	**7.35**	**10.77**	**17.47**	**20.66**	**24.86**	**9.75**	**125**	**100**

IMPLEMENTATION ARRANGEMENT

The Uttarakhand Health System Development Project (UKHSDP) would be implemented by the Uttarakhand Health and Family Welfare Society (UKHFWS) constituted under the Department of Health and Family Welfare, Government of Uttarakhand. The Mission Director of the National Health Mission will also be the Project Administrator for UKHSDP and will lead the project implementation under the overall guidance and supervision of the Principal Secretary, Department of Medical Health and Family Welfare, who is also the Chairman of the Society (Refer Figure 1.0).

A Project team would consist of Nodal officers for each of the key implementation area who will be supported by core group of experts and supporting staff. The project will be implemented over a Six year period by the GoUK, and utilize the standard on lending arrangements from the GoI to the state.

Figure 1.0: ORGANOGRAM/INSTITUTIONAL STRUCTURE

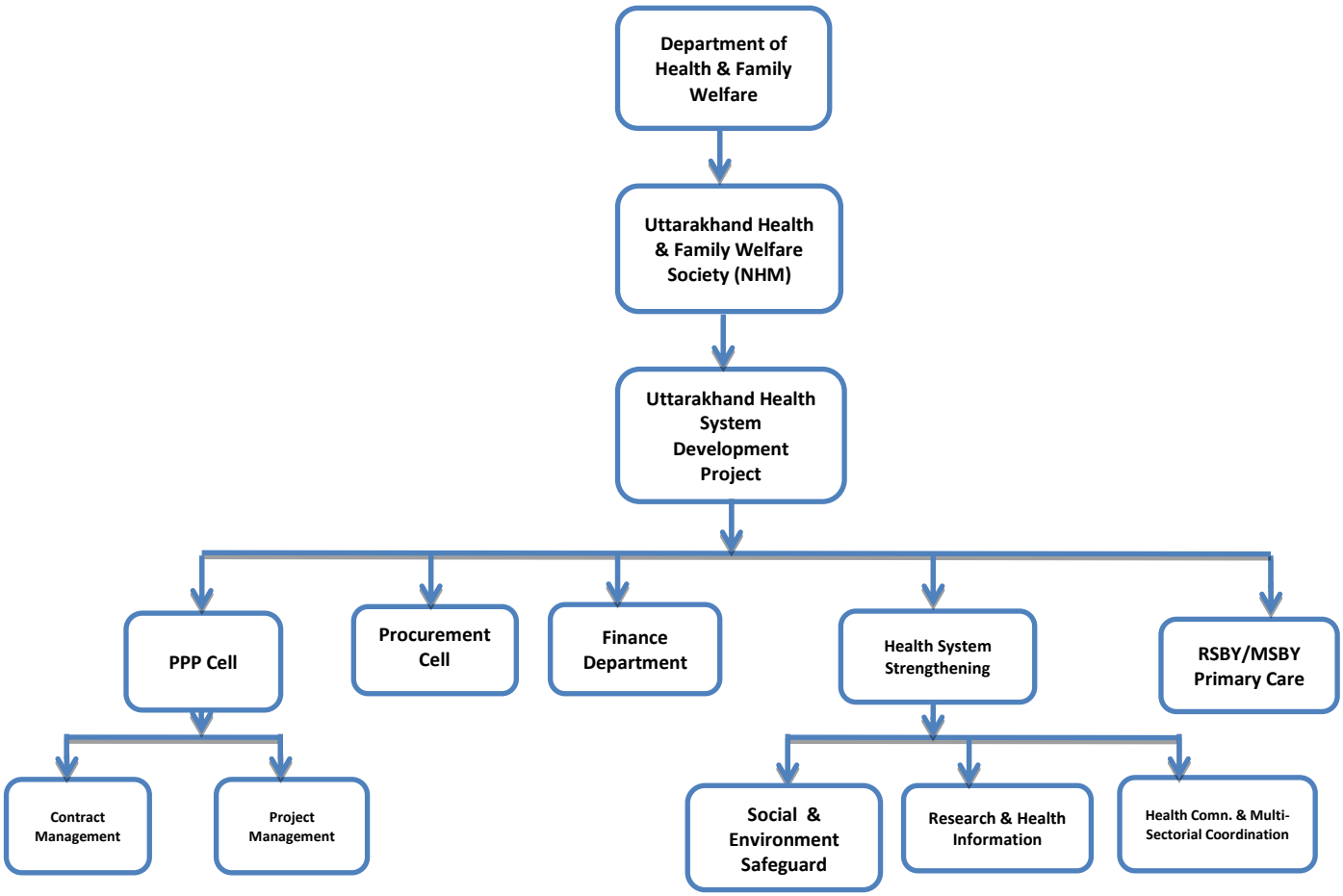


Dedicated wings for key project activities would be established to implement and monitor the specific activities (Refer Figure 1.1), innovation in engaging private sector component would be implemented by PPP cell supported by Joint Director, Two Assistant Director and two consultant under each joint director and support staff *(Detailed structure is depicted on Page No.35*), also the health system strengthening cell/department is have further divided for Social Safeguard cell, research cell and health communication and multi sectoral coordination cell. Procurement cell, Finance department, and independent wing for RSBY/MSBY and primary care activities would be setup with required expertise and support staff at Uttarakhand Health and Family Welfare Society.

The Project will be administered and monitored at various levels:

- ***Project Governing Board (PGB)*** of the UKHSDP at the apex level, headed by the Chief Secretary, GoUK

Figure 1.1: IMPLEMENTATION ARRANGEMENT



- ***Project Steering Committee (PSC)*** of the UKHSDP headed by Principal Secretary, Medical, Health and Family Welfare.
- ***Project Implementation Team (PIT)*** under the Project Director who is also the Mission Director of National Health Mission, UKHSDP (Details of members would be find in Annexure 1)

Project Governing Board (PGB):- Will be constituted under the Chairmanship of the Chief Secretary, Government of Uttarakhand to provide overall direction, approval of posts and financial and legal sanctions. The PGB can delegate powers to the Project Steering Committee (PSC) and the Project Director (PD) in the interest of efficiency in the execution of project activities.

Project Steering Committee:-The PSC will be constituted under the Chairmanship of Principal Secretary Medical, Health and Family Welfare under UKHSDP will have delegation of financial and procurement authority from the PGB for hospital equipment, supplies and consultancy contracts, as well as constituting selection committees to select staff/consultants for project. PSC will consider all proposals administrative, financial, and project components placed before it by the Project Director and accord sanction. The Project Steering Committee will meet at least once in quarter.

Project Implementation Team: -PIT will based at Uttarakhand Health and Family Welfare Society and responsible for managing the timely and effective implementation of the project. It will be led by the Project Director, who will be supported by an Additional Project Director (APD). In addition, the PIT will have team members drawn from the Departments of Medical Health and Family welfare (MH&FW) and their respective Directorates.

The PIT will interact with the health and family welfare society of Uttarakhand and Departments of Medical Health (MH) and Family Welfare in the Government. The Project team will provide technical assistance to PIT/Cells for implementation of the various components and activities as planned in the PIP. The PIT will be responsible to Secretary (MH&FW)/Project Director, the World Bank and Govt. of Uttarakhand for smooth and timely implementation of the Project programs and reporting.

PIT will be based in Five different department/cell under which PPP Cell and Health System Strengthening are two major department/cell, who will be responsible for the implementation of major component of the UKHSDP, however Procurement cell and Finance cell is responsible for the procurement and financial activities of the project respectively, also RSBY/MSBY cell is responsible for the implementation of the health financing component of the project, Project Implementation team is also equipped with Quality assurance and coordination cell is who will be responsible for the day-to-day monitoring and supervision of the project.

Department/Cell head will be responsible for all the activities carried out by the respective department and all the support staff under each department will report to the department/cell head on daily basis, who intern would report to the Additional Project Director (APD) UKHSDP on daily/weekly basis. The Project director will be updated by APD on daily basis. Within PIT routine meetings at least once a month would be held to review the progress of the project under chairman ship of Project director.

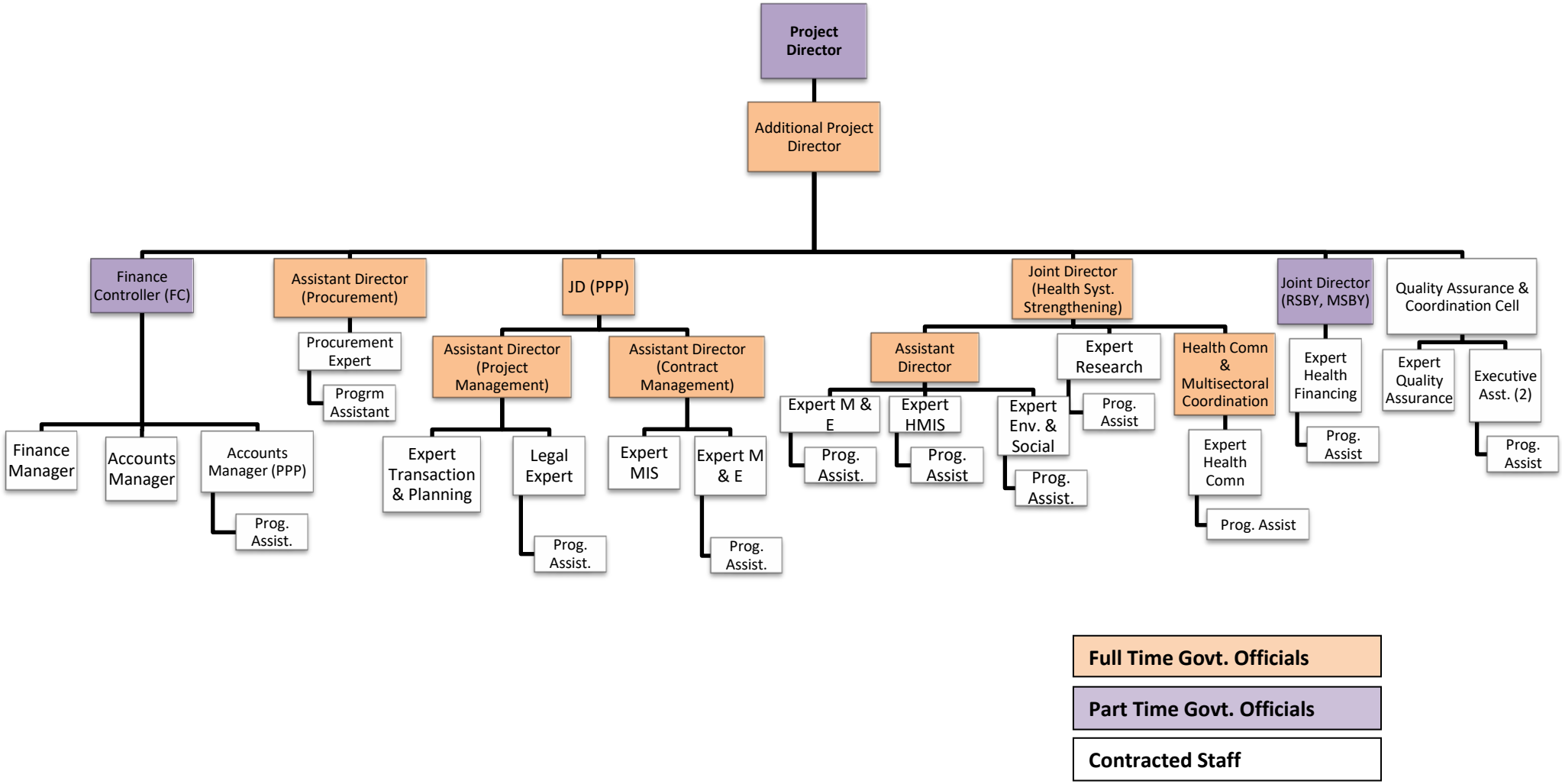
Detailed compositions of department/cells are as below.

Procurement Cell: - Procurement of goods and services including non-consulting services shall be conducted by procurement cell, Procurement cell would be headed by full time Assistant director level official who is supported by Procurement Expert and Program assistant.

Finance Department: - Finance department of project is responsible for all project related financial transactions and this department is headed by Finance Comptroller from Department of health and family welfare of GoUK, FC will be supported by finance expert and accounts manager

The planned constitution of the Project Governing Board, Project Steering Committee, and Project Implementation Team is presented at Section-10 (Annexure)

Detailed Organogram of UKHSDP PIT



Health Communication and Multi Sectoral coordination Cell: This cell is responsible for the activities which involve health communication as well as improved coordination with other departments that have linkages with health; this cell will develop the mechanism for effective sectoral integration for better coordination between departments. Cell will be headed by State IEC officer who will be supported by one full time contractual expert for health communication and multi sectoral coordination.

Social and Environmental safeguard: -Social and environmental safeguard cell is responsible for all activities of the project focusing on social, environmental and indigenous people. This cell will be handled by full time deputed person from DGHS to UKHSDP and supported by couple of national consultants and other support staff.

RSBY/MSBY Primary care: -RSBY/MSBY primary care component of the project will be handled by the RSBY/MSBY cell. This cell will be headed by standing program officer (Joint Director Level) of the RSBY department of state and supported by health financing expert and for effective implementation of the project activities the staff already involved in RSBY/MSBY implementation at state level will also be part of the day to day activities.

PPP Cell: - Public private partnership cell is the important department under PIT; this cell will be responsible for the implementation of private sector component of the project. The Joint Director level official from DGHS on full time deputation to the UKHSDP will head the PPP Cell who will also responsible for all PPP activities of the project, further the PPP cell will be divided into two categories for managing the PPP project efficiently.

The Contract management unit of the cell is headed by Assistant director level official who will be full time official on deputation from DGHS to UKHSDP for efficient management of the PPP projects, Assistant director of contract management unit has supported by at least two Expert one for MIS and other one is for monitoring and supervision of the project activities, also this unit is responsible for payment to the private partner that will be process by accounts manager with coordination to finance department.

The Project management unit of the PPP cell is responsible for development and planning of PPP projects which involved development of transaction mechanism, bid evaluation, project management, etc. as this unit mainly involved in project management activities the full time Assistant Director rank official on deputation from DGHS to UKHSDP will head this department, this unit is also supported by two Expert one expert for transaction and planning and another legal expert, who will looking after the legal part of the PPP contracts.

PPP cell will also supported by few Program assistants who will responsible for making day to day documentation and reporting for efficient integration of PPP cell with private partner, UKHSDP, DGHS and GoUK, also few field coordinators are placed in PPP cell with having main responsibility of monitoring and supervision of private partner and its day to day activities.

