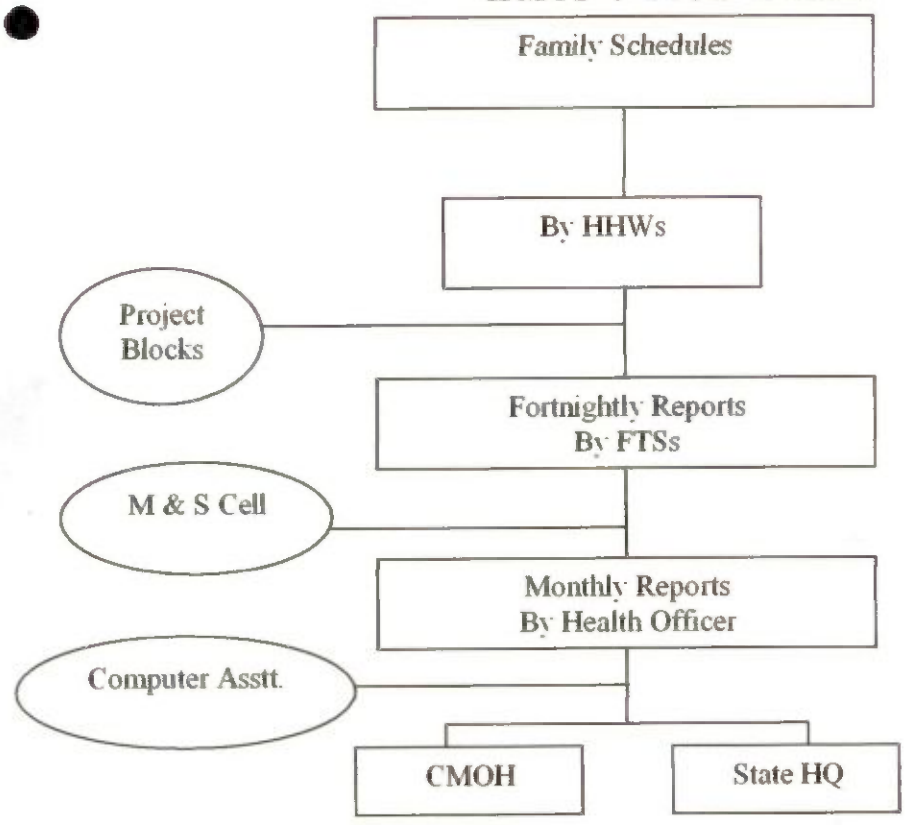
HMIS : Flow Chart



4. Capacity building of Health personnel of SUDA

- Technical capacity strengthening of Medical Professionals and other staff i.e. MIES, Accounts, Clerk and Computer.
- Managerial training of Medical Professionals.
- Monitoring & supervisory training of all personnel.
- Exposure / exchange visit.

5. Capacity building of Health personnel of ULBs i.e. grass root health functionaries (HHWs, FTSs), Health Officer, Medical Officer, Sanitary Inspector etc.

- Technical – initial and re-training time to time.
- Managerial
- Monitoring & supervisory
- Exposure / exchange visit

6. Job description of personnel of Health Wing, SUDA

Technical Adviser

- Technical head for implementation of the programme, including development of training manuals, collection of IEC resources and strategies, MIES methodology and conduction of survey, documentation process, monitoring and evaluation.
- Will provide technical guidance to the Project Officer and other technical personnel of Management & Supervision Cell.
- Will attend meetings, seminars.
- Will liaison with Department of Health and Family Welfare, Department of Municipal Affairs for strategic framework of urban health care as and when necessary.

Project Officer

- Co-ordinating head for implementation of the programme.
- Will function apropos direction of the Director SUDA and in consultation with Technical Adviser.
- Maintain liaison with Department of Health and Family Welfare, Department of Municipal Affairs at State Level and ULBs at District Level.
- Will be responsible for planning, organising, monitoring and supervision of all the activities of the Community Based Primary Health Care Services in 63 Non-KMA ULBs.
- Will attend meetings, seminars.
- Will provide the necessary inputs to the Department of Health and Family Welfare for documentation of the HHW Scheme.
- Will act as team leader with the Medical Officer at zonal level, MIES Officer and Finance Officer to ensure the accountability of the Scheme.

Assistant Project Officer

- Will assist Project Officer in respect of administration.
- Will be responsible for planning, implementation, monitoring of IEC programme at ULB level.
- Will be responsible for undertaking all the procurements centrally at SUDA.
- Will plan & organize technical training to the different categories of health manpower at ULB level.
- Will assist Project Officer in respect of procurement at ULB level.
- Will liaise with Medical Officer of SUDA at zonal level.

Medical Officer

- Will be responsible for providing technical and managerial guidance to the Health Officer/ Assistant Health Officer in planning, organising, monitoring and supervision of all health programmes in the municipalities.
- Will visit ULBs regularly to monitor & supervise ongoing health activities.
- Will be responsible for providing technical and managerial guidance to the Health Officer/ Assistant Health Officer in organising training and capacity building programmes.
- Liaison with District Health Offices for establishing the referral services, particularly with RCH and disease control Programme Officers, public health.
- Follow up with HO/AHO for timely submission of Report and Returns.
- Assist in identification of suitable accommodation of CBO's for Sub-Centre jointly with the ULB.
- Facilitate and check the supply of stores, furniture, equipment, medicines and others from SUDA and arrange to maintain Stock Register, and distribution of the same to the appropriate health facilities.
- Detailing out of general work plan along with time frame and monitoring of the work apropos laid down target.
- To conduct periodical review meeting with members of the Management & Supervision Cell of ULB and sometimes with grass root level functionaries and supervise the maintenance of minute book.
- To attend different meetings, seminars / workshops.
- In addition, to perform such other functions as may be entrusted to him by the Project Officer.

Finance Officer

By FA

Additional Accountant

By FA

Additional Cashier

By FA

Accounts Assistant

By FA

MIES Officer

- To design the reporting format.
- To supervise the work of Computer Assistant.
- To analyze the data and prepare ULB-wise as well as consolidated monthly reports indicating trend and measures to be taken.
- Submit reports to Project Officer.
- Provide feed back to Medical Officer (Zonal Medical Officer).
- Field verification as and when required.
- Provide training / re-training to grass root level functionaries.
- Attend workshop, discussion, meeting etc.

Computer Assistant

- To develop system as to compare the data of different municipalities.
- To maintain computerised filing system at Health Wing, SUDA.
- To prepare all the reports and returns at Health Wing, SUDA.
- To enter data as and when received from different municipalities.
- To perform any other duty as will be assigned by the MIES Officer.

Clerk cum Storekeeper

- To despatch and receive office correspondence and maintain office records in appropriate files.
- To make list for necessary indents, collection and maintenance of stock and supply of logistics.
- To assists officers of Health Wing, SUDA in effective functioning of project activities.
- To perform any other duty as will be assigned by the competent Authority.

Multipurpose Helper

- Work at office / outdoor as messenger / peon.
- To perform any other duty as will be assigned by Project Officer.

7. Documents

(a) Design and estimate of Sub-Centre & HAU

Enclosed.

(b) ULB staffing pattern

By Director, SUDA

(c) IPP-VIII agreement copy.