Overview of Administrative Approval Processes

This section describes and defines the administrative processes that needs to be undertaken for the implementation of the project with the objective of smooth implementation of project and clarity among different stakeholders the administrative approval process has been divided in to the following

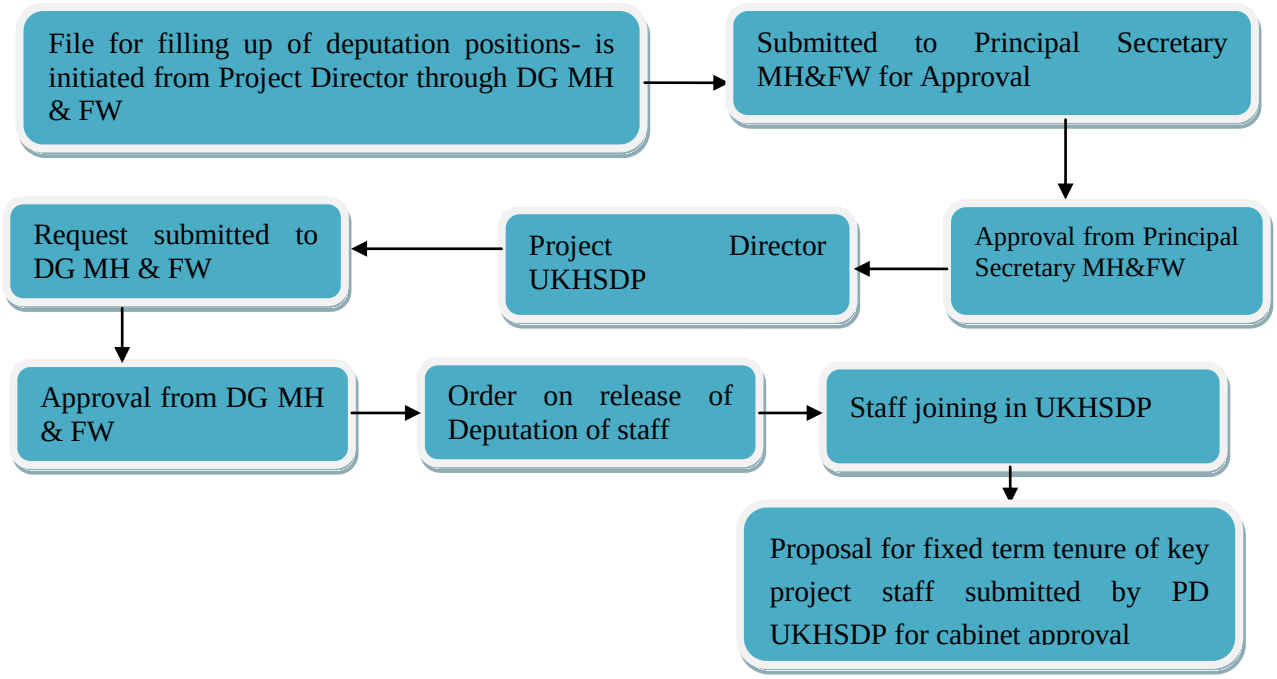
a. Administrative processes related to Human resource management
b. Administrative process related to Procurement
c. Administrative process related to Financial approval system

Administrative Process: Human Resource Management:

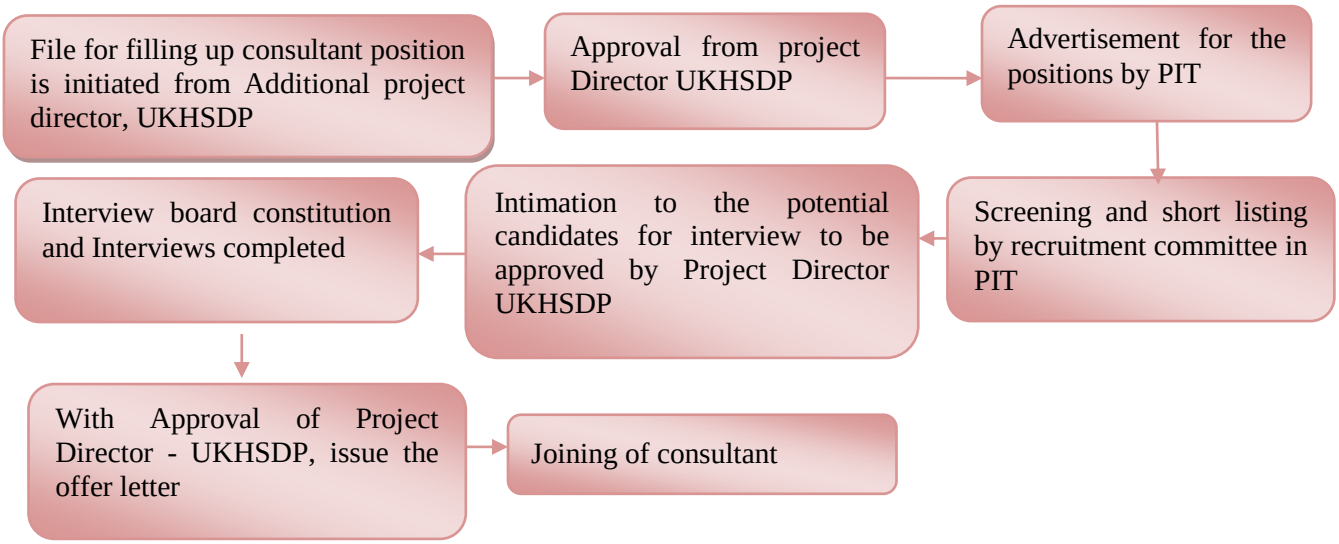
This section provides overview of process for hiring of staff, performance management, day to day operations (travel, salary etc). The projects staffs of UKHSDP, as approved in the organogram in this document, are combination of

- Deputation from departments and
- Consultants hired on contractual basis.

Deputations: For deputations, the project will be required to have people on deputation, particularly for the positions of Director (1), Joint Director (3) and Assistant Director (3). The state has agreed in principle for deputation of these key staff. The staff will be deputed as per the government rules and procedures of the state.

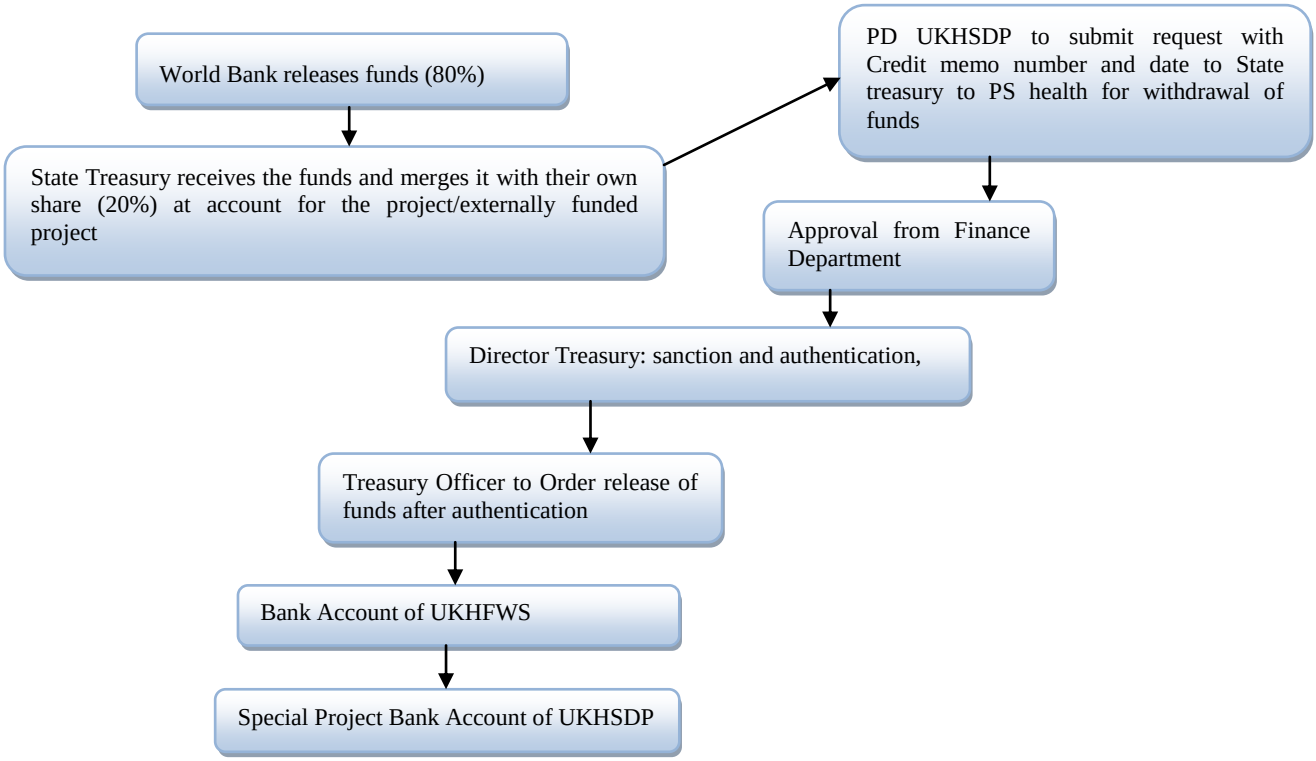


Hiring of consultants:



Administrative process related to financial approval system

The administrative process for financial approval is in line with current administrative process for the funds received by state from GoI for National Health Mission. The drawl authority for the project is Project Director UKHSDP.



Delegation of administrative and financial power:

The state will adhere to provisions of the Delegation of Financial Powers mentioned in UKHFWS society guidelines, guidelines are appended as annexure.

Procurement Management Arrangements

Uttarakhand Health and Family Welfare Society (UKHFWS) is the implementing agency of UKHSDP. Under the current system, procurement was handled by respective units in silos and there was no coordination among these units. It is planned to establish dedicated procurement cell within UKHFWS that would handle all types of procurement (goods, works, non-consulting services and consulting services) in coordination with respective units. Procurement of goods and Non-Consulting Services shall be conducted using e-procurement platform available at https://uktender.gov.in while Consultancy Services shall conducted following normal Bank's procedures. All types of procurement for the project shall be conducted following World Bank's "Guidelines for procurement of goods, works and non-consulting services under IBRD loans and IDA credits & grants by World Bank borrowers," dated January 2011, revised July 2014 ("Procurement Guidelines") and "Guidelines for selection and employment of consultants under IBRD loans and IDA credits & grants by World Bank borrowers," dated January 2011, revised July 2014 ("Consultant Guidelines") and the provisions stipulated in the Financing Agreement (FA). For each contracts to be financed by the loan, the different procurement methods or consultants selection methods, prior review threshold, timeframe etc. are agreed in the Procurement Plan. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. General Procurement Notice (GPN) was published on May 30, 2014 in UNDB and Specific Procurement Notice (SPN) shall be published against corresponding contract packages when it becomes ready. All goods, works and services financed under the project shall be procured using the Bank's Standard Bidding Documents (SBDs) and Standard Request for Proposals (SRFPs) except PPP contracts.

1. The Procurement Cell within the Project Management Unit (PMU) shall facilitate procurement of goods, works and services in coordination with respective units handling procurement.

2. Staffing of Procurement Cell: The Procurement Cell shall have adequate staff supported by a consultant and support staff. The Procurement Cell shall operate under the overall directions and guidance of the Additional Project Director. All procurement activities under this project shall be processed through this cell.

3. Procurement Committee: Evaluation of contracts for procurement of goods, works, non-consulting services and consultancies will be managed by the procurement Committee. Membership of procurement committee is as follows (in line with the arrangements under Uttarakhand health and family welfare society & Directorate of Health and FW):

- Additional Project Director (APD) – UKHSDP
- Nodal Officer – Procurement UKHSDP
- Finance Officer- UKHSDP
- Technical Officer (Concerned Technical Area)
- Joint Director Procurement of Services/ Joint Director Procurement of Goods (Directorate of H&FW)

4. Verification Committee: Verification of items as per the terms of reference and agreement with the contractor/ supplier in terms of specifications, functionality, quality, quantity to be verified by the verification committee on regular basis. Verification committee needs to take in to account the field visit report of project staff and working group members on the items received by the state under this project. Membership of verification committee is as follows:

- Additional Project Director (APD) - UKHSDP
- Nodal Officer - Procurement
- Consultant procurement

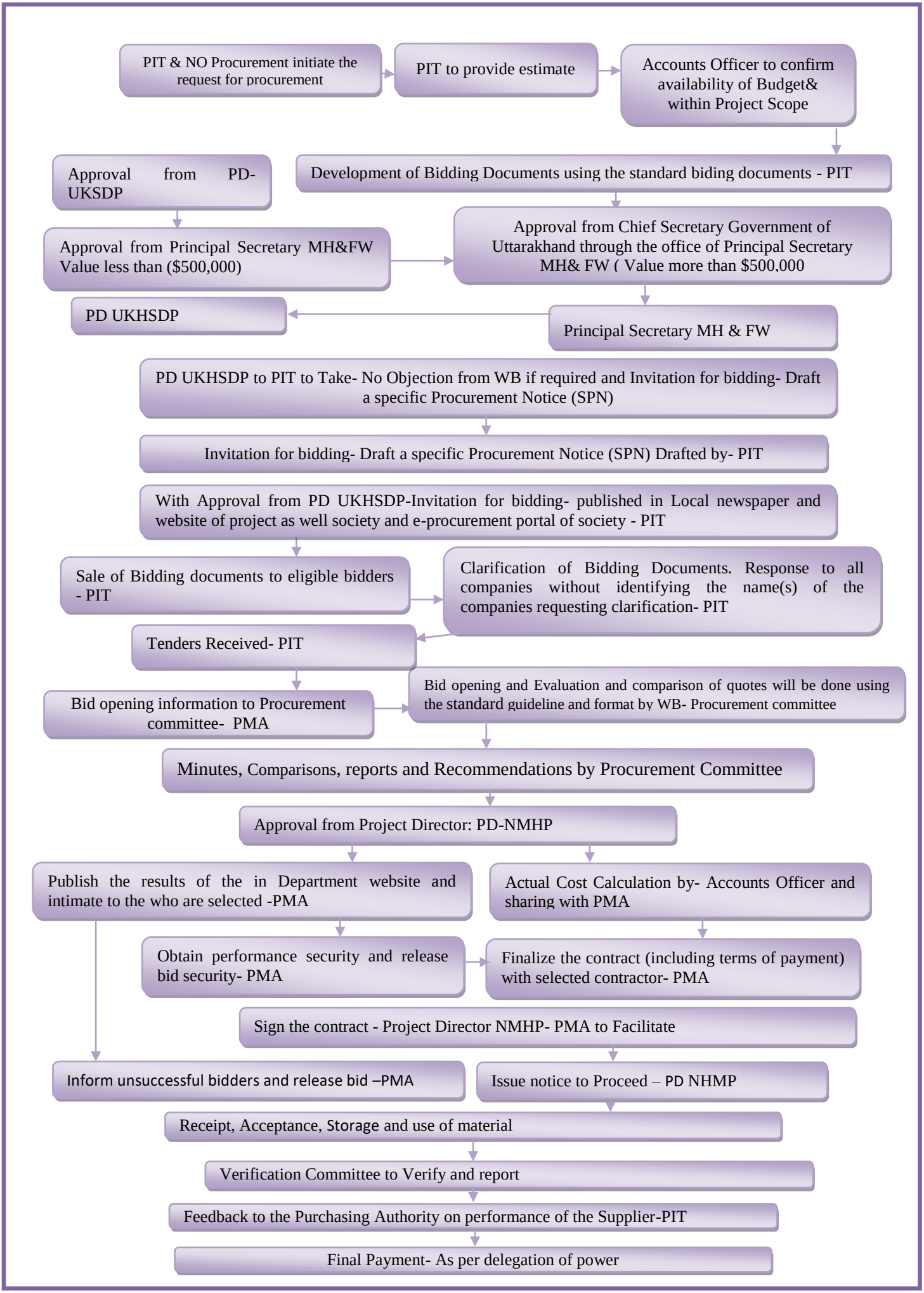
- Consultant Monitoring and Evaluation

Procurement methods:

1. Procurement of Goods, Works and Non-Consulting Services shall be conducted using following methods: **International Competitive Bidding (ICB) :**Procurement of all 3 packages under component 1 shall be conducted using ICB methods using modified Non-Consulting Service model document. The project team has modified this document to suit procurement of integrated Health Services in the form of Public Private Partnership (PPP) model and it will be used for all 8 packages after validation form the state government and the World Bank. There is no Works Contract foreseen for this project.

2. **National Competitive Bidding (NCB):** Procurement of goods, works and non-consulting services which are below the ICB threshold level shall be conducted NCB method in accordance with paragraph 3.3 and 3.4 of the World Bank Procurement Guidelines and following additional provisions shall apply:
   - Only the model bidding documents for NCB agreed with the Government of India's Task Force (and as amended from time to time), shall be used for bidding.
   - Invitations for bid shall be advertised in at least one widely circulated national daily newspaper (or on a widely used website or electronic portal with free national and international access along with an abridged version of the said advertisement published in a widely circulated national daily inter-alia giving the website/electronic portal details from which the details of the invitation to bid can be downloaded), at least 30 days prior to the deadline for the submission of bids
   - No special preference will be accorded to any bidder either for price or for other terms and conditions when competing with foreign bidders, state-owned enterprises, small-scale enterprises or enterprises from any given State.
   - Except with the prior concurrence of the Bank, there shall be no negotiation of price with the bidders, even with the lowest evaluated bidder.
   - Extension of bid validity shall not be allowed with reference to Contracts subject to Bank prior review without the prior concurrence of the Bank (i) for the first request for extension if it is longer than four weeks; and (ii) for all subsequent requests for extension irrespective of the period (such concurrence will be considered by Bank only in cases of Force Majeure and circumstances beyond the control of the Purchaser/ Employer).
   - Re-bidding shall not be carried out with reference to Contracts subject to Bank prior review without the prior concurrence of the Bank
   - The system of rejecting bids outside a pre-determined margin or "bracket" of prices shall not be used in the project
   - Rate contracts entered into by Directorate General of Supplies and Disposals (DGS&D) will not be acceptable as a substitute for NCB procedures unless agreed with the Bank on case to case basis. Such contracts will be acceptable however for any procurement under the Shopping procedures.