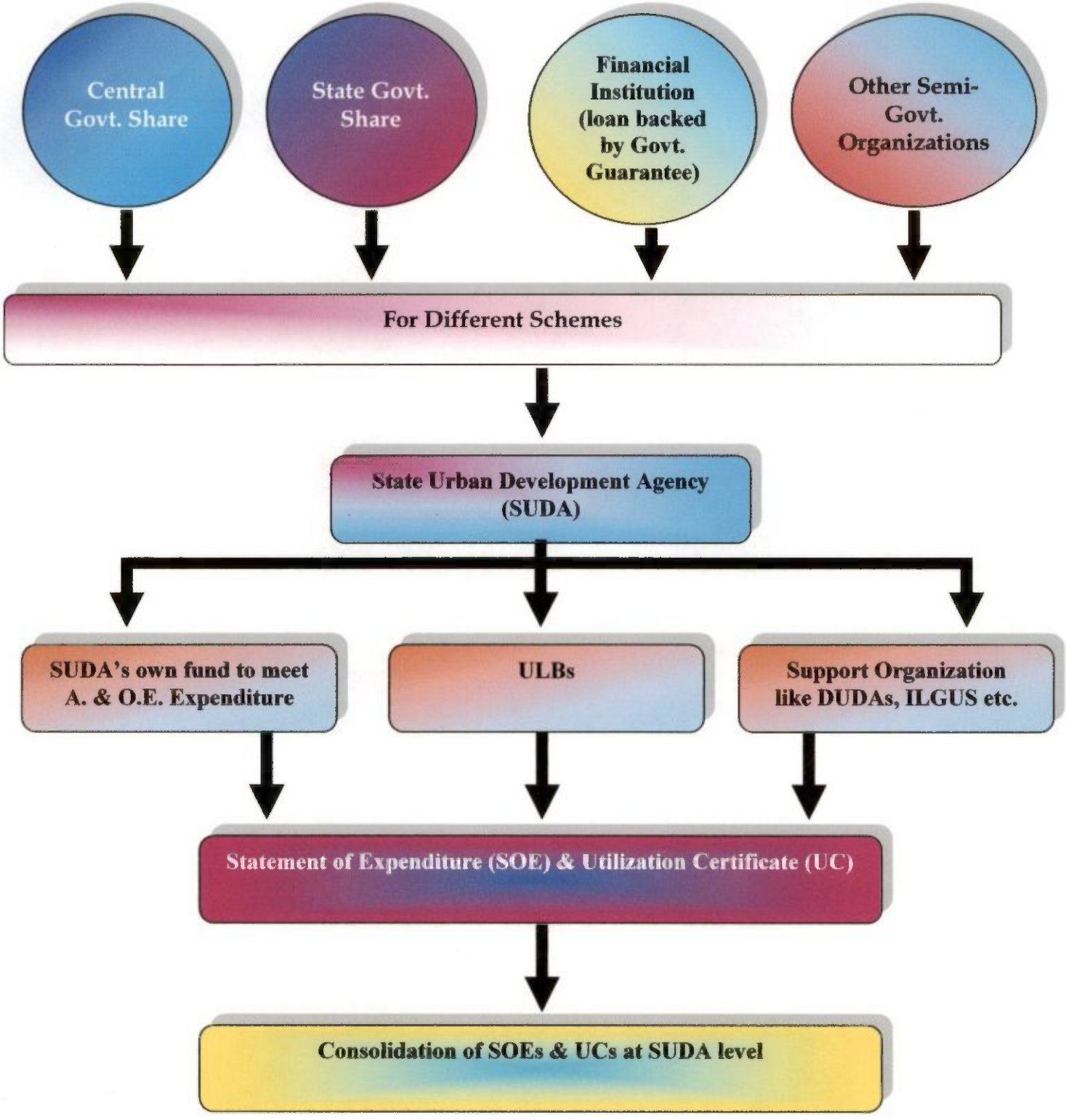
Enclosed.

Procurement Norms followed by SUDA

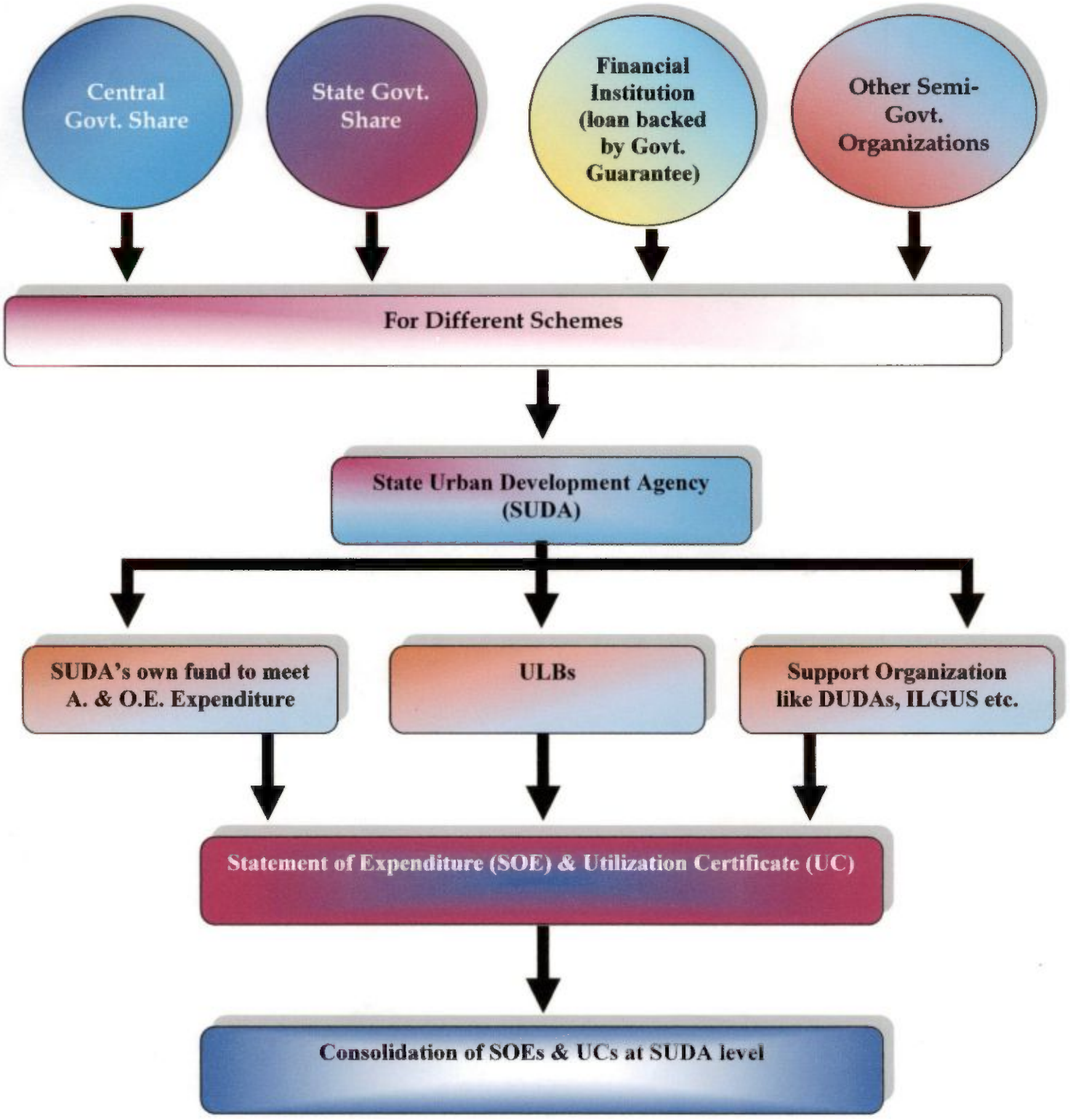
At par with State Govt. procurement norms.