- Two or three envelope system will not be used (except when using e-procurement system assessed and agreed by the Bank)


PIT & NO Procurement initiate the request for procurement
PIT to provide estimate
Accounts Officer to confirm availability of Budget& within Project Scope
Approval from PD-UKSDP
Development of Bidding Documents using the standard biding documents - PIT
Approval from Principal Secretary MH&FW Value less than ($500,000)
Approval from Chief Secretary Government of Uttarakhand through the office of Principal Secretary MH& FW (Value more than $500,000
PD UKHSDP
Principal Secretary MH & FW
PD UKHSDP to PIT to Take- No Objection from WB if required and Invitation for bidding- Draft a specific Procurement Notice (SPN)
Invitation for bidding- Draft a specific Procurement Notice (SPN) Drafted by- PIT
With Approval from PD UKHSDP-Invitation for bidding- published in Local newspaper and website of project as well society and e-procurement portal of society - PIT
Sale of Bidding documents to eligible bidders - PIT
Clarification of Bidding Documents. Response to all companies without identifying the name(s) of the companies requesting clarification- PIT
Tenders Received- PIT
Bid opening information to Procurement committee- PMA
Bid opening and Evaluation and comparison of quotes will be done using the standard guideline and format by WB- Procurement committee
Minutes, Comparisons, reports and Recommendations by Procurement Committee
Approval from Project Director: PD-NMHP
Publish the results of the in Department website and intimate to the who are selected -PMA
Actual Cost Calculation by- Accounts Officer and sharing with PMA
Obtain performance security and release bid security- PMA
Finalize the contract (including terms of payment) with selected contractor- PMA
Sign the contract - Project Director NMHP- PMA to Facilitate
Inform unsuccessful bidders and release bid –PMA
Issue notice to Proceed – PD NHMP
Receipt, Acceptance, Storage and use of material
Verification Committee to Verify and report
Feedback to the Purchasing Authority on performance of the Supplier-PIT
Final Payment- As per delegation of power

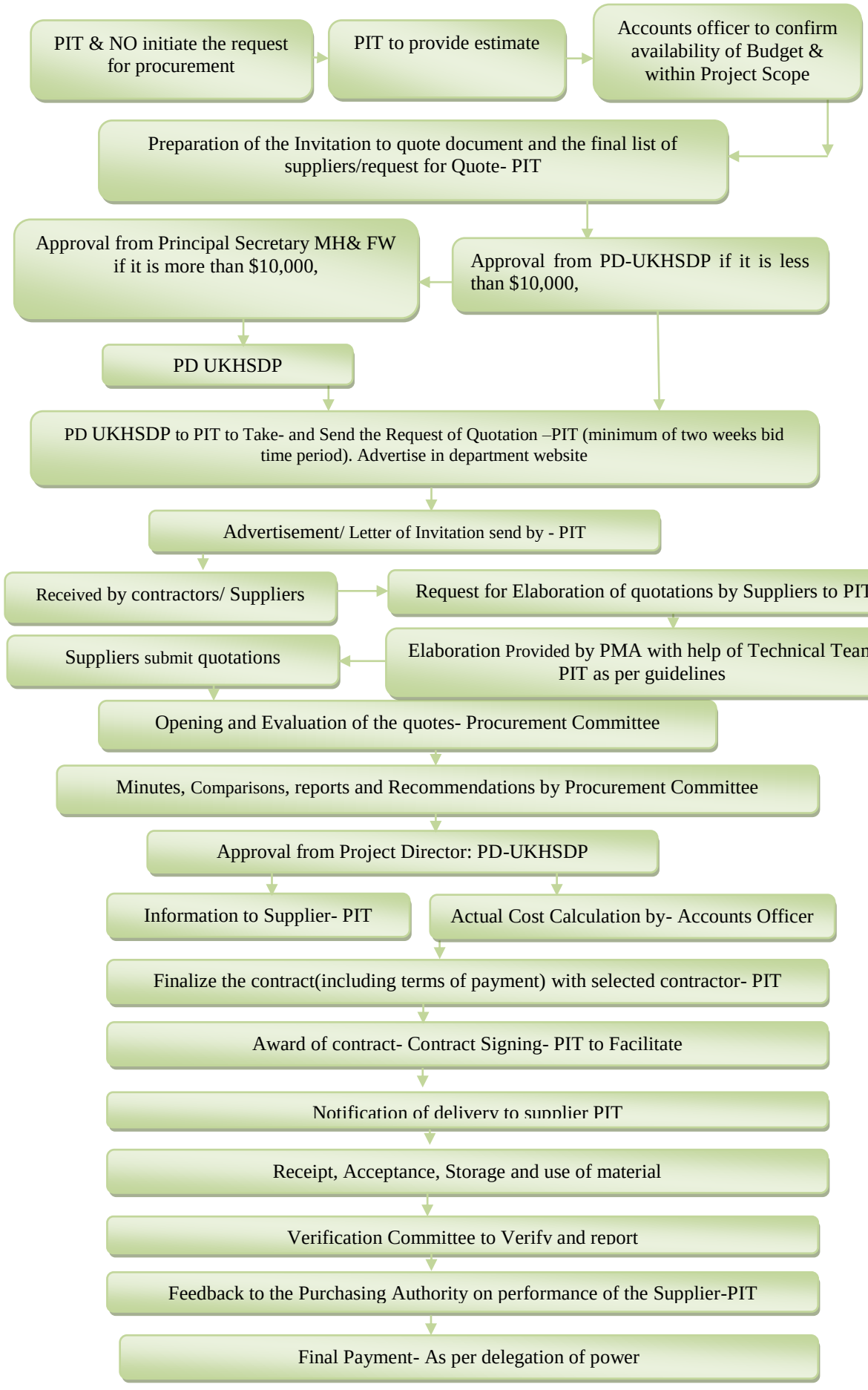
3. **Shopping method:** Shopping method in accordance with paragraph 3.5 of the Procurement Guidelines shall be adopted for procuring readily available off-the-shelf goods of value less than US$ 100,000. For shopping procedure, list of vendors/contractors already registered with government departments may be used for inviting quotations. The procurement plan should determine the cost estimate of each contract, and the aggregate total amount. The borrower should solicit at least three price quotations for the purchase of goods, materials, or services (non-consulting), to formulate a cost comparison report.

   For the PPP mode of contracting, the Project has developed bidding documents to be used for procurement of private health service provider. The new bidding document fits well within the parameter so of World Bank Procurement guidelines as well as the PPP policies of the state government.
4. **Direct Contracting:** Goods, works and non-consulting services which meets the requirement of para 3.6 of the Bank Procurement Guidelines may be procured following Direct Contracting method.
5. **Advance Procurement:** Retroactive financing up to an amount of 20% of the Credit amount will be available for financing expenditures incurred 12 months prior to the Financing Agreement signing date
6. **Method of Procurement:** The following methods of procurement shall be used for procurement under the project. It has been agreed that if a particular invitation for bid comprises of several packages, lots or slices, and invited in the same invitation for bid, then the aggregate value of the whole package determines the applicable threshold amount for procurement and also for the review by the Bank.

Table 2: Procurement Methods

Category	***Method of Procurement***	***Threshold (US$ Equivalent)***
Goods and Non-consulting services(excluding TI contracts)	*ICB*	*>3,000,000*
	LIB	*wherever agreed by Bank*
	NCB	*Up to 3,000,000 (with NCB conditions)*
	Shopping	*Up to 100,000*
	DC	*As per para 3.7 of Guidelines*
	Force Account	*As per para 3.9 of Guidelines*
	Framework Agreements	*As per para 3.6 of Guidelines*
Works	*ICB*	*>40,000,000*
	NCB	*Up to 40,000,000 (with NCB conditions)*
	Shopping	*Up to 100,000*
	DC	*As per para 3.7 of Guidelines*
	Force Account	*As per para 3.9 of Guidelines*
Consultants' Services	*CQS/LCS*	*Up to 300,000*
	SSS	*As per para 3.9-3.11 of Guidelines*
	Individuals	*As per Section V of Guidelines*
	QCBS/QBS/FBS	*for all other cases*
	(i) International shortlist *(ii) Shortlist may comprise*	*>800,000*

	national consultants only	*Up to 800,000*


PIT & NO initiate the request for procurement
PIT to provide estimate
Accounts officer to confirm availability of Budget & within Project Scope
Preparation of the Invitation to quote document and the final list of suppliers/request for Quote- PIT
Approval from Principal Secretary MH& FW if it is more than $10,000,
Approval from PD-UKHSDP if it is less than $10,000,
PD UKHSDP
PD UKHSDP to PIT to Take- and Send the Request of Quotation –PIT (minimum of two weeks bid time period). Advertise in department website
Advertisement/ Letter of Invitation send by - PIT
Received by contractors/ Suppliers
Request for Elaboration of quotations by Suppliers to PIT
Suppliers submit quotations
Elaboration Provided by PMA with help of Technical Team PIT as per guidelines
Opening and Evaluation of the quotes- Procurement Committee
Minutes, Comparisons, reports and Recommendations by Procurement Committee
Approval from Project Director: PD-UKHSDP
Information to Supplier- PIT
Actual Cost Calculation by- Accounts Officer
Finalize the contract(including terms of payment) with selected contractor- PIT
Award of contract- Contract Signing- PIT to Facilitate
Notification of delivery to supplier PIT
Receipt, Acceptance, Storage and use of material
Verification Committee to Verify and report
Feedback to the Purchasing Authority on performance of the Supplier-PIT
Final Payment- As per delegation of power

Procurement Category, Threshold, Method, Review and Approving authority:

The first contract shall be prior reviewed by the Bank irrespective of value. In addition, the justifications for all contracts to be issued on LIB, single-source (>US$ 30,000) or direct contracting (>US$ 30,000) basis will be subject to prior review. These thresholds are for the initial 18 months period and it may be modified based on the procurement performance of the project.

Prior Review by the World Bank

The Bank shall prior review the following contracts:

- Goods: All contracts more than US$ 2 million equivalent;
- Services (Other than consultancy):All contracts more than US$ 2 million equivalent;
- Consultancy Services: Above US$ 1 million equivalent for firms; and US$ 300,000 equivalent for individuals

The first contract shall be prior reviewed by the Bank irrespective of value. In addition, the justifications for all contracts to be issued on LIB, single-source (>US$ 30,000) or direct contracting (>US$ 30,000) basis will be subject to prior review. These thresholds are for the initial 18 months period and it may be modified based on the procurement performance of the project

Supervision mission: In addition to the prior review to be carried out by the Bank office, procurement staff will participate in 2 formal review missions annually, along with the implementation support mission which will include Procurement Post Review (PPR). For the avoidance of doubt, the Bank shall be entitled to conduct, at any time, independent procurement reviews of all the contracts financed under the Credit. The IA shall prepare a list of contract and submit it to the Bank for conducting PPR. The PPR will be conducted on annual basis.

Procurement **Planning:** UKHFWS shall prepare Procurement Plan covering first 18 months of the project implementation. The prior review thresholds will also be indicated in the procurement plan. The Procurement Plan shall be agreed between the Borrower and the Bank before negotiation and shall be subsequently updated annually (or earlier/later, if required) and will reflect the changes in prior review thresholds, if any. All Procurement Plans, their updates or modifications shall be subject to Bank's prior review and no objection before implementation. In addition, the Bank will carry out an annual ex post procurement review of the procurement falling below the prior review threshold mentioned above.

STEP: An online Procurement Plan Execution System called Systematic Exchanges in Procurement (STEP) shall be adopted to update the agreed Procurement Plan. It is a web-based tool owned by the Bank which helps in tracking dates of the different stages of a procurement activity that is planned or under implementation. The system establishes a new, easy to use, and more efficient way for Bank teams and Bank clients to interact, while at the same time providing an audit trail of the process. The Bank will make arrangements to train the staff of IAs in operating STEP.

Complaint Handling Mechanism: UHFWS shall establish complaint handling mechanism to address complaints/grievances from contractors/suppliers more effectively. On receipt of complaints, immediate action will be initiated to acknowledge the complaint and redress within a reasonable timeframe. All complaints during bidding/award stage as well as complaints during the contract execution along with the analysis and response of the PMU/PIU shall invariably be submitted to the Bank for review.

Selection of Consultants:

The hiring of consultants shall be undertaken through competition among the qualified short listed firms using Quality and Cost Based Selection (QCBS) methods. However, there are some cases when QCBS is not the most appropriate methods of selection. In such cases, the other selection methods mentioned below may be used. Appropriate selection method shall be adopted depending upon size and complexity of the assignment and such agreement shall be reflected in the Procurement Plan.

- Quality Based Selection (QBS);
- Selection under Fixed Budget (FBS);
- Least Cost Selection (LCS);
- Selection based on Consultant's Qualification (CQS);
- Single Source Selection (SSS); and
- Individuals.

Short list of consultants for services estimated to cost less than US$ 800,000 equivalent per contract may be composed entirely of national consultants in accordance with the provision of paragraph 2.7 of the Consultants Guidelines.

A) Steps for hiring under QCBS method

The following steps shall be used for hiring of Consultants under QCBS method:

- preparation of Terms of Reference (TOR);
- preparation of cost estimate and the budget;
- advertising;
- preparation of the shortlist of consultants;
- preparation and issue of the Request for Proposal (RFP);
- receipt of proposals;
- evaluation of technical proposals : consideration of quality;
- evaluation of financial proposal;
- final evaluation of quality and cost incorporating the weightage assigned to quality of the proposal and the cost as quoted ; and
- Negotiations and award of the contract to the selected firm.
- Publication of award in web and debriefing of unsuccessful consultants.

a) Steps for preparing the TOR:

- Background
- A precise statement of objectives;
- An outline of the tasks to be carried out;
- A schedule for completion of tasks;
- The support/inputs provided by the client;
- The final outputs that will be required of the Consultant;
- Composition of Review Committee (not more than three members) to monitor the Consultant's works and procedures for; and

- Midterm review and Progress Reports required from Consultant;
- Outlining of training needs if any;
- Review of the final draft report,
- List of key positions whose CV and experience would be evaluated.

b) Cost estimate and the budget

The Cost Estimates or Budget should be based on the PMU's assessment of the resources needed to carry out the assignment; staff time, logistical support, and physical inputs (for example, vehicles and laboratory equipment). Costs shall be divided in to two broad categories; (a) fee or remuneration and (b) reimbursable and further divided into foreign and local costs.

c) Advertisement

PMU to prepare and submit to the Bank a Draft REOI notice for advertisement in UNDB. Contracts expected to cost more than US $300,000 shall be advertised in UNDB online, National/ International newspapers and technical magazines.

d) Short listing

PMU irresponsible for preparation of the shortlist and shall give first consideration to those firms expressing interest, which possess the relevant qualifications. The shortlists shall comprise of six firms with a wide geographic spread as per Guidelines for Selection of Consultants. For the Contract that is expected to cost less than US$ 800,000, the short list may comprise of entirely national consultants.

e) Request for Proposals (RFPs)

The RFP shall include:

- a Letter of Invitation (LOI);
- Information to Consultants;
- the TOR; and
- the proposed contract

The project shall use Bank's SRFP for hiring of consultants.

f) Evaluation:

Evaluation of technical proposals shall be done first before opening the Financial Proposal. The Evaluation criteria shall be specified in the information to the consultants. The Technical Evaluation report shall be completed in the format prescribed by the Bank. For all prior review cases the Technical evaluation report shall be forwarded to the World Bank for "no objection". On receipt of no objection, the financial proposal shall be opened publicly. Thereafter the combined Technical and Financial evaluation shall be done for final section of the consultant and the selected firm shall be invited for negotiation.

The factors given in the table are generally taken into account for evaluation:

Technical Evaluation Factors (For guidance only)

Evaluation Factors		Points
Quality (Each should have a sub-criteria not exceeding three)	Experience	0 to 10
	Methodology	20 to 50
	Key Personnel *	30 to 60
	Transfer of Knowledge	0-10
	Nationals in key staff	0-10
Price (cost)	Exclusive of taxes	
Combined	Quality	75
	Cost	25

* The individuals shall be rated in the following three sub-criteria, as relevant to the task

- General qualifications: General education and training, length of experience, positions held, time with the consulting firm as staff, experience in developing countries and so forth;
- Adequacy for the assignment: Education, training, and experience in the specific sector, field, subject, and so forth, relevant to the particular assignment; and
- Experience in the region: Knowledge of the local language, culture, administrative system, government organization, and so forth.

g) Negotiations

Negotiations shall include discussions of the TOR, the methodology, staffing, PIUs inputs, and special conditions of contract.

The selected firm should not be allowed to substitute key staff, unless both parties agree that undue delay in the selection process makes such substitution unavoidable or that such changes are critical to meet the objectives of the assignment. Financial negotiations shall include clarification of the consultants' tax liability in the PIU's own country (if any), and how this tax liability has been or would be reflected in the contract. No Financial Negotiation shall take place on unit rate when cost is a factor of an evaluation.

h) Publication of Award

The project shall publish all contracts awarded to the consultants in the website. All prior review contracts should be published in the client's website as well as in UNDB.

i) Debriefing

Consultants desirous of knowing why they were not selected should be debriefed.

B) Other Methods for selection of Consultants

a) Quality-Based Selection (QBS)

For complex or highly specialized assignments or those, which invite innovations, high downstream impact etc., selection based on the quality of the proposal (Quality-Based Selection [QBS]), would be more appropriate. RFP may request submission of technical proposal only or both technical and financial proposals in separate envelopes. RFP shall provide either the estimated budget or the estimated number of key staff time as indicative only. The financial proposal and the contract shall then be negotiated.

b) Fixed Budget selection (FBS)

This method is appropriate only when the assignment is simple and can be precisely defined. RFP shall indicate the available budget and request the consultants to provide their best technical and

financial proposals. Consultant who submitted the highest ranked technical proposal shall be invited to negotiate.

c) Selection based on Consultant's qualifications (CQS)

This method is used for very small assignments for which the need for preparing and evaluating competitive proposals is not justified. In such cases, the employer shall prepare the TOR, request for EOI and consultant's experience and competence relevant to the assignment, establish a short list, and select the firm with the most appropriate qualifications and references. The selected firm shall be asked to submit a combined technical- financial proposal and then be invited for negotiating the contract.

d) Single Source Selection (SSS)

This method should be discouraged, it is appropriate only if it presents a clear advantage over competition:

(a) for tasks that represent a natural continuation of previous work carried out by the firm;
(b) where a rapid selection is essential (emergency operation)
(c) for very small assignments; or
(d) When only one firm is qualified or has experience of exceptional worth for the assignment.

These cases should be identified and agreed between the Borrower and the Bank and should be specified in the Procurement Plan.

e) Selection of Individual Consultant:

Selection of Individual Consultants is resorted to when teams of personnel are not required or no additional outside (home office) professional support is required.

Review of the Procurement Process**:** The review of the complete procurement process is a necessity and will be carried out by the World Bank as follows:

- Goods: All contracts more than US$ 2million equivalent;
- Services (Other than consultancy):All contracts more than US$ 2 million equivalent;
- Consultancy Services: Above US$ 1 million equivalent for firms; and US$ 300,000 equivalent for individuals

Prior review shall be carried out by the Bank at following stages during the process of procurement:

- Terms of Reference and cost estimates;
- Short List;
- RFP documents containing Letter of Invitation, Information to Consultants and Conditions of Contract;
- Evaluation report of the technical proposals;
- Report after financial / combined evaluation and recommendation of the winning firm (for information only);
- Initialed Negotiated draft contact; and
- Final Contract (to be accompanied by Checklist) for obtaining WBR number from the WB.

All other contracts which do not come under the ambit of Prior Review shall be post reviewed by the Bank. Post review covers the final contract along with appendices and copy of evaluation note/award recommendations, which should be submitted along with the Checklist.

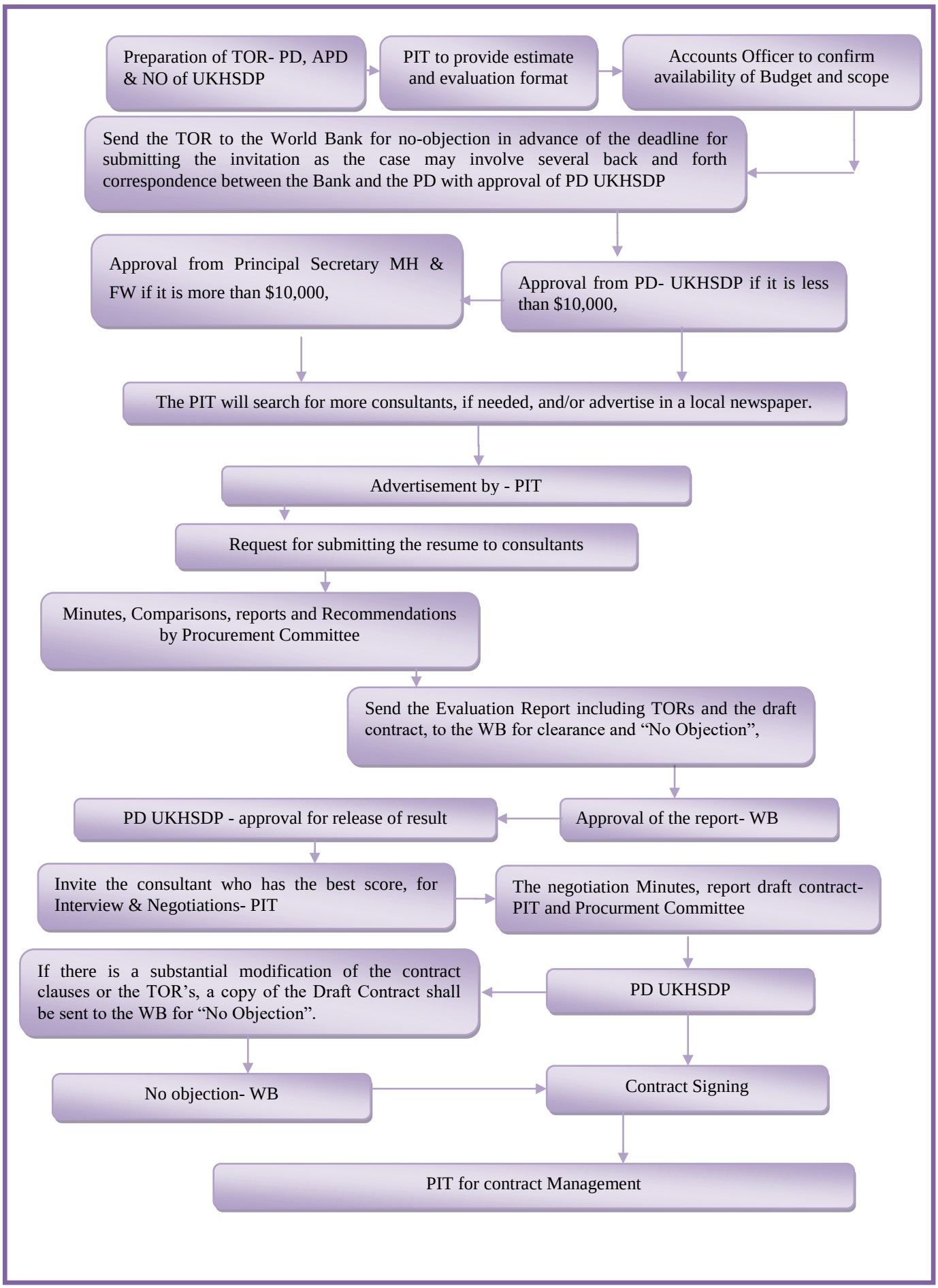
Types of Consulting Contracts

A) Lump Sum: Lump Sum contracts are used for assignments in which the content and the duration of the work is clearly defined. Payment is made upon delivery of outputs. The main advantage of this type of contract is that it is easy to administer. Examples of Lump Sum contracts include:

- Feasibility Studies
- Environmental Studies
- Detailed design of a standard structure

B) Time Based: Time Based contracts are used for assignments in which it is difficult to define the scope and the duration of the service to be performed. Payment is based upon agreed hourly, daily, or monthly rate, plus reimbursable expenses using actual expenses or agreed-upon unit prices. This type of contract provides for a maximum total payable amount that includes a contingency amount for unforeseen work and duration, price adjustments etc. Examples of Time Based Contracts include:

- Complex Studies
- Supervision of construction
- Training assignments
- Advisory services


Preparation of TOR- PD, APD & NO of UKHSDP
PIT to provide estimate and evaluation format
Accounts Officer to confirm availability of Budget and scope
Send the TOR to the World Bank for no-objection in advance of the deadline for submitting the invitation as the case may involve several back and forth correspondence between the Bank and the PD with approval of PD UKHSDP
Approval from Principal Secretary MH & FW if it is more than $10,000,
Approval from PD- UKHSDP if it is less than $10,000,
The PIT will search for more consultants, if needed, and/or advertise in a local newspaper.
Advertisement by - PIT
Request for submitting the resume to consultants
Minutes, Comparisons, reports and Recommendations by Procurement Committee
Send the Evaluation Report including TORs and the draft contract, to the WB for clearance and "No Objection",
PD UKHSDP - approval for release of result
Approval of the report- WB
Invite the consultant who has the best score, for Interview & Negotiations- PIT
The negotiation Minutes, report draft contract- PIT and Procurment Committee
If there is a substantial modification of the contract clauses or the TOR's, a copy of the Draft Contract shall be sent to the WB for "No Objection".
PD UKHSDP
No objection- WB
Contract Signing
PIT for contract Management

Publication of results and debriefing:

Publication of contract awards by the project is required for all ICB, LIB, NCB, direct contracting, and the selection of consultants for contracts exceeding US$ 100,000. In addition, where prequalification has taken place, the list of prequalified bidders will be published. With regard to ICB, LIB, and consulting contracts, the project is required to publish contract awards, upon receipt of a "No Objection" notice for the recommended award from the World Bank. With regard to direct contracting and NCB, local publication of contract awards may be made on a quarterly basis in the format of a summary table covering the previous period. Also, all competing consultants, irrespective of the contract amount, should be informed of the result of the technical evaluation (number of points that each firm received), before the opening of the financial proposals. Project entities are required to offer debriefings to unsuccessful bidders and consultants at their request.

Procurement Plan: The PIT would prepare a Procurement Plan which will be approved by the World Bank at the time of negotiation of the project setting forth: (a) The particular contracts for the goods, works, and/or services required to carry out the project during the initial period of at least 18 months; (b) The proposed methods for procurement of such contracts that are permitted under the legal agreement; (c) The proposed methods for selection of consulting services; and (d) The related World Bank review procedures.

The Procurement Plan will be implemented in the manner in which it has been approved by the World Bank. The World Bank will disclose the initial Procurement Plan to the public after the project has been approved; additional updates will be disclosed after the World Bank has approved them.

Procurement Records: Procurement processes are subject to post review and audit by the World Bank. In-order to ensure that the ex-post reviews and audits reflect the process used, the project will maintain procurement records in order, in accordance with sound procurement practices (including related supervision, review and auditing). All Procurement records will be retained until at least two years after the project closing date. Procurement Records include:

- For the procurement of goods and services: public notices of bidding opportunities; bidding documents and addenda; bid opening information; bid evaluation reports; formal appeals by bidders and outcomes; signed contracts, addenda and amendments; records on claims and dispute resolution; records of time taken to complete key steps in the process.
- For the selection of consultants: public notices for expressions of interest; requests for proposals and addenda; technical and final evaluation reports; formal appeals by firms and related outcomes; signed contracts, addenda and amendments; records on claims and dispute resolution, records of time taken to complete key steps.

Mis-procurement: Procurement by the project is subject to prior and post-review by the World Bank. If such review finds that all or portions of the goods, works, or services were not procured in accordance with the agreed procedures in the legal agreement and Procurement Plan, the World Bank may declare "Mis-procurement". In such a case the World Bank may cancel that portion of the credit allocated to those goods, services or consultant services

NOTE:

- PIT will interact with the World Bank with due concurrence/advice of PSC for various procurement/No Objections. The PIT is supposed to take turn-key responsibility as per above responsibility matrix for the procurement cycle after receiving the indent from the project.
- All the documents/communications will be submitted to the World Bank electronically and PIT will ensure the quality/correctness of the documents before submission to the Bank.

Procurement Monitoring: The approved Procurement Plan will be used for monitoring of procurement implementation. The PIT should review the procurement plan every four weeks and update the actual dates for each of the steps in the procurement cycle. The PIT should advise the Project Director (UKHSDP) indicating any delays component by component. The Project Director (UKHSDP) should take appropriate actions to rectify the problem and ensure that the procurement plan is followed accordingly. The PIT shall call a monthly meeting with the project staff through Project Director (UKHSDP) to review progress of procurement.

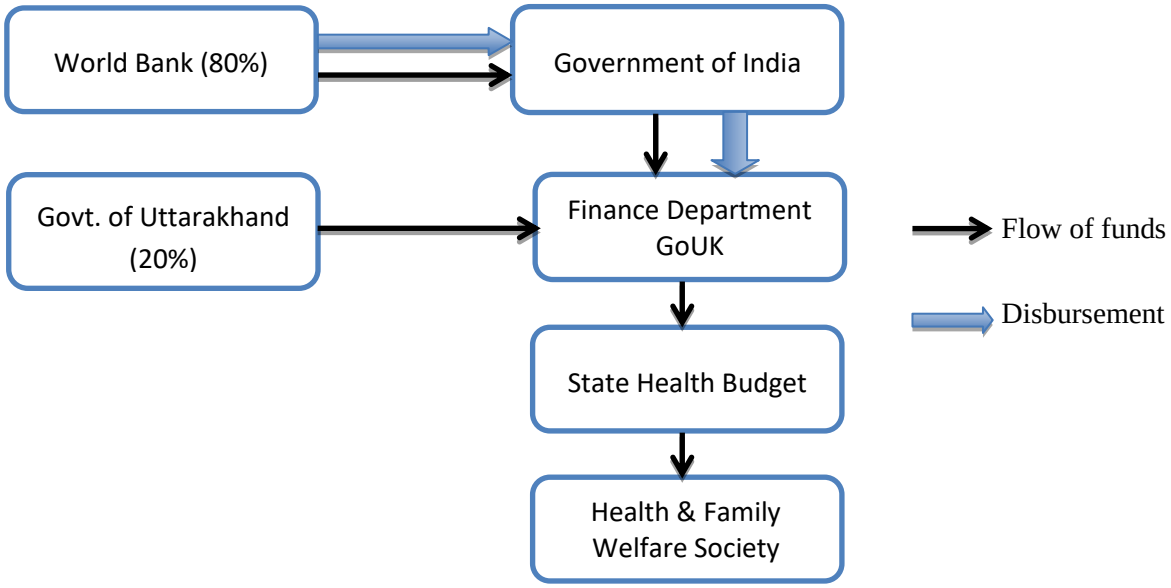
FINANCIAL ARRANGEMENT

The Uttarakhand Health and Family Welfare Society ('Society') implementing the NHM in the state would also be the implementing agency for this project, and this Society has successfully implemented the earlier Bank-supported Uttar Pradesh and Uttaranchal Health System Development Project (UAHSDP) in the state. The Society has functioning finance management (FM) systems which meets the requirements of the project and the Bank reporting.

The project FM arrangements are summarized as follows: (a) a budget head has been created by the Government of Uttarakhand (GoUK) for the project along with an initial allocation of funds. The current system of transferring financial resources from the budget to the Society Bank account will be followed by the project. A separate Project Bank account will be opened by the Society which will be handled jointly by the Project Director and Finance Controller (FC) who will be the joint signatories. All payments and procurements will be carried out by the Society; (b) currently the Society is following Double Entry cash basis of accounting as per NHM rules. As a part of the Society's computerized accounting system, project accounts will be maintained separately. The accounts department is managed by Finance Controller (FC), who is deputed from the Finance Department of the State. It was agreed that the FC would be supported by key staff who will be employed on contract basis. Currently the FC is supported by contract staff from NHM, including accounts manager and tally accountant, and audit officer; (c) all financial controls applicable to routine expenditures will also apply to the expenditures under the project. All payments would be approved/ vetted in accordance with the schedule of powers in place for UKHFWS. All project related receipts and payments/ withdrawals would be reconciled with periodic Bank Statements; (d) an internal audit would cover all activities under the project and could be carried out by a Chartered Accountancy (CA) firm as per Terms of Reference (ToR) agreed with the Bank. The auditor will be appointed within one year of project effectiveness. The audit reports along with the compliance will be shared with the Bank. The Project financial statement to be audited by the CA firm will need to be submitted to the Bank within nine months from the end of each fiscal year; and (e) Interim unaudited financial reports (IUFR) based disbursement will be used for the project which is to be submitted to the Bank on a half yearly basis within 45 days from the end of the half year. The IUFRs will disclose receipt and utilization of project funds (both Bank share and counterpart contribution).
Disbursements: Disbursement will be on reimbursable basis as the state will provide the budget for project expenditure. The following are the disbursement categories envisaged for the project

Category	Amount of the Financing Allocated USD Million	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) Goods, works, non-consulting services, and consultants' services, IOC, training and workshops for the Project	74	80%
(2) Medical Insurance Claims and Medical Insurance Premiums for Sub-component 1.2of the project	26	80%
TOTAL AMOUNT	100	

1. Contract Management: Due to the nature of PPP projects being planned in the project, contract management is very essential for this project. The project needs to hire suitable persons with financial legal and technical background to manage the contracts. The project also needs to build MIS for tracking these contracts during the project period. Contract and variation management will be one of the key challenges for the project.



Project would follow all financial control mechanism applicable to routine financial transaction of Government of Uttarakhand, and state health and family welfare society. All payments would be approved/ vetted in accordance with the schedule of powers in place for SHS. All project related receipts and payments/ withdrawals would be reconciled with periodic Bank Statements. Internal audit would cover all activities under the project and could be carried out by a Chartered Accountancy (CA) firm as per Terms of Reference (ToR) agreed with the Bank or through creation of an internal audit cell as deemed appropriate. The auditor would be appointed within six months of project effectiveness. The audit reports along with the compliance would be shared with the Bank. The Project SOE statement to be audited by CA will be monitored, with the due date of 6 months after the end of each fiscal year (March 31st).