- Upto Rs. 500/- = Direct purchase
- Rs. 501/- to 20,000/- = At least 3 quotations
- Above Rs. 20,000/- = Wide circulation and tendering

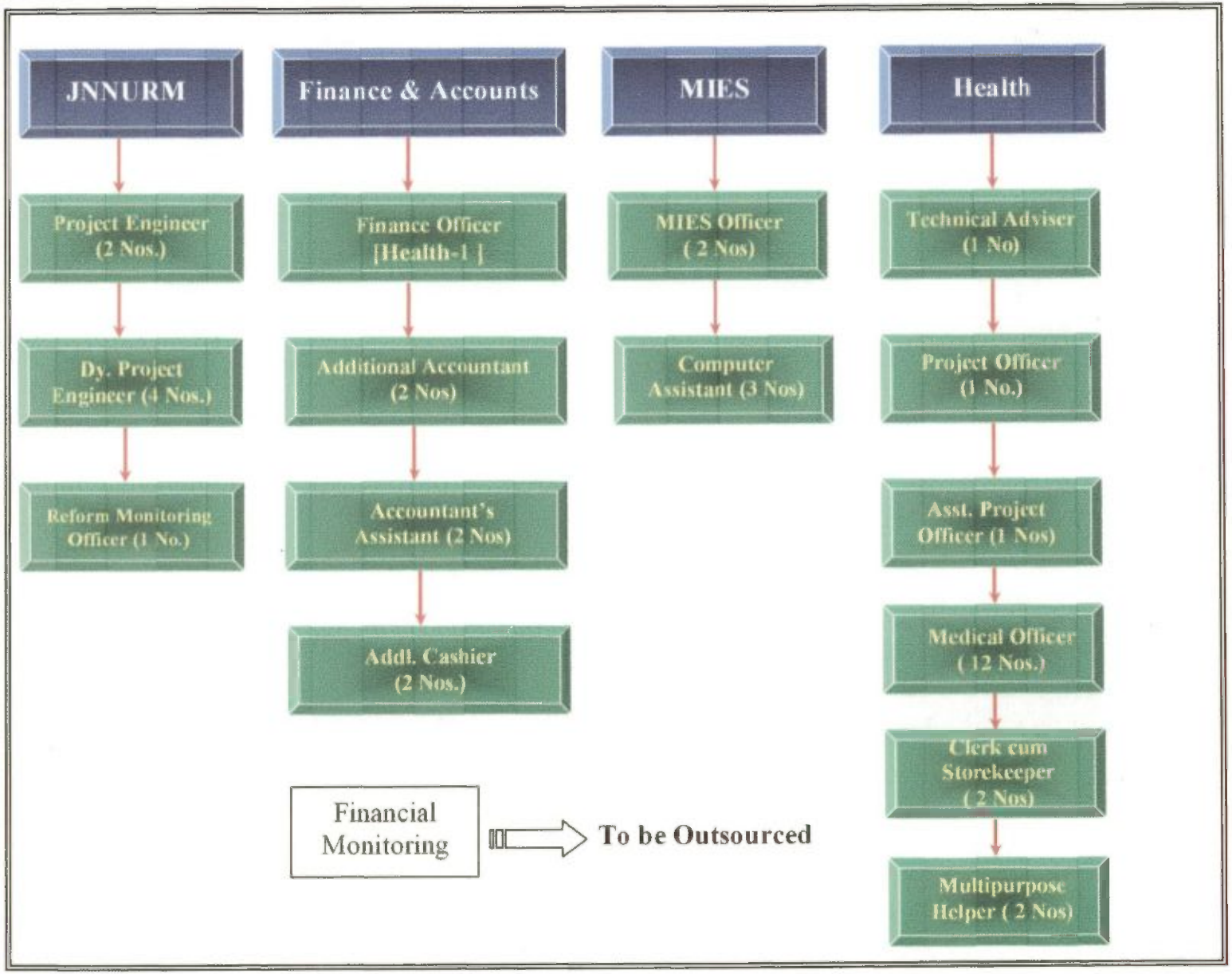
Fund Flow Mechanism



Fund Flow Mechanism

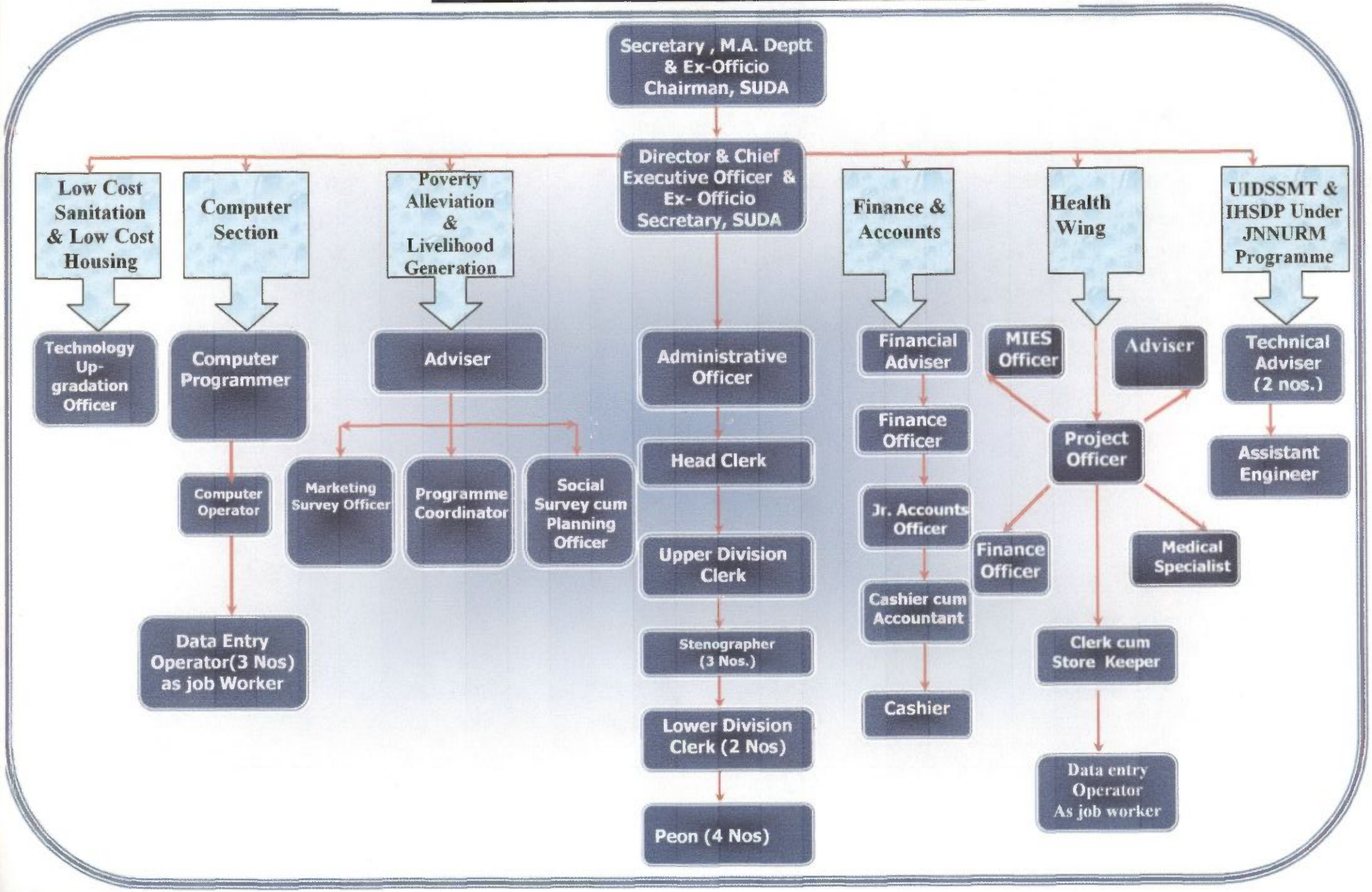


Additional Manpower Requirement



SUDA

EXISTING ORGANISATION STRUCTURE



GOVERNMENT OF WEST BENGAL
HEALTH AND FAMILY WELFARE DEPARTMENT
NATIONAL RURAL HEALTH MISSION
SWASTHYA BHAWAN, 4th FLOOR,
GN-29, SECTOR-V, BIDHANNAGER
KOLKATA -700 091

No. HFW/NRHM/160/07 Dated: April 23, 2007

From: **Dr. K. K. Bagchi,**
Addl. Chief Secretary,
Department of Health and Family Welfare,
Government of West Bengal

JS(SM)
Please attend along with Dr SVDB as R may not be at HQ on that day.
25/4/07

To: **Principal Secretary** to the
Government of West Bengal
Municipal Affairs Department

Sub: First meeting of the State Health Mission under NRHM

Sir.

I am to inform you that the first meeting of the State Health Mission will be held at the Cabinet Room in Writers' Buildings, Kolkata on 30th April, 2007 at 12.30 p.m.

The background paper and the agenda are enclosed for your kind perusal.

Shri Buddhadeb Bhattacharya, Hon'ble Chief Minister of the Government of West Bengal, has kindly consented to preside over the meeting.

I am directed to request you kindly to make it convenient to attend the meeting.

Yours faithfully,

Enclosure: As stated

(Dr. K. K. Bagchi)

HD health. 069. in

Agenda for discussion in the first meeting of the State Health Mission, West Bengal to be held on 30th April, 2007

1. Brief discussion on the objectives of NRHM
2. Current status of implementation of NRHM in the State
3. Involvement of PRIs in Rural Health issues and ULBs in urban areas
4. Inter-sectoral convergence issues :
   a) Female literacy
   b) Early marriage of girls
   c) Safe drinking water
   d) Sanitation
   e) Nutrition
5. Miscellaneous

CM
Improv. of the service, Infrastructure, Lab. PHC → BPHC → Rural Hosp.
Female literacy (SHG) - 78 Lakhs women are left out
Early Marriage, Dowry, Immoral trafficking
Safe drinking water (Arsenic)
Sanitation (RED zone) Rainy Block of Burdwan (Worst Zone)
Nutrition.
Vegetable, Fish → Hygienic problem
Upgradation of Rural Hl. sectors
ISPL - 20%.

GOI.
People's health in people's hand.

ANM:
550 in 18 months
3500 ANM already