Budgetary Provision:

The separate budget head under state budget (Treasury route) has been already created as "2210-01-110-97-01-42" this head would be used for the project, finance department of GoUK share as well IDA (World Bank) fund would directly route through this head into UKHSDP account which is under UKHFWS society.To open the bank account, permission needs to be obtained from the Finance and Health Departments and a Government Order needs to be issued. This bank account will be handled jointly by the PD and FC who would be the joint signatories. All payments and procurements will be carried out by the Society.

Budgeting: A budget head "2210-01-110-97-01-42" has been created for the project and this head would be used for the project throughout the project life. Adequate budgetary provision needs to be created for FY 14-15 before project negotiations are initiated.

Fund flow: The current system of transferring financial resources from the budget to the Society Bank account will be followed by the project. A separate Project Bank account will be opened by the society. To open the bank account, permission needs to be obtained from the Finance and Health Departments and a Government Order (GO) needs to be issued. This bank account will be handled jointly by the PD and FC who would be the joint signatories. All payments and procurements will be carried out by the Society.

Accounting: Project accounts will be maintained in Tally software by the Society. The Society has implemented Tally for all other accounts and they will follow the same procedure for this project as well. Accounting is being done on Double Entry cash basis as per NRHM rules. The project accounting system shall be implemented within three months of effectiveness. A list of chart of accounts and details will be worked out as per the requirement of the project cost table and the IFR formats. A CA firm/Tally consultants can be hired to support the project in preparing accounting manual, setting up the Tally chart of accounts and provide initial training to the project staff.

Staffing: The accounts department will be managed by Finance Controller (FC), deputed from the Finance Department of the State. The FC will be supported by the finance team which will support project's finance related activities. It was agreed that the following staff will be hired for the project from market: (a) Finance Manager -1: CA with adequate experience in accounting, auditing and financial management; (b) Accounts Manager -1: M.Com with adequate experience in maintaining accounts in Tally; (c) Audit officer 2 – CA (Inter) with adequate experience in Audit; and (d) Tally accountants 2 – B.com with Tally accounting experience. All payments and accounting will be centralized in the headquarter location of the society.

Reporting: Interim unaudited financial reports (IUFR) based disbursement will be used for the project which is to be submitted to the Bank on a quarterly basis within 45 days from the end of the quarter. The IUFRs will disclose receipt and utilization of project funds (both Bank share and counterpart contribution). The IUFR will be based on project accounts and will reflect the actual expenditure for the project components based on figures reconciled with Bank. Any advances given by the project will be separately shown in the IUFRs. The IUFRs will provide contract wise payments and project progress in physical and financial terms. The project is required to work out the draft formats for Bank's consideration and finalization. The IUFR format will be agreed and finalized during negotiations. In terms of disbursement, the project will first spend from the budget and then claim reimbursement from the Bank. All expenditures reported in the IUFRs will be subject to annual project audit.

Auditing: The annual audit of the Project Financial Statements (PFS), will be carried out by a CA firm (empanelled with the CAG panel of firms for audits) appointed by the project as per the terms of reference agreed with the Bank.

All supporting records and documents under the project will be subject to this audit. The PFS will summarize all receipts and expenditures reported in the IUFRs. The annual audit report will consist of (i) annual audited project financial statements (ii) audit opinion and (iii) management letter highlighting weaknesses, if any, and identifying areas for improvement. The annual project audit report and accounts will be submitted to the Bank by December 31 each year. Any difference between

the expenditure reported in the IUFRs and those reported in the annual project audit reports will be analyzed and those expenditures which are confirmed by the Bank as being not eligible for funding will be adjusted in the subsequent disbursements. The following audit report will be monitored:

Contract Management:Due to the nature of PPP projects being planned in the project, contract management is very essential for this project. The project will hire suitable persons with financial legal and technical background to manage the contracts. The project will also build a MIS for tracking these contracts during the project period. Contract and variation management will be one of the key challenges for the project.

Internal audit: The internal audit will be an integral part of the project design and will cover all activities under the project. The internal audit will be carried out by a Chartered Accountancy (CA) firm as per Terms of Reference (ToR) agreed with the Bank. The Terms of Reference (ToR) for the internal audit will cover review of aspects covering internal controls and contract management. The auditors will be appointed based on selection criteria agreed with the Bank, which will be finalized as a part of the FM manual. The auditor will be appointed within six months of project effectiveness. The audit reports along with the compliance will be shared with the Bank. Also the project needs to constitute an audit committee at the HO level which will review all the audit reports and follow up on the action taken.

Internal Control:All financial controls applicable to routine GoUK expenditures will also apply to the expenditures under the project. All payments would be approved/ vetted in accordance with the schedule of powers in place for SHS. All project related receipts and payments/ withdrawals would be reconciled with periodic Bank Statements.

FM for components: Component 1A deals with PPP contracts and so financial payments will follow the achievement of service delivery indicators and will be made as per the contractual terms. In terms of Component 1B which funds RSBY/MSBY payments, it will be based on the claims in the initial years and achievements of agreed milestones. From year 2, it would be based on actual payments of premium to vendor who is procured competitively and based on achievements of agreed milestones. These milestones will be defined in the legal agreement. In terms of component 2, since it will provide for goods, services and incremental operating costs, it will be reimbursed based on actual payments as per contracts and expenditure incurred by the project.

Disbursements: Disbursement will be on reimbursable basis as the state will provide the budget for project expenditure. Two disbursement categories is envisaged for the project one for RSBY related insurance premium which will be based on achievement of certain milestones as well as payment of insurance premium/claims and the second category to handle all other categories of payment. A uniform percentage of 80% will be applied for all payments.

PRPOSED RESULT FRAMEWORK AND MONITORING SYSTEM

The PIT will be responsible for overall M&E and reporting on the project. The project will use the existing information systems available with Department of Health and Family welfare and other similar information systems used by other departments to use the existing information for project planning and monitoring propose. The project will collate additional information through the existing health system staff placed at various health centres/ levels to ensure non duplication of information collection process. The project includes funds for contracting technical assistance to support project M&E and Information Technology. Capacity building in health information management will be a critical component of this technical assistance. This Result Framework will still in discussion and will be finalize with consultation with World Bank by finalization of project.

Overall Project Indicators

PDO Level Results Indicators*	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (indicator definition etc.)
			YR 1	YR 2	YR3	YR 4	YR5	YR6				
1) Increase in outpatient visits to PHCs, CHCs, and mobile vans per year, in hilly districts of the state	%	For Financial Year 2015-16: Uttarakhand HMIS (All PHCs and CHCs) 670,804 + DoMHFW MHVs 64762 + NHM MHVs 39360= Total 774,926	0	5	10	20	35	50	Annual	Regular reporting from facilities	CHC level	Indicator of access to health services Numerator: number of outpatient visits to PHCs, CHCs and mobile vans in the year Denominator: number of outpatient visits to PHCs, CHCs and mobile vans at baseline. Separate analysis will be performed by gender, by geographical areas.
2) Persons who used the Health Helpline to receive health information/ advice,	#	81192 (From May 2016 to 25th November 2016)	0	0	5000	10000	30000	50000	Annual	Administrative data	Health Helpline-Project Admin. Unit	Indicator of access to health advice and a guide to available health services Numerator: number of people who used the Health Helpline and received health information/ advice Denominato

PDO Level Results Indicators*	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (indicator definition etc.)
			YR 1	YR 2	YR3	YR 4	YR5	YR6				
												r: total number of people who called the Health Helpline. Separate analysis will be performed by gender, by geographical areas.
3) Patients who used the Health Helpline that are satisfied with the health services provided to them (per year)	%	NA	0	0	60%	60%	70%	70%	Annual	Administrative records from Health Helpline	Health Helpline- and Project Admin. Unit	Indicator of access to quality health services Numerator: number of people who used the Health Helpline satisfied with the services Denominator: total number of people who called the Health Helpline. Separate analysis will be performed by gender.
4) Government and non-government healthcare facilities issued with an entry (or higher) level certification by the National Accreditation Board for Hospitals	#	2.00	1	2	2	4	4	6	Annual	Reports from National Accreditation Board for Hospitals	National Accreditation Board for Hospitals	Indicator of access to quality health services.
5) People covered under any form of health insurance supported by the project (RSBY and MSBY), per year),	# (in millions)	4,335,000	0	0.5	0.5	1	2	4	Annual	Administrative reports	Health Insurance Companies andProject Admin. Unit	Indicator of financial protection. Separate analysis will be performed by gender.

PDO Level Results Indicators*	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (indicator definition etc.)
			YR 1	YR 2	YR3	YR 4	YR5	YR6				
6)Cumulative number of hospital admissions and outpatient consultations covered by any form of health insurance supported by the project (RSBY and MSBY),	#	46040 (MSBY Phase I-: 1st April 2015-July 2016)	0	5000	15000	40000	90000	150000	Annual	Administrative records	Health Insurance Companies &Project Admin. Unit	Indicator of financial protection. Separate analysis will be performed by gender.
Component wise Intermediate Indicators												
Component 1: Innovations in engaging the private sector; **Sub-component 1.1: Innovations in integrated delivery of healthcare services**												
1) Covered children who receive an annual assessment	%	1675912 (FY 2015-16)	NA	15	20	25	30	40	Annual	Routine reporting under the primary care cover	CHCs	The annual assessment includes the services, vaccinations and screening tests listed in the protocols and will be divided in age bands. Numerator: number of children who receive an annual assessment by mobile vans or CHCs Denominator: total number of children covered by RSBY/MSBY
2) Cumulative number of patients who use the services provided by the mobile health vans, by gender	#	DoMHFW MHVs: 64762+ NHM MHVs 39,360= Total 104,122	0	4000	10000	20000	30000	50000	Annual	Routine reporting from mobile health vans	Mobile health vans	N.A
3) Patients utilizing the emergency services of the outsourced CHCs per year	#	NA	0	500	1000	1000	2000	2000	Annual	Routine reporting of the CHCs	CHCs	N.A
4) Cumulative number of emergency Cesarean sections performed in the outsourced CHCs	#	NA	0	2	10	20	35	50	Annual	Routine reporting of the CHCs	CHCs	N.A

PDO Level Results Indicators*	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection	Description (indicator definition etc.)
			YR 1	YR 2	YR3	YR 4	YR5	YR6				
Sub-component 1.2: Innovations in Healthcare Financing												
5) Benefit package of child health services finalized and piloted	text	0.00	No	Yes	Yes	Yes	Yes	Yes	Annual	Administrative records	UKHFWS	N.A
6) Benefit package of NCDs services finalized and piloted	text	0.0	No	No	No	Yes	Yes	Yes	Annual	Administrative records	UKHFWS	N.A
7) Eligible households enrolled under RSBY/MSBY during the year	%	45.7	46	50	50	50	50	55	Annual	RSBY and MSBY-administrative reporting	RSBY Unit, implementing agencies	Numerator: number of households enrolled under RSBY/MSBY in the year Denominator: total number of households eligible for RSBY/MSBY coverage in the year
Component 2: Stewardship and system improvement												
Number of specialists working in the outsourced health facilities (and augmenting the positions functionally vacant in the public system) (Number)	%	25	25	35	35	50	50	50	Annual	Routine reporting of the CHCs + state HR cell data	UKHFWS	Numerator: number of vacant specialists positions at CHC level Denominator: total number of specialists positions at CHC level
1) Development and periodical update of a comprehensive disaster response plan at the state level	text	Does not exist	Does not exist	In process	Plan available	Plan available	Plan available	Plan updated	Annual	Administrative records	UKHFWS	Development should be done by year 1 and update by year 6

PROJECT MONITORING SYSTEM

The PIT will be responsible for overall M&E and reporting on the project. The project will use the existing information systems available with Department of Health and Family welfare and other similar information systems used by other departments to use the existing information for project planning and monitoring propose. The project will collate additional information through the existing health system staff placed at various health centers/ levels to ensure non duplication of information collection process. The project includes funds for contracting technical assistance to support project M&E and Information Technology. Capacity building in health information management will be a critical component of this technical assistance.

Monitoring and Reporting:

❖ **Quarterly Reporting to Project Steering Committee**

Document to be prepared by the nodal officer of each cell under UKHSDP and submitted to Project Director (UKHSDP) for onward submission which includes:

- Summary of Major Achievement of the quarter.
- Quantitative measure of Target v/s achievement, with respect to base line and as per approved plan
- Quarterly project finance report to be prepared and shared by finance officer to M&E Officer
- Summary of decisions taken during the last quarter and achievements against each including narrative
- Analysis of non-achievement
- Next steps

❖ **Half-yearly and Yearly Reporting to Project Governing Board and World Bank**

One half yearly report and One Annual Report to be prepared by the nodal officer of each cell under UKHSDP, submitted to Project Director for onward submission which includes:

- Major Achievement of the quarter.
- Quantitative measure of Target v/s achievement, with respect to base line and as per approved plan
- Half yearly project finance project finance report to be prepared and shared by finance officer to M&E Officer
- Summary of decisions taken during the month and achievements against each including narrative
- Case studies of field level experience and Analysis of non-achievement
- Major activities for next six months

❖ **Supportive Supervision**

Field visit for the purpose of supportive supervision needs to be made to ensure scale and quality of project implementation as per the project proposal. Below is the suggested list of staff and required field visit for the project

- Project Director: 5-7 days in quarter

- Nodal Officers: 15 days in quarter
- National Consultants at PMU: 5 days per month
- Joint visit by PIT : Once in quarter

❖ **Operations research and Evaluations**

- Half yearly evaluation by World Bank team
- Midterm external evaluation in year 3
- End term external evaluation in year 5
- Operations research as per the approval of PSC/PGB

❖ **Surveys**

Three surveys will be undertaken during different time period:

- Base line
- Mid term
- End line

BUDGET SUMMARY BY COMPONENTS AND ACTIVITIES

The total budgetary outlay of UKHSDP is approximately Rs. 850 Crore (US$ 125 Million). The activity and year-wise break-up of this budgetary outlay is presented in tables ahead—

Sr.No.	PROJECT COMPONNENT & ACTIVITIES IN DETAIL	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Total	% Cost
	Component 1: Innovations in engaging the private sector component									
	A. Innovations in integrated delivery of healthcare services (primary, referral and emergency care)									
1	**Distt operator- MHV+ CHC + DH strengthening (Integrated Model)**	**0.25**	**5.50**	**6.00**	**9.00**	**9.50**	**9.50**	**2.75**	**42.50**	**34.00**
2	**Health Triage + Telemedicine**	**0.00**	**0.67**	**1.00**	**1.00**	**1.00**	**1.00**	**0.33**	**5.00**	**4.00**
	B. Innovations in Healthcare Financing (USD 35 m)									
3	**RSBY/MSBY child health**	**0.00**	**1.50**	**3.50**	**4.00**	**5.00**	**5.00**	**1.33**	**20.33**	**16.26**
4	**RSBY/MSBY NCD**	**0.00**	**0.00**	**1.00**	**2.00**	**4.00**	**4.00**	**1.00**	**12.00**	**9.60**
	Component 2: Stewardship and system improvement component									
	A. Project core team and office expenses									
5	**Project core team and office expenses**	**0.97**	**1.07**	**1.17**	**1.29**	**1.42**	**1.56**	**1.72**	**9.20**	**7.36**
6	**Office Expenses Office Equipment & maintenance, Transport expenses**	**0.84**	**0.61**	**0.59**	**0.68**	**0.74**	**0.80**	**0.87**	**5.13**	**4.11**
	B. Capacity building, Information System, Research as per PP									
7	**Training Capacity building and consultation workshop**	**0.39**	**0.90**	**0.95**	**0.95**	**0.47**	**0.27**	**0.22**	**4.15**	**3.32**
8	**Consultation Workshop & communication**	**0.55**	**0.45**	**0.50**	**0.29**	**0.19**	**0.14**	**0.10**	**2.22**	**1.78**
9	**Sector Strengthening, Research, Monitoring and Evaluation**	**0.85**	**3.47**	**3.50**	**4.60**	**4.90**	**5.20**	**1.95**	**24.46**	**19.57**
	Total Component 1	0.25	7.67	11.50	16.00	19.50	19.50	5.41	79.83	64
	Total Component 2	**1.81**	**1.68**	**1.77**	**1.97**	**2.16**	**2.36**	**2.59**	**45.17**	**36**
	Total Component 1 + Component 2	**3.31**	**7.35**	**10.77**	**17.47**	**20.66**	**24.86**	**9.75**	**125**	**100**

Annexures

Annexure-I

PROJECT GOVERNING BODY (PGB)

Sr. No.	Office	Member
1	Chief Secretory, GOUK	Chairman
2	Principal Secretary/Secretary (Finance)	Member
3	Principal Secretary/Secretary (Law)	Member
4	Principal Secretary/Secretary (Planning)	Member
5	Principal Secretary/Secretary (Medical, Health & FW)	Member
6	Principal Secretary/Secretary (Pollution Control)	Member
7	Principal Secretary/Secretary (Disaster Management)	Member
8	Project Director (UKHSDP)	Member Secretary
9	Director General Health Services, GOUK)	Member
10	Nominee of Ministry of Health & Family Welfare, (GOI)	Member
11	Special Invitee Members (2 to 4)	Member

PROJECT STEERING COMMITTEE (PSC)

Sr. No.	Office	Member
1	Principal Secretary/Secretary (Medical, Health & FW)	Chairman
2	Secretary/Additional Secretary, Medical & Health	Member
3	Secretary/Special Secretary, Family Welfare	Member
4	Secretary/Special Secretary, Finance, GoUK	Member
5	Project Director (UKHSDP)	Member
6	Director General (Medical Health and Family Welfare, GoUK)	Member
8	Additional Project Director, UKHSDP	Member Secretary
9	Special Invitee Member	Member

PROJECT IMPLEMENTATION TEAM (PIT)

Sr. No.	Office	Member
1	Project Director, UKHSDP	Chairman
2	Director General (Medical Health and Family Welfare, GoUK)	Member
3	Additional Project Director (UKHSDP)	Member Secretary
4	Additional Director (PPP Cell)	Member
5	Joint Director (Public Private Partnership)	Member
6	Joint Director (Research & Health Information System)	Member
7	Joint Director (Multispectral Coordination)	Member
8	Joint Director (Capacity Building & Training)	Member
9	Joint Director (Procurement)	Member
10	Joint Director (Social Safeguard)	Member
11	Joint Director (Environment)	Member
12	Financial Controller-National Health Mission, UKHFWS	Member

Annexure II

Schedule for Interim Unaudited Financial Report (IUFR)

UTTARAKHAND HEALTH SYSTEMS DEVELOPMENT PROJECT

Application No.

Interim Unaudited Financial Report for the quarter ended _____

IUFR-1

(Rs. In Millions)

Description		Expenditure	Non Eligible for claim	Eligible Expenditure for claim	Reimbursement %	Reimbursable amount
		Current Qtr.	Current Qtr.			
		1	2	(3)=(1) - (2)	4	5=3x4/100
Sources of Funds						
1	**Opening Balance in the bank account for the project**	-	-	-	-	-
2	**Sources of funds**	-	-	-	-	-
i	Amount received from IDA-World Bank					
ii	Amount received from GoUK					
3	**Total Sources of Funds (1+2)**	-	-	-	-	-

IUFR-1

(Rs. In Millions)

Description		Expenditure	Non Eligible for claim	Eligible Expenditure for claim	Reimbursement %	Reimbursable amount
		Current Qtr.	Current Qtr.			
		1	2	(3)=(1) - (2)	4	5=3x4/100
Uses of funds						
	Component 1: Innovations in engaging the private sector component (A+B)	-	-	-	-	-
A	**Innovations in integrated delivery of healthcare services**	-	-	-	-	-
A.1	District operator- MHV+ CHC + DH strengthening					
A.2	Health Helpline 104 + Telemedicine					
B	**Innovations in Healthcare Financing**	-	-	-	-	-
B.1	RSBY/MSBY child health					
B.2	RSBY/MSBY NCD					
	Component - 2: Stewardship and system improvement component (C+D)	-	-	-	-	-
C	**Project core team and office expenses**	-	-	-	-	-

IUFR-1

(Rs. In Millions)

Description		Expenditure	Non Eligible for claim	Eligible Expenditure for claim	Reimbursement %	Reimbursable amount
		Current Qtr.	Current Qtr.			
		1	2	(3)=(1) - (2)	4	5=3x4/100
D	**Capacity building, Information System, Research as per PP**	-	-	-	-	-
D.1	Training Capacity building and consultation workshop					
D.2	Consultation Workshop & communication					
D.3	Sector Strengthening, Research, Monitoring and Evaluation					
4	**Total Uses of Funds (A+B+C+D)**	-	-	-	-	-
5	**Closing Balance (3-4)**	-	-	-	-	-

FA

Project Director

Date:

Notes:

1. This statement is prepared on a cash basis of accounting as per provisions of the Financial Manual for the project.
2. The above figures will be based on monthly consolidation done by HO of the records maintained with the DPDs.
3. The staff cost of Govt. will be non-reimbursable.
4. The beneficiaries' contribution is included in GoUK.

UTTARAKHAND HEALTH SYSTEMS DEVELOPMENT PROJECT

Application No.

Interim Unaudited Financial Report for the quarter ended _____

IUFR-2 **(Rs. In Millions)**

	Description	Expenditure	Non claimable	Eligible Expenditure	Reimbursement %	Reimbursable amount
		Cumulative	Cumulative			
		1	2	(3)=(1) - (2)	4	5=3x4/100
Sources of Funds						
1	**Opening Balance in the bank account for the project**	-	-	-	-	-
2	**Sources of funds**	-	-	-	-	-
i	Amount received from IDA-World Bank					
ii	Amount received from GoUK					
3	**Total Sources of Funds (1+2)**	-	-	-	-	-
Uses of funds						
	Component 1: Innovations in engaging the private sector component (A+B)	-	-	-	-	-

IUFR-2 **(Rs. In Millions)**

Description		Expenditure	Non claimable	Eligible Expenditure	Reimbursement %	Reimbursable amount
		Cumulative	Cumulative			
		1	2	(3)=(1) - (2)	4	5=3x4/100
A	**Innovations in integrated delivery of healthcare services**	-	-	-	-	-
A.1	District operator- MHV+ CHC + DH strengthening			-		
A.2	Health Helpline 104 + Telemedicine					
B	**Innovations in Healthcare Financing**	-	-	-	-	-
B.1	RSBY/MSBY child health					
B.2	RSBY/MSBY NCD					
	Component - 2: Stewardship and system improvement component (C+D)	-	-	-	-	-
C	**Project core team and office expenses**	-	-	-	-	-
D	**Capacity building, Information System, Research as per PP**	-	-	-	-	-
D.1	Training Capacity building and consultation workshop					

IUFR-2 **(Rs. In Millions)**

Description		Expenditure	Non claimable	Eligible Expenditure	Reimbursement %	Reimbursable amount
		Cumulative	Cumulative			
		1	2	(3)=(1) - (2)	4	5=3x4/100
D.2	Consultation Workshop & communication					
D.3	Sector Strengthening, Research, Monitoring and Evaluation					
4	**Total Uses of Funds (A+B+C+D)**	-	-	-	-	-
5	**Closing Balance (3-4)**	-	-	-	-	-

FA

Project Director
Date:

Notes:

1. This statement is prepared on a cash basis of accounting as per provisions of the Financial Manual for the project.
2. The above figures will be based on monthly consolidation done by HO of the records maintained with the DPDs.
3. The staff cost of Govt. will be non reimbursable.
4. The beneficiaries contribution is included in GoUK.

UTTARAKHAND HEALTH SYSTEMS DEVELOPMENT PROJECT

Interim Unaudited Financial Report for the quarter ended _____

IUFR-3 **(Rs. In Millions)**

Date	Period	IUFR No.	Expenditure Reported	Claims Requested	Claims Reimbursed	RF/WF No.

FA **Project Director**

Date:

Interim Unaudited Financial Report for the quarter ended

Payments made during Reporting Period Against Contracts

IUFR 4 **(Rs. In Millions)**

Contract Number/ Work order no.	Supplier	Contract Date	Original Contract Amount	Revised contract amount	Payment in this quarter	Total amount paid till date	Payment vs. contract percentage
-	-	-	-		-	-	-
-	-	-	-		-	-	-

FA

Project Director
Date:

IUFR 5

Interim Unaudited Financial Report for the quarter ended

Period	Hospital Name	Number of Claims	Amount Paid
	-	-	-
	-	-	-
	-	-	-
	-	-	-
Grand- Total		-	-

FA

Project Director
Date:

Annexure-III

Summary of the Environment and Social Management Plan (ESMP)

Background

Health System of Uttarakhand

The Uttarakhand health system constitutes a large network of health care facilities based on three-tier system. The objective of the system is to reduce disease burden through preventive and curative health services and also to work on other indirect health determinant like water and sanitation, health education etc.

The National Health Mission (NHM) acts as convergence medium for departments of medical and health with the departments of national programs at state and district level. The state NHM is objected to strengthening infrastructure, increase involvement of community mobilizer, preparation and Implementation of an inter-sectoral District Health Plan including drinking water, sanitation & hygiene and nutrition among others.

The state health system falls under state ministry of health and family welfare, which is further headed by principal health secretary (PHS). State health system is divided into 4 departments i.e.

- Directorate of medical and health is responsible to regulate administration and medical education. It looks after the affairs related to drugs & logistics, medical treatment, mobile health component, public private partnership (PPP) communicable and non-communicable disease, IDSP, birth and death registration system.
- Director of national programme is responsible to regulate all national health programmes through its corresponding departments, including RNTCP, National Vector Borne Disease Control Programme, RCH-II, Universal Immunization Programme, Leprosy, Blindness control, HIV/AIDS,NACP ARSH, Prevention and Control of Non Communicable Disease, National Mental Health Programme, MenstrualHygiene etc. The department is also responsible to generate awareness through IEC and to map implementation progress.
- Finance
- Drug controller.

From 2000-2008, the state implemented the Uttaranchal health Systems development project, supported by the World Bank which aimed at improving the health status of state through investments in health, strengthening management component of health system, improvement in service delivery, health sector policy reform and human resources development.

Uttarakhand Health System Development Project

Overview of the Project

Uttarakhand Health Systems Development Project (UKHSDP), requested by the Government of Uttarakhand (GOUK); supported by the World Bank and being implemented by Uttarakhand Health and Family Welfare Society (UKHFWS), plans to improve equitable access to quality health services and providing health financial risk protection for the predominantly remote population of the state, through strengthening public and private health-delivery systems; promoting greater stewardship and managerial capacity in the state directorate; improving information systems; augmenting monitoring and research; and extending coverage of RSBY beyond hospitalization to include primary healthcare services.

The PDO is to improve access to quality health services and to expand health financial risk protection for the residents of Uttarakhand.

In particular, the project would focus on improving access to health services in remote areas of the state. A key area that the project intends to support is the development of innovative mechanisms for Uttarakhand to engage with private health care providers, expanding their role in meeting the unmet access needs of the state's population. A greater involvement of the private sector would create additional human resource availability for the public health system as a whole, while also providing an opportunity to redeploy existing public staff in a more efficient and effective manner. Interventions will support the state's plans for scaling up health system reform initiatives and making progress towards universal health coverage. Special focus would be on improving access to quality health services for the geographically dispersed and remote populations in the state, and finding innovative ways to engage with the private sector. The project also aims to reduce financial risk and make affordable, high quality healthcare available to all of the state's citizens.

The project will benefit the residents of the entire state of Uttarakhand, and in particular those residing in the remote, hilly and rural areas with poor availability of health services. Successful implementation of the project will have a particularly positive impact on the underserved population (women, elderly and communities living in remote areas). The strengthened availability of primary care services and improved disaster response capabilities will also support the very large floating population that visits the state for business, pilgrimage and tourism.

The project will have two components: a) Stewardship and system improvement and b) Innovations in engaging the private sector. The total project cost is US $ 125 million.

Integration of Environmental Aspects into core UKHSDP activities

Environmental aspects will be an integral part of the project with focus on institutional and skill strengthening, multi-sectoral coordination, and innovations in engaging with the private

sector. Under component 1, the state will support strengthening of skills and systems needed for sound practices in infection control and good methods for treatment and disposal of infectious and hazardous waste, as well as engagement with related sectors. These include the Department of Environment, Uttarakhand-Pollution Control Board, urban authorities, municipalities for better monitoring and enforcement of waste transportation, treatment and disposal at central treatment facilities (CTFs). An integrated approach towards better sanitation, hygiene and infection management will support the project objective in providing cleaner health facilities and providing high-quality health services.

Under component 2, the state can strengthen the PPP system arrangements for waste collection and treatment with the centralized facilities and develop a waste tracking system. As the project is contemplating to increase engagement with private sector in health service delivery, it will be ideal to include Infection Control and Waste Management (ICWM) as integral part of contract. Performance based incentive can also include clauses related to proper ICWM which can be monitored on regular basis. Various innovative mechanisms of BMW management are needed to be thought through in certain PPP arrangements such as mobile health vans and outreach, surgical camps etc.

Mobile health vans provide health services to the remote populations often located in difficult to reach areas. BMW generated at such locations does not get disposed in proper manner due to lesser quantity and lack of availability of disposal mechanism. Interventions such as smaller vehicle retrofitted to carry BMW from such locations can be useful in these circumstances.

Environmental and Social Issues related to the health sector

Environmental:

The nature of this project provides tremendous opportunities to enhance the sanitation, hygiene and infection control and waste management systems and processes in the state so as to further promote sound public health outcomes, while also ensuring that there are no adverse impacts to the environment. There is pressing need to strengthen the capacity on waste management and infection control, ensure the availability of human resources designated to waste management and strengthen the monitoring system to ensure compliance with the Government of India's national regulations.

Infectious waste

Biomedical waste is the waste that is generated during the process of patient care and their quantities in cities have been ranging from 1.5 to 2% of the municipal solid wastes. WHO fact sheet reported that from total of waste generated by health care activities 20% is hazardous. Though quantity is relatively small, it can pose grave risks if not managed properly. All the biomedical waste generated (body parts, organs, tissues, blood and body fluids along with soiled linen, cotton, bandage and plaster casts from infected and contaminated areas along with used needles, syringes and other sharps) is very essential to be properly collected, segregated, stored, transported, treated and disposed of in safe manner to prevent spread of

infection. Failing to do this might lead to spread of hazardous infections such as HIV, Hepatitis and other viral or bacterial infections, which pose huge risk to the health of the public, patients, medical professionals and contribute to environmental degradation.Improper occupational practices and unsafe handling of infectious waste potentially expose health care workers, waste handlers, patients and the community to infection and injuries. Open and uncontrolled slow burning of mixed waste which includes plastic waste produces emissions, such as dioxins and furans, which can be potentially hazardous and carcinogenic.

Wastewater from HCFs

Health-care wastewater is any water that has been adversely affected in quality during the provision of healthcare services. It is mainly liquid waste, containing some solids produced by staff and patients or during health-care-related processes, including cooking, cleaning and laundry. A large part of the wastewater from health-care facilities is of a similar quality to domestic wastewater and poses the same risks but smaller proportions of wastewater generated in HCFs will pose a higher risk than domestic wastewater depending on the service level and tasks of the health-care facility. The wastewater might contain chemicals, pharmaceuticals and contagious biological agents, and might even contain radioisotopes. This highly contagious water may leak into groundwater in absence of watertight and efficient sewers.

Clean water and sanitation

Provision of good health services requires maintenance of clean and hygienic healthcare facilities, with adequate supply of clean, potable water and proper systems for sanitation and cleanliness. Prevention of vector borne diseases and infections from poor quality food and water is essential for reducing the rate of Hospital associated infections. Proper solid waste management is also essential to prevent spread of diseases and infections to patients, healthcare providers and general community.

Mercury Waste

In health care facilities, products containing mercury include thermometers, sphygmomanometers, esophageal, Abbott & Cantor tubes and dental amalgams. Mercury is classified as a hazardous substance that is known to cause serious health impacts and can be fatal if inhaled and harmful if absorbed through the skin. Around 80% of the inhaled mercury vapour is absorbed into the blood through the lungs. The nervous, digestive, respiratory and immune systems and kidneys can be harmed, as well as the lungs. Adverse health effects from mercury exposure can be tremors, impaired vision and hearing, paralysis, insomnia, emotional instability, developmental deficits during fetal development, and attention deficit and developmental delays during childhood.

Environmental Enhancements

A health facility should be spacious, airy with provision for ample of natural light and pleasant greenery in sight. Rightly located departments and wards, ergonomic placement of ward furniture for patients, optimal yet efficient use of space and energy etc. creates positive

environment for the patients and also reduce negative environmental footprint. In future plan should be to embrace use of appliances which use green energy such as solar water heaters, solar lightings, biogas plant etc. Under the project, there is no major civil works or building any physical infrastructure.