starting
22% Muslim

ACS. - Health crash.
2003 - Society at State, District & Block level
Rogi Kalyan Samity → Flexible fund utilised.
Green Pantry & HR - at least on centre to provide
Hl. Services.

126 ULBs

BPHC --
PHC - 922 - at least 1 to be upgraded in a block.
[Problem with engagement of Sp. Doctors]
2005 -
COST 2. → 47,000 Died. in 1st month
IMR. 2001 - 83252
38000
19000
15-19 aged Female - 2,22,000 Drivers. Lady at home.
class VIII reading - 5 lakhs
Scholarship of Rs. 500/- per year for continuing education
upto VIII

CDR – 6·4 mut up.
unmet need – 11%.
Gap between two successive bent 71%. – more than 3 years

38% mothers below wt.
63% " are anaemic.
Exclusive breast feeding – 59%.
To start br. feeding c in 1st hr. of birth – 24%.
2001-02 per capita H.C. exp. 775/–
181/– from Govt, rest by party.

Awareness on hl. seeking behavior – 126
73% of indoor treatment – in Govt. hosp.

Neonatal care at home –
Identification of place & cause of death for mother & children.

1st yr – 18 cases.
2nd yr. – 115 cases.
3rd yr. – 150 cases.

HC. Ministr.
Adolescent girls, → Anaemia, awareness on HIV/AIDS.
IFA Tablets – increase in consumption.
Murshidabad & Nadia – Nutrimix supply.
Village-wise data on Disease
Early 90's. – Disease Burden Study by ASCI.

Disease Surveillance Prog
V. Cholera, Arsenic & Fluoride – comm monitoring.

Convergence –

Background paper for discussion in the first meeting of State Health Mission, West Bengal to be held on 30th April, 2007

National Rural Health Mission (NRHM) had been launched in the country on 12th April, 2005 with a view to bringing about significant improvement in the health system and health status of the people, especially those who live in the rural areas in the country.

NRHM Concept :

- NRHM seeks to improve access of rural people, especially poor women and children to equitable, affordable, accountable and effective Primary Health Care;
- NRHM seeks to make necessary corrections to improve the overall health scenario of the country;
- It will be implemented across the country with focus on EAG, North Eastern States, J&K and Himachal Pradesh;
- In the process, the Mission would help achieve goals under the National Health Policy and the Millennium Development Goals;
- It will increase the capacity to absorb the expected outlay under CMP of UPA Govt.