Social& Tribal Issues

The overarching issue that determines utilization of services and health outcomes appears to be the difficult geographical terrain. Several villages were inaccessible from the road, and located between 5-32 km deep into the hills and forests. While the 108 ambulances deployed across the state have significantly enhanced availability of emergency transport, communities that live deep inside hills and forests, this facility is not available. The difficult terrain, among other things, has had a negative impact on availability of human resources in the health sector. This is particularly felt at the community level, since often the only health service accessible to many remotely located communities is the community health worker. Indigenous people, categorized as tribal in Indian context endure specific disadvantages in terms of social indicators of quality of life, economic status, and usually as subjects of social exclusion. Consequently, they are unable to participate in the development process on an equal footing with the rest in the community, nor are able to reap a fair share of the benefits of developmental projects. It is important to identify issues that may constrain their participation in development process, suggest measures to enhance their involvement, and enable them to access healthcare at par with others.

There are significant differences in key maternal health indicators among rural-urban differential district-wise variation in disease prevalence.

Few key issues faced by tribal communities like- widespread poverty, low level of illiteracy, malnutrition, lack of personal hygiene, limited access to safe drinking water, lack of sanitary living conditions and health education, poor access to maternal and child health services, and ineffective coverage by national health and nutritional services. Tribal settlements tend to be small, isolated and difficult to reach with facilities and services. Tribals are also facing some key issues of state health system with their specific issues described above, like unavailability/lack of qualified health care providers and diagnostic services in vicinity of their dwellings; poor health infrastructure, lack of awareness, high prevalence of communicable diseases with increasing incidence of non-communicable diseases, perceived higher cost in seeking health care services, etc.

Low awareness of health issues and understanding of requirements among communities such as lack of treatment for diarrhea and regular immunization is another issue that needs to be addressed.

The declining sex ratio, particularly in certain districts of the state, is a cause for concern. Although literacy rates are higher than the national average, there is a growing preference for male children. The easy availability of testing facilities, particularly in urban areas, could be a

contributing factor. There is active monitoring of violations of the PCPNDT Act; however, the effectiveness of this in curtailing violations is questionable. This is only one aspect of the gender issue; access to health care is another important dimension that needs to be addressed, since there is some evidence that males are more likely to receive treatment for various conditions as compared to females (AHS 2011-12).

Healthcare provision to tribal community faces unique challenges such as their perception that the doctors in public sector health facilities do not provide good care. Another reason for lack of utilization of the government health centers was lack of any health center near their dwellings. Tribal women face social, physical and economic barriers in seeking health care and are often seen to accord very low priority to their health care needs. The Jaunsaritribals of Uttarakhand, who are mainly centred on the Jaunsar-Bawar region of Dehradun and Mori region of Uttarkashi are polyandrous in nature. This gives rise to high parity and illegal abortions.

Sauka, Raji, Jaunsari, and Boxa, which have developed their own cultures based on available natural resources, characterize the socio-cultural fabric in the state, and use of locally growing medicinal plants forms part of the measures they adopt for addressing their health care needs.

The tribal habitants of the Upper Himalayas are mostly dependent on the local herbal cure system, which they inherited from their ancestors. Further, some of the other healing practices like “jhaadphook”, “jaadutona” and other traditional eating practices, lead to increase in health ailments among them.

Applicable Policies and Guidelines

Environmental Protection Act, 1986

The Government of India (GoI) enacted the Environmental Protection Act, 1986, under Article 253 of the Constitution. The purpose of this Act is to serve as an “umbrella” legislation designed to provide a framework for central government coordination for the activities of various established central and state authorities.
As this is an “umbrella” and all-encompassing legislation, this is relevant to the health sector activities as well. There are rules / notifications that have been brought out under this Act. These are directly relevant to the health sector. These rules / notifications are covered in the rest of this section.

Bio-medical Waste Management Rules, 1998 (amended 2016)

Under the Environmental Protection Act, 1986, the Bio-medical Waste Management Rules were introduced. These Rules are directly relevant to the health sector. The salient features of these Rules are as follows:

- Bio-medical wastes means waste that is generated during the diagnosis, treatment or Immunization of human beings or animals or in research activities pertaining thereto or in the production or testing of biologicals.
- It is the duty of every occupier of an institution generating bio-medical waste which includes a hospital, nursing home, clinic, dispensary, veterinary institution, animal house, pathological laboratory, blood bank by whatever name called to take all steps to ensure that such waste is handled without any adverse effect to human health and the environment..
- Bio-medical waste shall be segregated into containers/bags at the point of generation in accordance with Schedule II and treated and disposed in accordance with Schedule I of these Rules. The Rules also require compliance with the standards prescribed in Schedule V, which gives standards for different treatment technologies. These are covered in the Operational Guidelines of this IMEP Guidance Manual.

Environmental Protection Act, 1986

The Government of India enacted the Environmental Protection Act (EPA) under Article 253 of the Constitution. This Act serves as an "umbrella" legislation to provide a framework for coordination of environment activities of various established central and state authorities. It also empowers the Central Government to take appropriate measures to protect and improve environmental quality and to prevent, control and abate environmental pollution, including collection and dissemination of information. There are rules and notifications under this Act, which are directly relevant to the health sector.

Municipal Solid Wastes (Management and Handling) Rules, 2000

As a result of the plague epidemic in Surat, Gujarat, in 1994 the Supreme Court, under pressure from civic and environmental activists, directed to the Ministry of Environment and Forests (MOEF) to draft the Municipal Solid Wastes (MSW) Rules in 2000. These rules apply to every municipal authority responsible for collection, segregation, storage, transportation, processing, and disposal of municipal solid wastes.

The Water (Prevention and Control of Pollution) Act 1974

The Act establishes standards for water quality and effluent and also establishes an institutional structure for preventing and abating water pollution. Polluting industries must seek permission to discharge waste into effluent bodies. The Central Pollution Control Board (CPCB) was constituted under this Act.

Right to Information Act, 2005

The RTI Act confers a right on every citizen to secure access to information under the control of public authorities, consistent with public interest, in order to promote openness, transparency and accountability. It provides for the constitution of a Central or State Information Commission(s), which are empowered to enquire into complaints from persons who have not been able to secure information requested under the Act. The Indian Courts

have also allowed citizens and social action groups and pressure groups access to public records, subject to the condition that disclosure may be refused for reasons of security.

Guidelines for establishing and operating a Common Bio-medical Waste Treatment Facility

A Common Waste Treatment Facility for health care facilities (CWTF) is a set up where health care waste, generated from a number of health care units, is imparted necessary treatment to reduce adverse effects that this waste may pose. The CWTFs are cost effective, easy to operate and maintain rather than individual healthcare facilities having their own waste treatment and disposal options.

As a signatory to the Stockholm Convention on persistent Organic Pollutants and the Minamata Convention on Mercury, Government of India is required to take action on reducing the emissions of POPs (dioxins and furans) and mercury. In this regard, These are addressed by GOI's mandate of centralized treatment facilities and phasing out of mercury containing healthcare equipment. The GOI has disseminated **"Environmentally sound management of mercury waste generated from the health care facilities" in 2012".**

The World Bank Operational Policy (OP) requires that Environmental Assessment of projects for Bank financing be conducted to ensure that they are environmentally sound and sustainable with an objective to improve decision making process. This project has been classified as a **Category B p**roject as its potential adverse environmental and social impacts are well defined and manageable.

Mitigatory measures to address Environmental and Social issues:

Environmental Issues

S. No.	Type of Waste	Location	Segregation	Institution Treatment	End Treatment at CTF	Final Disposal At the Common treatment facility
1	Infectious anatomical waste	OT, Labour room, Wards	To be collected in yellow plastic bags kept in yellow buckets	-	Incinerator	Deep burial in case of PHCs &Sub-centres
2	Infectious organic waste	All wards, OT, Labour rooms, Lab, ICU,	Red bucket lined with red plastic liners stored in red drums with plastic liners	-	Auto clave	Deep burial/ Secure landfill
3	Infectious plastic waste	All wards and departments	Red buckets stored in Red drum lined with Red plastic liner	5% Hypo chlorite solution for 30 minutes	Autoclave and shredding	secure landfill & Bags disposed by Recycling
7.	Sharps (needles, slides, bottles etc)	All wards departments All wards departments	mutilation by needle destroyer then put in sharps container with hypo chlorite solution 1%	1% hypochlorite for 30 minutes	Auto clave	Encapsulation or recycled
9.	Discarded medicines/expired drugs/Cytotoxic drugs	Kept at medical stores after collection from department	Kept in secured box in medical stores, then put in yellow bags	-	No treatment required	Secure land filling
11	Liquid waste/chemicals/blood	All wards/ Autopsy rooms	-	5% Hypo chlorite for 30 minutes & discarded in drain	-	-
12	Capacity building in occupational practices in infection control	Provision of PPE (gloves, masks, boots etc) as required Training and capacity building				

S. No.	Type of Waste	Location	Segregation	Institution Treatment	End Treatment at CTF	Final Disposal At the Common treatment facility
13	Wastewater management	Designated/separate sewer system for wastewater - Operation and maintenance of sewer system Pre-treatment of hazardous liquids before discharging Integrate storage and sewerage systems into hospital building design, in consultation with relevant state agencies				
14	Mercury Waste	Phase-out plan should be developed and implemented for mercury containing instruments Should be treated as hazardous waste and managed as per GOI Guidelines				
15	Awareness building	Awareness to be created among the community and Private health providers about the Health Care Waste Management, method of collection , storage, transportation disposal, and the end treatment at the CTF. Health personnel & paramedical workers should be sensitized in segregation and safe disposal of Health Care Waste, risks in HCWM, etc. Provision of awareness materials including hoardings, wall writing stickers etc				
16	Grievance readdresal	Community based feedback mechanism Designated person at facility, district and state level to raise grievance though convenient communication mode (phone, email, social media etc.)				
17	Procurement and Supply chain management of IC and BMW goods	Needs assessment of IC and BMW consumables Setting up specifications for goods with consultation with appropriate authority IT based prompt supply chain management to ensure timely supply of goods and consumables Feedback mechanism for quality and quantity of consumables				

Social and Tribal Issues

1	Enhancing availability of primary care services	Increasing the availability and outreach activities of Mobile Health Vans: The state had already deployed a number of MHVs that provide health care on a fixed schedule. Expand number of mobile vans to increase both coverage and frequency such that communities could rely on these mobile units for their regular health needs. There needs to be a strategic plan for reaching rural communities with key health messages, increasing their awareness of various health issues and serving as catalysts for action. Increase the quality and availability of services in tandem in order to enhance the credibility of the system and make a sustainable change in health seeking behavior of communities. Introduction of a Health Helpline that not only provides health information and advice, but also guides patients through the health systems to offer a more coordinated, systemic response Monitoring and evaluation mechanisms will ensure the regular tracking of progress and impact of project interventions on women and vulnerable populations. At all levels, data will be maintained on utilization of services by women, and this data will be regularly reviewed and evaluated. Similarly, disaggregated data on each district will be maintained and reviewed by an appropriately constituted team. This will ensure that regional and inter-district imbalances are appropriately addressed in a timely manner. In addition, the report of the committee monitoring the implementation of the PCPNDT Act will be regularly reviewed by the Project Director and the Secretary Health to ensure that all violations are being strictly followed up. there is a need to pursue a multi-sectoral approach to health, especially at the community level. The community level workers are meant to work in a coordinated manner, with the ASHA, ANM and Anganwadi worker all working together with the common goal of serving the needs of children and their mothers. Similarly, the annual health check-up is done in coordination between the Health and Education departments. Mechanisms for coordination, such as joint state- and district-level committees that oversee the coordinated action of these departments, will greatly facilitate the quality and effectiveness of these programs.

2	Supporting Public Private Partnerships	Partnering with NGOs: NGOs have proved to be effective partners in several programs, notably the Adolescent Reproductive and Sexual Health program, the Urban Health Centers and the ASHA Plus program. While the capacity of NGOs in UK is limited, and their location in the really remote areas is sparse, they could yet be effective resources to reach out to areas which are currently underserved. The current PPP arrangement for the management of the CHCs should be evaluated and scaled up if possible. With the increase in service delivery at the CHC close to the capital, there is a need to expand the physical infrastructure at the facility to sustain further increase in the service supply; however, this does not seem likely at this stage. A deeper understanding of the costs of care. The reimbursement of services is done on the basis of number of diagnostic tests carried out, but it is not clear what the impact of this on over-prescription of diagnostic tests is, how much of that cost is borne by the patient, and whether this model is viable for the private partner. The terms of the contract need to be examined critically to ensure that the private partner also comply with the requirements of the public health programs. The private partner is not held accountable under the contract for delivery of national programs. So there is a focus on diagnostic and curative care, but programs such as RNTCP, and VBDCP, are completely neglected.
3	Indigenous people: Difficult geographical terrain is barrier to access of health care services	To reach at the doorstep of indigenous people through innovative mechanisms by strengthening the expansion of MHV network under PPP
4	Low awareness regarding health care related issues among the tribal communities	Create awareness on key health issues through innovative solutions Development of IEC/BCC activities
5	Gender Imbalance	Create awareness on Gender issues via proper behaviour change activities Increasing awareness through IEC/BCC activities
6	Shortage of manpower	Innovative solutions as alternative for key health delivery activity Private sector engagement, outsourcing of CHC's
7	Due to Poverty, poor healthcare seeking practices	Innovation in financial risk protection by RSBY/MSBY

Action Plan

Waste Management	Actions to be taken	Responsibilities
Waste Storage, Transportation, Treatment and Disposal	Central Facilities Undertake needs assessment of waste generated and location of healthcare facilities Discuss CTF strategy and prepare CTF mapping for the state in consultation with Pollution Control Board and Municipalities Follow-up with stakeholders with regard to availability of land for placement of CTFs, bidding documents for CTFs etc Coordinate discussions related to CTF contracting rates, frequency of collection, transportation and disposal options and other administrative logistics PHCs/SCs Needs assessments of conditions of deep burial pits Discussions on next steps with (1) NHM for construction of new pits (2) PCB for one-time emptying of pits where scarcity of land Discussions with stakeholders on innovative approaches for hilly/remote areas Storage Areas Provide guidelines for existing facilities to improve storage site Provide recommendations for improved storage areas into hospital building design	**Health dept. with help from Environment consultant (Would hire private partner to carry out needs assessment)**
Consumables	Complete needs assessment of consumables (bags, bins, needle cutters, sharps boxes, PPE etc) for all facilities Develop technical specifications and include requirements into procurement plan Develop time-schedule for annual procurement based on requirement from the facilities Establish system of feedback on quality of consumables for improving technical specifications and procurement	
Capacity Building	Prepare a training plan based on needs assessment; Review alternative options such as involving local NGOs, medical and nursing associations, medical colleges and private service providers to ensure state-wide capacity-building. Develop training modules; All training and awareness material must be in the local language Coordinate training activities in state;	**Health dept. with help from Environment consultant (private partner will be hired to carry out task)**

Waste Management	Actions to be taken	Responsibilities
	Training would be provided in train-the-trainer modules which would be replicated within individual facilities by designated trained staff on a regular basis Set up system for receiving completion reports from individual facilities, for better monitoring. timely compliance with environmental authorizations and clearances. Develop simple WM guidelines for Mobile health vans, outreach activities, camps, blood donation camps, boat etc	
Environmental Enhancements	Water testing for quality Institute systems for improved sanitation and cleanliness Good practices in hygiene Consider options for more energy efficiency	**Appropriate government authority (apart from health dept.) will be given inputs from Health dept.**
Environment consultancy for PPP contracts	All the PPP contracts can be given inputs from environmental cell about making strict provision in the contract about proper management of BMW. Private partner can be penalized for unsatisfactory compliance or incentivized for innovations in eco-friendly disposal of BMW	**Health dept.**
Monitoring and enforcement	Establish monitoring system (including photographic evidence) and include into project MIS Institute waste tracking and GPS systems, in consultation with PCB, for implementation by private operators Develop innovative solutions for monitoring, such as joint departmental inspections, outsourcing to medical colleges, medical and nursing associations and NGOs or community based organizations. This monitoring should include health care facilities and CTFs, after discussion with Pollution Control Board. Review options for community involvement in enforcement for CTFs Discussion with CTF for improved enforcement All healthcare facilities will maintain records related to the generation, collection, reception, storage, disposal and/or any form of handling of bio-medical waste. All records will be subject to inspection and verification by the prescribed authority at any time	**Health dept.**

Waste Management	Actions to be taken	Responsibilities
	Institute systems for accident reporting and actions to be taken to treat the emergencies HCF administration would undertake routine supervision and random checks within facilities and reporting of performance indicators and corrective measures Undertake mid-term review of ESMP implementation Commission an independent evaluation of ESMP in year 5 of the project	
Mercury phase-out	Develop phase-out plan for mercury containing equipment Discuss with UK PCB as to systems for storage of decommissioned mercury equipment	**Health dept.**
IEC	Awareness to be created among the community and Private health providers about the Health Care Waste Management, method of collection , storage, transportation disposal, and the end treatment at the CTF. Health personal &paramedical workers should be sensitized in segregation and safe disposal of Health Care Waste, risks in HCWM, etc. The IEC activities will be given through mass media, and also the methods as suggested by communication experts	**Communication dept. within directorate in consultation with Environment Consultant**
Social & Tribal Issues	Proposed Mitigation	
Expanding Public Private Partnerships (PPP's)	Provisioning of healthcare care services by expanding coverage of MHV Increase number of CHC's under PPP mode for better delivery of health care in remote locations. Improving financial risk protection by RSBY/MSBY	**Health Dept. (activities outsourced under PPP model)**
Previsioning of Primary care	Provisioning of Primary care services child care & NCD care through RSBY/MSBY mechanisms Outpatient packages for Child care & NCD to be developed Improving financial risk protection by RSBY/MSBY	**RSBY/MSBY cell**
IEC/BCC Activity	Awareness to be created among the community and Private Health providers about the Social issues. Health personal & paramedical workers should be sensitized on gender issues, health seeking behaviour, institutional	**Health Dept.**

Waste Management	Actions to be taken	Responsibilities
	delivery, etc. IEC/BCC activities to be developed for community on appropriate use of traditional medicine, faith healers & local remedies The IEC activities will be given through mass media, and also the methods as suggested by communication experts	
Human resources for health	Expanding PPP models for greater availability of qualified HR in remote locations Increasing the availability and outreach activities of Mobile Health Vans & Community health centres through PPP integrated model. Advocacy at state level for rational deployment of HR in state	**PPP Cell**
Monitoring and Evaluation	Generating evidence by mapping of Indigenous communities in state, baseline on health needs & health seeking behaviors Establish monitoring system and include into project MIS Continues monitoring of healthcare utilization by community Undertake mid-term review of IPDP implementation Commission an independent evaluation of IPDP activities in year 5 of the project	**Health Dept. with help of evidence policy and health information cell of UKHSDP**
Capacity building	Prepare a training plan based on needs assessment, particularly focusing on healthcare needs and disease patterns at community level Develop training modules; All training and awareness material must be in the local language	**Health Dept.**

Annexure IV

TERMS OF REFERENCE FOR THE AUDIT OF PROJECT FINANCIAL STATEMENTS OF PROJECT

Background:

Uttarakhand Health Systems Strengthening Project (UKHSDP) is conceived as a strategic initiative to enhance people's access to quality health care services in the state of Uttarakhand. The project seek to support Uttarakhand in progressing towards Universal Health Coverage, as measured by improvement in access to and quality of health services and in providing health financial risk protection. Specifically, the project would focus on improving access to health services for the predominantly remote population of the state, through strengthening public and private health-delivery systems; promoting greater stewardship and managerial capacity in the state directorate; improving information systems; augmenting monitoring and research; and extending coverage of RSBY beyond hospitalization to include primary healthcare services. A key area the project supports is innovative mechanisms for Uttarakhand to engage with private health care providers, expanding their role in meeting the unmet access needs of the state's population. A greater involvement of the private sector would create additional human resource availability for the public health system as a whole, also providing an opportunity to deploy existing public staff in a more efficient and effective manner.

Implementation arrangements:

The Uttarakhand Health System Development Project (UKHSDP) would be implemented by the Uttarakhand Health and Family Welfare Society (UKHFWS) constituted under the Department of Health and Family Welfare, Government of Uttarakhand. The Mission Director of the National Health Mission will also be the Project Administrator for UKHSDP and will lead the project implementation under the overall guidance and supervision of the Principal Secretary, Department of Medical Health and Family Welfare, who is also the Chairman of the Society.

A Project team would consist of Nodal officers for each of the key implementation area who will be supported by core group of experts and supporting staff. The project will be implemented over a Six year period by the GoUK, and utilize the standard on lending arrangements from the GoI to the state.

The annual audit of the Project Financial Statements (PFS) would be carried out by CA firm[1] registered under Institute of Chartered Accountants of India (ICAI) as per the following terms of reference agreed. All supporting records and documents under the Project would be subject to this audit. The auditor will audit all implementing agencies under the Project and provide a consolidated report for the Project. The annual project audit report and accounts would be submitted to the Bank by December 31 each year.

The detail scope of audit is outlined below:

[1] *The firm selected for audit should be acceptable to the Bank.*

Objective

The essence of the World Bank[2] audit policy is to ensure that the Bank receives adequate independent, professional audit assurance that the proceeds of World Bank loans were used for the purposes intended,[3]that the annual project financial statements are free from material misstatement, and that the terms of the loan agreement were complied with in all material respects.

The objective of the audit of the Project Financial Statement (PFS) is to enable the auditor to express a professional opinion as to whether (1) the PFS presentfairly, in all material respects, the sources and applications of project funds for the period under audit examination, (2) the funds were utilized for the purposes for which they were provided, and (3) expenditures shown in the PFS are eligible for financing under the relevant loan or credit agreement. In addition, the auditor will express a professional opinion as to whether the Interim Unaudited Financial Reports submitted by project management may be relied upon to support any applications for withdrawal.

The books of account that provide the basis for preparation of the PFS are established to reflect the financial transactions of the project and are maintained by the project implementation agency at the head office.

Standards

The audit will be carried out in accordance with the Auditing Standards promulgated by the ICAI**.**The auditor should accordingly consider materiality when planning and performing the audit to reduce audit risk to an acceptablelevel that is consistent with the objective of the audit.Although the responsibility for preventing irregularity, fraud, or the use of loan proceeds for purposes other than as defined in the legal agreement remains with the borrower, the audit should be planned so as to have a reasonable expectation of detecting material misstatements in the project financial statements.

Scope[4]

The CA Firm would audit all the project components and certify the Project Financial Statements.In conducting the audit, special attention should be paid to the following:

(a) All external funds have been used in accordance with the conditions of the relevant legal agreements and only for the purposes for which the financing was provided. Relevant legal agreements include theFinancing Agreement, the Project Agreement, Grant Agreement and the Minutes of Negotiations;

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[2] *"World Bank" includes the International Development Agency and the International Bank for Reconstruction and Development. "Loans" includes credits and grants to which the TORs would apply; and "borrower" includes recipients of such loans.*

[3] *The Bank's charter [Article III Section V(b) of IBRD's Articles of Agreement and Article V Section 1(g) of IDA's Articles of Agreement] specify that: "The Bank shall make arrangements to ensure that the proceeds of any loan are used only for the purposes for which the loan was granted, with due attention to considerations of economy and efficiency and without regard to political or other non-economic influences or considerations."*

[4] *In response to identified project risks, the scope may be expanded to include a report or the expression of an opinion on specific aspects of the operation such as internal controls, compliance with Bank procurement policies, or efficiency and effectiveness in the use of loan proceeds.*

(b) Counterpart funds have been provided and used in accordance with the relevant legal agreements and only for the purposes for which they were provided;

(c) All necessary supporting documents, records, and accounts have been kept in respect of all project transactions including expenditures reported via IUFRs where applicable. Clear linkages should exist between the books of account and reports presented to the Bank; and

(d) The project accounts have been prepared in accordance with consistently applied Institute of Chartered Accountants of India Standards and present fairly, in all material respects, the financial situation of the project at the year end and of resources and expenditures for the year ended on that date.

Project Financial Statements

The Project Financial Statements should include-

A. Statement of Sources and Applications of Funds: The formats of PFS are set out in Annexure 1.

B. Reconciliation of Claims to Total Applications of Funds. The PFS include reconciliation between expenditure reported as per the Statement of Sources and Applications of Funds and expenditure claimed from the World Bank through report based methods of reimbursement. The formats are outlined in Annexure 2.

C. Management Assertion: Management should sign the project financial statementsand provide a written acknowledgement of its responsibility for the preparation and fair presentation of the financial statements and an assertion that project funds have been expended in accordance with the intended purposes as reflected in the financial statements. An example of a Management Assertion Letter is shown at Annexure 3.

Interim Unaudited Financial Reports

In addition to the audit of the IUFR's, the auditor is required to audit all withdrawal applications made during the period under audit examination. The auditor should apply such tests as the auditor considers necessary under the circumstances to satisfy the audit objective. In particular, these expenditures should be carefully examined for project eligibility by reference to the relevant financing agreements. Where ineligible expenditures are identified as having been included in withdrawal applications and reimbursed against, these should be separately noted and qualified by the auditor.

Audit Report

An audit report on the Project Financial Statements should be prepared in accordance with the Auditing Standards promulgated by the ICAI. Those standards require an audit opinion to be rendered related to the financial statements taken as a whole, indicating "unambiguously whether it is unqualified or qualified and, if the latter, whether it is qualified in certain respects or is adverse or a

disclaimer of opinion."[5]In addition, the audit opinion paragraph will specify whether, in the auditor's opinion, (a) with respect to IUFRs, adequate supporting documentation has been maintained to support claims to the World Bank for reimbursements of expenditures incurred; and (b) except for ineligible expenditures as detailed in the audit observations, if any, appended to the audit report[6], expenditures are eligible for financing under the Loan Agreement.

The project financial statements and the audit report should be received by the Bank not later than 9 months after the end of the fiscal year. The auditor should also submit two copies of the audited accounts and audit report to the Implementing Agency.

Management Letter

In addition to the audit report on the project financial statements, the auditor may prepare a management letter containing recommendations for improvements in internal control and other matters coming to the attention of the auditor during the audit examination.

Where a management letter is prepared by the auditor, a copy of the same will be supplied to the Bank. Else, a written advice may be made that no management letter was prepared together with the audit report on the project financial statements.

General

The auditor should be given access to any information relevant for the purposes of conducting the audit. This would normally include all legal documents, correspondence, and any other information associated with the project and deemed necessary by the auditor. The information made available to the auditor should include, but not be limited to, copies of the Bank's Project Appraisal Document, the relevant Legal Agreements, a copy of these Guidelines, and a copy of the Bank's Financial Management Assessment of the project entity.It is highly desirable that the auditor become familiar with other Bank policy documents, such as OP/BP 10, the Bank's internal guidelines on Financial Management that include financial reporting and auditing requirements for projects financed by the World Bank. The auditor should also be familiar with the Bank's Disbursement Manual. Both documents will be provided by the Project staff to the auditor.

[5] *See relevant portions of Auditing Standards of the ICAI as applicable from time to time.*

[6] *A sample audit report wording for an unqualified audit opinion is shown at Annexure 4.*

Annexure 1

UTTARAKHAND HEALTH AND FAMILY WELFARE SOCIETY

UTTARAKHAND HEALTH SYSTEMS DEVELOPMENT PROJECT

STATE HEALTH SOCIETY: UTTARAKHAND

SCHEDULE OF EXPENDITURE AND UNSPENT BALANCE UNDER RNTCP (TUBERCULOSIS) AS ON MARCH 31, 20XX

	Particulars						Amount in Rs.Millions
A)	Opening Balance as on 01.04.20XX						
B)	Grant received from State Government during the year						
C)	Bank interest and other receipts collected during the year						
D)	Total fund available for spending						
E)	Expenditure made during the year						
Sl. No.	**Major Head**	**Qtr I**	**Qtr II**	**Qtr III**	**Qtr IV**	**Total**	
1	District operator- MHV+ CHC + DH strengthening						
2	Health Helpline 104 + Telemedicine						
3	RSBY/MSBY child health						
4	RSBY/MSBY NCD						
5	Project core team and office expenses						
6	Training Capacity building and consultation workshop						
7	Consultation Workshop & communication						
8	Sector Strengthening, Research, Monitoring and Evaluation						
	Total	**0**	**0**	**0**	**0**	**0**	
	Unutilised Grant						
F)	**Advances**						
G)	**Closing Balance**						

(Name of Firm)
Chartered Accountants

Firm Registration Number

Mission Director, NRHM Place:
Date:

(Name of Chartered Accountant)

Director Finance, NRHM Partner, M.No.

Notes:

1. *The above figures will be based on monthly/quarterly abstract accounts prepared by the accounts compiling officers, duly reconciled by the respective DDOs, with details of un-reconciled amounts to be furnished.*
2. *Names of accounting units whose financial statements are aggregated to prepare the consolidated accounts.*
3. *Any other project specific Note.*

Annexure 2

Reconciliation of Claims to Total Applications of Funds

Name of the Project **Loan / Credit / Grant No.**

Report for the year ended _____

	Schedules	Amt (Rs. '000)		
		Current Year	Previous Year	Project to date
Bank Funds claimed (A)	**I**			
Withdrawal Claims for 1st quarter as per IUFR				
Withdrawal Claims for 2nd quarter as per IUFR				
Withdrawal Claims for 3rd quarter as per IUFR				
Withdrawal Claims for 4thquarter as per IUFR				
Total bank funds claimed				
Total Expenditure made during the year (B)				
Expenditure as per books of account				
Less: Outstanding advances (C)	**II**			
Ineligible expenditures (D)	**III**			
Expenditures not claimed (E)	**IV**			
Total Eligible Expenditures Claimed (F)=(B)-(C)-(D)-(E)				
World Bank Share (G= @100% of F)				
Claims in excess of expenditure (A-G)				

Signature	Signature	Signature
Project Director	Finance Person	Auditor

Notes:

1. *Total expenditure made during the year (B above) must be the same as the Total Expenditures shown on the Statement of Sources and Applications of Funds (F on the Statement of Sources and Applications of Funds)*
2. *Outstanding Advances (C above)reflect funds drawn but not settled by the end of the year (i.e. unsettled advances).*
3. *Expenditures not claimed (E above) may reflect timing differences for eligible expenditures incurred during the year but claimed after the year end.*

(Rs. In millions)

Disbursement Category and Expenditure

Disbursement Category	Expenditure	Eligible Expenditure	%	Claim Amount
Total				

Signature	Signature		Signature
Project Director	Finance Person		Auditor

Annexure 3

Example of a Management Assertion Letter[7]

(Project Letterhead)

(To Auditor) (Date)

This assertion letter is provided in connection with your audit of the financial statements of the _____ Project for the year ended _____. We acknowledge our responsibility for the fair presentation of the financial statements in accordance with the cash basis of accounting followed by the Government of India, and we confirm, to the best of our knowledge and belief, the following representations made to you during your audit:

- The project financial statements are free of material misstatements, including omissions.
- Project funds have been used for the purposes for which they were provided.
- Project expenditures are eligible for financing under the Loan/Credit agreement.
- There have been no irregularities involving management or employees who have a significant role in internal control or that could have a material effect on the project financial statements.
- We have made available to you all books of account and supporting documentation relating to the project.
- The project has complied with the conditions of all relevant legal agreements, including the Financing Agreement, the Project Agreement, the Project Appraisal Document, the Minutes of Negotiations, and the Borrower's Project Implementation Plan.

_____

(Project Director)

_____

(Finance Person)

[7] *This sample management assertion letter is based on ISA 580, "Management Representations," Handbook of International Auditing, Assurance and Ethics Pronouncements, International Federation of Accountants, 2007*

Annexure 4

Sample Audit Report—Unqualified Opinion

Auditor's Report

Addressee[8]

Report on the Project Financial Statements

We have audited the accompanying financial statements of the _____ Project financed under World Bank Grant No._____, which comprise the Statement of Sources and Applications of Funds and the Reconciliation of Claims to Total Applications of Funds[9] for the year ended _____, these statements are the responsibility of the Project's management. Our responsibility is to express an opinion on the accompanying financial statements based on our audit.

We conducted our audit in accordance with the Auditing Standards promulgated by the Institute of Chartered Accountants of India. Those Standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. Our audit examines, on a test basis, evidence supporting the amounts and disclosures in the financial statements. It also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements present fairly, in all material respects, the sources and applications of funds of _____ Project for the year ended _____ in accordance with Institute of Chartered Accountants of India accounting standards.

In addition, in our opinion, (a) with respect toIUFRs, adequate supporting documentation has been maintained to support claims to the World Bank for reimbursements of expenditures incurred; and (b) except for ineligible expenditures as detailed in the audit observations, if any, appended to this audit report, expenditures are eligible for financing under the Loan/Credit Agreement. During the course of the audit, IUFRs (each application no. and amount to be indicated) and the connected documents were examined and these can be relied upon to support reimbursement under the Loan/Credit Agreement.

[Auditor's Signature]

[Auditor's Address]

[Date[10]]

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[8] *The auditor's report should be addressed to the person stipulated in the underlying loan agreement as responsible for providing audited project financial statements.*

[9] *Insert titles of other required statements and schedules included in or annexed to the project financial statements, if any.*

[10] *The report should be dated as of the date to which the auditor has become aware of and considered the effects of events and transactions. This is generally the final date of fieldwork, as opposed to the date of signing the audit report.*