NRHM Objectives :

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR) ;
- Universalize access to public health care services such as, women's health, child health, water, sanitation & hygiene, immunization and nutrition;
- Prevention and control of communicable and non-communicable diseases including locally endemic diseases ;
- Strengthening health infrastructure and delivery of services ;
- Access to Integrated comprehensive and quality Primary Health Care;
- Population stabilization, gender and demographic balance;
- Revitalize local health tradition and mainstream of AYUSH (Ayurveda, Yoga, Unani, Siddha & Homeopathy);
- Promotion of healthy life styles;

NRHM Strategies :

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services;
- Selection of 2nd ANM / training for 18 months / engagement for all the Sub-centres of the State on contractual basis;
- Strengthening of Sub-centres / Construction of Sub-centre buildings including one ANM's residential accommodation;
- Untied Funds for the Sub-centres to enable local planning and actions for rendering better services through the Sub-centre / additional funds for providing drug kits for the ANMs posted at the Sub-centres;
- Engagement of Accredited Social Health Activists (ASHA) i.e. Village Health Worker in each village (1/1000) of each ITDP Block and other weaker blocks of the State / Selections through social mobilization process / training for 23 days / no salary but performance based incentives out of various schemes / supply of drug kits to ASHAs / control of Local Panchayat Bodies;
- Constitution of Rogi Kalyan Samitis for ensuring community ownership in running the health facilities ;
- Up-gradation and operationalisation of one PHC in each block to provide 24 hours round the clock service / engagement of Medical Officers and other support staff / clear quality standards / better community support / untied fund to enable Rogi Kalyan Samitis to achieve these standards;
- Up-gradation of all the BPHCs of the State to 30-50 bed capacities and making these operational / engagement of Medical Officers including specialists / additional support staff / supply of additional drugs / its decentralized administration by Rogi Kalyan Samiti / adequate funds and powers to enable these Samitis to reach desired levels;
- Preparation and implementation of an inter sector District Health Plan prepared by the District Health Mission including other social determinants of health like, nutrition, drinking water, sanitation etc,
- Technical support to National, State, District Health Missions, for public health management;
- Integration of vertical Health and Family Welfare Programmes at National, State, District and Block levels / Merger of societies;

- Developing capacities for preventive health care at all levels for promoting healthy life style / reduction in consumption of tobacco and alcohol etc.;
- Promoting non-profit sector particularly in underserved areas
- Re-orienting Medical Education to support rural health issues including regulation of medical care and medical ethics;
- Effective and visible risk pooling and social health insurance to the poor by ensuring accessible, affordable, accountable and good quality health care;
- Mobile Medical Unit

Expected Outcomes of NRHM :

i) **National Level :**

- IMR reduced to 30/1000 live births / Present status – National : 58, West Bengal : 38 (SRS – 2005)
- MMR reduced to 100/1,00,000 / Present status – National : 301 (SRS : 2001-03). West Bengal : 194 (RGI / SRS : 2005);
- Total Fertility Rate (TFR) reduced to 2.1 / Present status - National : 2.9 (SRS : 2004), West Bengal : 2.1 (SRS : 2005);
- Bringing down the Mortality Rates on account of Malaria, Kala-azar and Dengue by 60%, 100% and 50% respectively by the year 2012. Present Mortality Rates in respect of these three diseases in West Bengal are 0.13%, 0.54% and 0.75% respectively.
- Filaria/Microfilaria – reduction rate 80% by 2012 and elimination by 2015, increasing cataract operation to 46 lakhs per year till 2012 (West Bengal for the last 5 years have exceeded the targets fixed by the Govt. of India). Leprosy Prevalence Rate to be reduced to less than 1/10,000 (present status of West Bengal : 1.06/10,000) and maintaining DOTS services for Tuberculosis at 85% cure rate (In West Bengal the cure rate for New sputum positive cases is : 86.1%).
- Upgrading all the BPHCs to Indian Public Health Standards
- Increase utilization of First Referral Units from less than 20% to 75%
- Engaging female Accredited Social Health Activists (ASHA)

ii) **Community Level :**

- Improved access to Universal Immunization

- Availability of trained community level worker at village level with a drug kit for generic ailments
- Village Health Day – on a fixed day in every month with provision of immunization, ante/post- natal check-ups and services related to mother and child health care including nutrition
- Availability of generic drugs for common ailments at Sub-centre and hospital levels
- Access to good hospital care through assured availability of doctors, drugs and quality services at PHC/BPHC level and assured referral – transport – communication systems to reach these facilities in time
- Improved facilities for institutional deliveries through provision of referral transport, escort and improved hospital care subsidized under Janani Suraksha Yojona (JSY) for the BPL and SC/ST families
- Availability of assured health care at reduced financial risk through pilots of Community Health Insurance under the Mission
- Availability of safe drinking water
- Provision of household toilets
- Improved outreach services to medically underserved remote areas through mobile medical units
- Increased awareness about preventive health including nutrition

2. **Activities initiated by the Department under NRHM** :

a) State Health Mission and District Health Missions formed vide G.O. No.304/CFW/2005 dated 27th September, 2005 and No.HSL(Misc)-311/2005 dated 09.11.2005

b) State Health & Family Welfare Samiti, District Health & Family Welfare Samitis and Block Health & Family Welfare Samitis constituted after integration of all the Vertical Health Programmes vide this Department's No. HF/O/PHP/92/0-23/98 dated 21/02/2003, No. HF/O/PHP/322/0-23/98 dated 20/05/2002 and No. HF/O/PHP/619/0-23/98 dated 24/09/2003 respectively.

c) Project Management Unit, District Management Unit and Block Management Units at the State Level, District Level and Block Levels respectively have been formed by engaging appropriate professionals.

d) Memorandum of Understanding (MoU) containing the agreed financing pattern between the Ministry of Health & Family Welfare, Govt. of India and the Deptt. of Health & Family Welfare, Govt. of West Bengal signed on 10/04/2006.

e) Rogi Kalyan Samitis (Hospital Management Committees) have been formed up to the level of PHC to ensure community ownership in running the Hospitals/Health Centres with a view to render better services to the satisfaction of the people attending the health facilities. Under NRHM flexible funds @ Rs. 5.00 lakh and Rs. 1.00 lakh per Rogi Kalyan Samiti of District Hospital and Sub-divisional, State General and Rural Hospital/BPHC respectively have been received during 2006-07 and those have been sub-allotted to the concerned Rogi Kalyan Samitis. Suitable guidelines have also been issued for utilization of the funds with a view to extending better services to the patients attending the health facilities.

f) With the concurrence of the Finance Department 40% of the 'User Charges' are being retained by the hospitals up to Sub-division/State General Levels while the balance 60% are being transferred to the Corpus Funds at the State / District levels.

g) As a significant number of the Sub-centres of the State does not have suitable buildings, decisions have been taken to construct Sub-centre buildings with sufficient space for conducting ante-natal check ups, deliveries, immunization and other child health care programmes. Provision for residential accommodations of the ANMs have also been made. Under NRHM towards construction of 284 Sub-centre buildings, funds @ Rs. 4.94 lakh per sub-centre had been received during the year 2006-07. Funds have been released for 229 sub-centres in favour of the concerned District Health & Family Welfare Samitis which could identify the appropriate sites for construction of the buildings. Already funds for construction of 2073 Sub-centres have already been released in favour of all the District Health & Family Welfare Samitis from the funds available under DFID assisted HSDI programme. It is expected that by utilizing the funds available under different Externally Aided Programmes as well as under NRHM, all the Sub-centres of the State will have their own buildings by the end of the Mission Period (2012).

h) Untied Funds received under NRHM @ Rs. 10,000/- per Sub-centre for rendering better services to the people have already been sub allotted to the concerned District Health & Family Welfare Samities. Necessary guidelines for utilization of the Untied Funds have also been issued. The amounts are being kept in savings Bank Accounts operated jointly by the Pradhans of the concerned Gram Panchayats and the ANMs of the Sub-centres.

i) Steps have been taken to select and train 3,500 ANMs under NRHM. To accommodate the trainees 12 new Nursing Training Schools have been established in Government hospitals, capacities of existing 27 Nursing Institutes have been augmented and in addition, 12 new Nursing Training Schools have also been opened under Public-Private-Partnership. After successful completion of the training they will be engaged on contractual basis @ Rs. 7,000/- per month and posted at the respective Sub-centres from where they hail. It is expected that the entire selection and training process in respect of 10,356 ANMs will be completed during the Mission period.

j) It has been decided to engage 12,805 Accredited Social Health Activists (ASHAs) i.e., village level workers (1/1000) in 80 weaker blocks of the State of which 50 are tribal dominated I.T.D.P. Blocks and rest 30 Blocks are predominantly minority dominated. Process for selection of 2650 ASHAs has already been completed. Selected ASHAs will be undergoing training for a period of 23 days in five phases. Steps are also being taken to select other ASHAs to fulfill the State's target. These ASHAs will be voluntary workers but they are eligible to get performance based incentives, maximum Rs.800/- per month, out of different schemes.

k) Strengthening of Primary Health Centres is one of the mandates under NRHM. Already a decision has been taken to upgrade 342 PHCs (out of 922) of the State to 10-bedded facilities for rendering 24-hours round-the-clock services. Out of these PHCs steps have been taken to operationalize 102 PHCs. Necessary arrangements for engagement of Medical Officers, Nursing Staff and Laboratory Technicians have already been taken.

l) Under NRHM all the BPHCs of the State are to be upgraded to 30-50 bedded facilities (corresponding to the status of Rural Hospitals). Out of 341 Blocks of the State we are having 93 Rural Hospitals. Already 82 BPHCs have been

upgraded to 30-50 bedded facilities with the funds available under RIDF – IX, Basic Health Project and SHSDP-II and Externally Aided Programmes. Steps are being taken to operationalize these 82 upgraded BPHCs by engaging Medical Officers including Specialist and Nursing and other support staff. Steps have also been taken to upgrade additional 102 BPHCs to the status of Rural Hospitals with 30-50 bed capacities from the funds available under NRHM, DFID assisted HSDI and Kfw assisted Basic Health Projects.

m) Provision of arranging Mobile Medical Units at the District Head Quarters of the State for ensuring outreach health services in the remotest areas is one of the activities of NRHM. Considering the sizes of the district of the State, natural barriers and remoteness of certain areas, a proposal in substitution of GoIs Mobile Medical Unit Programme, was initiated by the department to provide ambulances at the identified upgraded PHCs under Public-Private-Partnership policy to ensure quick referral services for the patients in need. Govt. of India have since approved the State Govt's proposal and released fund of Rs.6.83 crore for procurement of 170 Ambulances. Concerned PHCs where these Ambulances would be placed have been identified and necessary activities for procurement of the Ambulances have been initiated.

n) For ensuring institutional deliveries which will improve the overall status of IMR and MMR in the State, steps have been taken to accredit private health facilities at the District Headquarters (AYUSHMATI SCHEME) for conducting normal / complicated deliveries free of cost in respect of women belonging to SC / ST / BPL families. Cost @ Rs.1790/- per delivery, will borne by the State Govt.

o) For extending better primary health care services particularly, in difficult areas, it has been decided that 100 Medical Officers would be hired by the P & RD Department in priority blocks for rendering necessary services for 3 days in a week(@ Rs. 500/- per day per Doctor). Necessary funds for the purpose have been transferred in favour of the Panchayat and Rural Development Department for getting the program implemented by the selected Gram Panchayats.

p) Constitution and empowerment of the Village Health and Sanitation Committees (VHSC) is one of the important activities under NRHM. A

decision has already been taken that in our State the activities of VHSCs would be undertaken by the Gram Unnayan Sansads already constituted by the P & RD Department instead of the Village Health and Sanitation Committees as suggested by the Government of India. For sensitization of the members of Gram Unnayan Sansad an amount of Rs. 1.00 crore has already been transferred in favour of the P & RD Department.

q) As per guidelines issued by the Govt. of India funds for 16770 VHSCs of the State had been received during the year 2006-07 @ Rs. 10,000/- per VHSC for creating public awareness about the essentials of Health Programmes, analyzing key issues and problems related to village level health and nutrition activities. maintenance village health register and health information board/calendar etc. Modalities for operationalizing all the 16770 Gram Unnayan Samsads are being worked out with Panchayat and Rural Development Department and to arrange early disbursement of the funds.

r) Funds have also been received during the year 2006-07 towards Untied Fund to PHCs, Annual Maintenance Grant for the PHCs and Annual Maintenance Grant for the BPHCs @ Rs. 25,000/-, Rs. 50,000/- per PHC and @ Rs. 1.00 lakh per BPHC respectively. All the funds so received have been sub-allotted in favour of the concerned District Health & Family Welfare Samitis with suitable guidelines for utilization of the amounts.

s) As a part of decentralized planning it has been decided to prepare Village Health Plans / Block Health Plans and District Health Plans from the year 2007-08 following the bottom-up approach. Necessary sensitizations for all the levels right from the State to the Village have already been conducted. It may be mentioned here that all the districts have already formulated their respective district plans for the year 2007-08 after taking into consideration the plans submitted by their respective blocks / villages. Preparation of State level plan under NRHM on the basis of the district plans is under process.

--------XXX-------

Group - A

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Kamarhati	1	Accountant	1
	2	Ambulance Attendant	8
	3	Assessment Inspector	1
	4	Assistant Accoutant	1
	5	Asstt. Mistry	1
	6	Asstt. Mistri (Workshop)	1
	7	Asstt. Water Works Mistri	20
	8	Burning-Ghat Sarkar	1
	9	C.I.	8
	10	Cashier	1
	11	Clerk	18
	12	Collecting Sarkar	24
	13	Driver	21
	14	Durwan	2
	15	Electrician	2
	16	Helper	2
	17	Helper W.W.	54
	18	Licence Inspector	3
	19	Light Inspector	1
	20	Majdoor	254
	21	MISTRY W.W.	7
	22	Office Superintendent	1
	23	Peon	19
	24	Pipeline Inspector	3
	25	Pump Operator	27
	26	Road Sarkar	5
	27	Sanitary Inspector	1
	28	Sardar	7
	29	Senior Clerk	20
	30	Sub Assistant Engineer (Dip.H	5
	31	Surveyor	1
	32	Teacher	1
	33	Typist-in-Charge	1
	34	Vaccinator	1
	35	Vaccinator	1
	36	Warrant Officer	1
Grand Total			**525**

Group - A

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Rajpur-Sonarpur	1	Ambulance Attendant	4
	2	Assessing Inspector	1
	3	Assessment Clerk	3
	4	Assessment-in-Charge	1
	5	Asstt. Mistri (Workshop)	3
	6	Cashier	1
	7	Clerk (junior)	1
	8	Clerk-Accounts	1
	9	Clerk-Lower Division	18
	10	Clerk-cum-Typist	1
	11	Collection Clerk	3
	12	Coolie	13
	13	Deputy Accountant	1
	14	Driver	8
	15	Engineer (B.E.)	1
	16	Head Clerk	1
	17	Helper	1
	18	Licence Clerk	1
	19	Light Supervisor	5
	20	Lower Division Clerk	3
	21	Majdoor	8
	22	Mechanic-cum-Driver	1
	23	Mistri	1
	24	Nightsoil Cleaner (Carter)	3
	25	Office Superintendent	1
	26	Office Sweeper	1
	27	Peon	25
	28	Pipeline Inspector	1
	29	Pump Operator	5
	30	Road Roller Helper	1
	31	Road Sarkar	1
	32	Sanitary Assistant	6
	33	Sanitary Inspector	2
	34	Secretary	1
	35	Store Keeper	1
	36	Store Keeper-cum-Clerk	1
	37	Tax-Collecting Sarkar	3
	38	Tubewell Helper	8
	39	Tubewell Mistri	1
	40	Typist	1
	41	Typist-in-Charge	1
	42	Ward Sarkar	2
Grand Total			146

Group - B

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Uluberia	1	Accountant	1
	2	Asst.Cashier	1
	3	Birth and Death Registration Clerk	1
	4	Cleaner	1
	5	Clerk	11
	6	Clerk-Store	3
	7	Collecting Sarkar	1
	8	Driver	5
	9	Head Clerk	1
	10	L.D.C.	2
	11	Licence Inspector	1
	12	Majdoor	12
	13	Mate	2
	14	Peon	13
	15	Roller Driver	1
	16	Sanitary Inspector	1
	17	Sub Assistant Engineer (Dip.Hol.)	2
	18	Tubewell Helper	4
	19	Tube-Well Mechanic	3
	20	Typist	1
	21	Work Sarkar	2
Grand Count			69

Group - B

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Haldia	1	Accountant	1
	2	Ambulance Attendant	1
	3	Assistant Accoutant	1
	4	Asst. to Cashier	1
	5	Bill Writer	1
	6	Cashier	1
	7	Clerk	5
	8	Compost Asstt.	1
	9	Doctor (Homeo)	1
	10	Draftsman	1
	11	Drain Coolie	3
	12	Driver	3
	13	Electrician	1
	14	Fitter	2
	15	Guard	2
	16	L.D.C	7
	17	Licence Clerk	1
	18	Licence Inspector	1
	19	Lightman	3
	20	Night Guard	3
	21	Peon	4
	22	Plumbing Mistri	1
	23	Pump Attendant	9
	24	Pump Driver	1
	25	Roller Driver	1
	26	Sanitary Assistant	1
	27	Sanitary Inspector	1
	28	Steno-Typist	1
	29	Store Keeper	1
	30	Sub Assistant Engineer (Dip.Hol.)	5
	31	Sweeper	3
	32	Tax Collector	1
	33	Tax-Collecting Sarkar	3
	34	Typist	1
	35	Upper Division Asstt.	1
	36	Water Work Asstt. (Clarical)	1
	37	Work Sarkar	1
Grand Total			**76**

Group - C

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Kanchrapara	1	Assistant Accoutant	1
	2	Asstt. Assessment-in-Charge	1
	3	Asstt. Pump Driver	3
	4	Asstt. Pump Operator	1
	5	Bill Writer	4
	6	Clerk	4
	7	Clerk-2nd	1
	8	Clerk-cum-Typist	1
	9	Conservancy Assistant	2
	10	Conservancy Majdoor	46
	11	Driver	9
	12	Electrician	1
	13	General Asstt. & Typist	6
	14	Head Clerk	1
	15	Majdoor	84
	16	Mason	1
	17	Peon	11
	18	Pipeline Inspector	1
	19	Rickshow Van Pullar	1
	20	Sanitary Inspector	1
	21	Store Attendant	1
	22	Sub Assistant Engineer (Dip.Hol)	1
	23	Tax-Collecting Sarkar	7
	24	Watchman	6
	25	Water Works Superintendent	1
	26	Work Assistant (P.W.)	2
	27	Work Assistant (P.W.)	1
Grand Total			199

Group - C

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Madhyamgram	1	Accountant	1
	2	Ambulance Attendant	4
	3	Assessment Inspector	1
	4	Asstt. Tubewell Mistri	1
	5	Cashier	1
	6	Clerk	22
	7	Clerk-Cum-Typist	1
	8	Draughtsman	1
	9	Driver(Ambulance)	4
	10	Driver(Tractor)	1
	11	Helper	16
	12	Licence Clerk	1
	13	Light Supervisor	1
	14	Majdoor	56
	15	Mate	6
	16	Peon	8
	17	Road Roller Driver	1
	18	Sanitary Assistant	2
	19	Sanitary Inspector	1
	20	Store Keeper	1
	21	Store Keeper Cum Clerk	1
	22	Sub Assistant Engineer (Dip.Hol.)	5
	23	Surveyor	1
	24	System Analiyst	1
	25	Tax Collector	3
	26	Tube Well Helper	1
	27	Tubewell Mistri	1
	28	Typist	2
	29	Upper Divison Clerk	1
	30	Work Sarkar	1
	31	Work Sarkar	1
		Grand Total	**148**

Group - D

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Taki	1	Accountant	1
	2	Ambulance Cleaner	1
	3	Asstt. Ambulance Driver	1
	4	Asstt. Tubewell Mistri	1
	5	Attendant (Guest House)	2
	6	Birth and Death Registration Clerk	1
	7	Burial Ground Recorder	1
	8	Burning-Ghat Recorder	1
	9	Cashier	1
	10	Cashier Peon	1
	11	Clerk	7
	12	Clerk-Despatch	1
	13	Collecting Sarkar	1
	14	Dome (Removal Carcuss)	1
	15	Electric Mistri	1
	16	General Clerk	1
	17	Head Clerk	1
	18	Helper Electric Mistry	1
	19	Helper to Tubewell Mistri	2
	20	L.D.C.Guest House	3
	21	Majdoor	3
	22	Majdoor (Burial Ground)	1
	23	Majdoor (Burning Ghat)	1
	24	Majdoor (Guest House)	1
	25	Night Guard	1
	26	Peon	2
	27	Roller Driver	1
	28	Sanitary Assistant	1
	29	Sanitary Inspector	1
	30	Store Keeper	1
	31	Street Light Checker	1
	32	Sub Assistant Engineer (Dip.Hol.)	2
	33	Sweeper	3
	34	Tax Daroga	1
	35	Tubewell Mistri	1
	36	Typist	1
	37	Work Sarkar	1
Grand Total			53

Group - D

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Katwa	1	Accountant	1
	2	Assistant Sanitary Inspector	1
	3	Asst. Cashier	1
	4	Asstt.Tubewell Mistri	1
	5	Burning-Ghat Recorder	1
	6	Care Taker	2
	7	Cashier	1
	8	Collecting Sarkar	3
	9	Compost Cleaner	4
	10	Dome	1
	11	Drain Cleaner	12
	12	Drain Coolie	1
	13	Driver(Tractor)	4
	14	Guard	1
	15	L.D.C	11
	16	Light Mistry	1
	17	Light Supervisor	1
	18	Lighting Helper	1
	19	Majdoor	2
	20	Mate	1
	21	Overseer (Diploma Holder)	3
	22	Peon	8
	23	Private Privy Cleaner	26
	24	Pump Operator	4
	25	Record-Keeper	1
	26	Road Cleaner	26
	27	Road Repair	2
	28	Roller Driver	1
	29	Roller Helper	1
	30	Sanitary Assistant	1
	31	Sanitary Inspector	1
	32	Store Keeper-cum Clerk	1
	33	Tubewell Assistant	1
	34	Tubewell Helper	3
	35	Tubewell Mistri	1
	36	Typist	1
	37	Typist Clerk	1
	38	Upper Divison Clerk	1
	39	Work Sarkar	1
		Grand Total	**135**

Group - E

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Dinhata	1	Accountant	1
	2	Assistant Accoutant	1
	3	Cashier	1
	4	Chowkidar	4
	5	Clerk	6
	6	Conservancy Inspector	1
	7	Correspondence Clerk	1
	8	Driver	2
	9	Majdoor	4
	10	Peon	2
	11	Rickshow Puller	1
	12	Scavanger	7
	13	Senior Clerk	1
	14	Street-Light Supervisor	1
	15	Tax Collector	6
	16	Tax Daroga	1
	17	Time-Keeper	1
	18	Typist	1
Grand Total			**42**

Group - E

Name of the ULB	Sl. No.	Name of the Post	No. of Post
1	2	3	4
Pujali	1	Accountant	1
	2	Ambulance Attendant	4
	3	Asstt. Ambulance Driver	4
	4	Birth and Death Registration C	1
	5	Electric Mistri	1
	6	Head Clerk	1
	7	Helper	1
	8	Helper-Electric Mistry	2
	9	L.D.C	3
	10	Majdoor	36
	11	Night Guard-cum-peon	1
	12	Peon	4
	13	Roller Driver	1
	14	Sanitary Assistant	2
	15	Sanitary Inspector	1
	16	Store-Keeper	1
	17	Sub Assistant Engineer (Dip.H	2
	18	Tax Collector	3
	19	Typist	2
	20	Work Sarkar	1
Grand Total			**72**

Draft 1 for discussion

Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No:

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED {LOAN/CREDIT}

IN THE AMOUNT OF SDR { } MILLION
(US$ 113.6 MILLION EQUIVALENT)

TO THE

GOVERNMENT OF INDIA

FOR A

WEST BENGAL HEALTH SECTOR DEVELOPMENT PROJECT

{PROJECT DATE}

CURRENCY EQUIVALENTS

(Exchange Rate Effective {Date})

Currency Unit =
= US$1
US$1.5 = SDR 1

FISCAL YEAR

April 1 – March 31

ABBREVIATIONS AND ACRONYMS

DIR	Detailed Implementation Review
DHFW	Department of health and Family Welfare
GoI	Government of India
GoWB	Government of West Bengal
HSDI	Health Sector Development Initiative
HSS	Health Sector Strategy
KMA	Kolkata Metropolitan Area
KMDA	Kolkata Metropolitan Development Agency
MDGs	Millennium Development Goals
MTEF	Medium-Term Expenditure Framework
MTR	Mid-Term Review
NRHM	National Rural Health Mission
PMU	Project Management Unit
POW	Program of Work
PPPs	Public-Private Partnerships
PRIs	Panchayat Raj Institutions
RCH	Reproductive and Child Health Program
SGEHFW	West Bengal State Government Expenditure on Health and Family Welfare
SIL	Sector Investment Loan
SPSRC	Strategic Planning Sector Reform Cell
UCS	Use of Country Systems
ULBs	Urban Local Bodies
WBHSDP	West Bengal Health Sector Development Program

Vice President:	{Praful Patel}
Country Manager/Director:	{Isabel Guerrero}
Sector Manager:	{Anabela Abreu}
Task Team Leader:	Paolo Carlo Belli

INDIA
West Bengal Health Sector Development Project

TABLE OF CONTENTS

West Bengal Health Sector Development Project

Date: Country Director: Isabel Guerrero Sector Director: Julian F. Schweitzer Sector Manager: Anabela Abreu Project ID: P071160 Lending Instrument: Specific Investment Loan	Team Leader: Paolo Carlo Belli Sectors: Health (100%) Themes: Health system performance (P);Child health (S);Other communicable diseases (S) Environmental screening category: Partial Assessment Safeguard screening category: B

Project Financing Data

[ ] Loan [X] Credit [ ] Grant [ ] Guarantee [ ] Other:

For Loans/Credits/Others:
Total Bank financing: US$ 100 m.
Proposed terms: Standard IDA terms

Financing Plan (US$m)-basic

Source	Local	Foreign	Total
BORROWER/RECIPIENT			
INTERNATIONAL DEVELOPMENT ASSOCIATION			
Total basic costs:			

A.

Borrower:
Department of Economic Affairs, Ministry of Finance, Government of India
North Block, New Delhi, 110 001 India.
Contact Person: Mr. Anirudh Tewari
Tel: 91-11-23094413
anirudh@finance.nic.in

Responsible Agency:
Government of West Bengal, Department of Health and Family Welfare

Estimated disbursements (Bank FY/US$m)									
	Year 1	Year 2	Year 3	Year 4	Year 5	Total			
Annual									
Cumulative									

Project implementation period: Start December 1, 2007 End: March 1, 2013
Expected effectiveness date:
Expected closing date: September 1, 2013

Does the project depart from the CAS in content or other significant respects? ***Ref. PAD A.3***	[ ]Yes [X] No
Does the project require any exceptions from Bank policies? Is approval for any policy exception sought from the Board?	[ ]Yes [X] No [ ]Yes [X] No
Does the project include any critical risks rated "substantial" or "high"? ***Ref. PAD C.4***	[X]Yes [ ] No
Does the project meet the Regional criteria for readiness for implementation? ***Ref. PAD D.6***	[X]Yes [ ] No

Project Development Objective
The PDO is to increase utilization of essential health services (preventive and curative), particularly in underserved areas.
Ref. PAD B.2, Technical Annex 3

Project description *[one-sentence summary of each component]*

Ref. PAD B.3, Technical Annex 4

Which safeguard policies are triggered, if any?
Environmental Assessment
Vulnerable Communities
Ref. PAD D.4, Technical Annex 10

Significant, non-standard conditions, **if any**, for:
Board presentation: N/A
Board presentation: N/A
Loan/credit effectiveness: N/A

Covenants applicable to project implementation:

B. STRATEGIC CONTEXT AND RATIONALE

1. Country and sector issues

1.1 Health outcomes and health system performance

1. In terms of GDP per capita and poverty prevalence the state of West Bengal is average in the country. In terms of health outcomes and health system performance it fairs better than the Indian average, but worse than the most advanced states, as Tables 1 and 2 below indicate.

Table 1: Key Development and Health Outcomes Indicators

	Per capita gross domestic product Rs. current prices 2001/02 (1990-91 data in parentheses)	Poverty Headcount Ratio[1] 1999/00 , (reduction since 1993 in parentheses)	Infant Mortality Rate-2004 (1990 data in parentheses)	Maternal mortality rate, 1995[2] (per 100,000)	Malnutrition among children (0-3y) (weight for age<-2sd) (1992-93 0-4y data in parentheses)
All India	20,164 (6,090)	22.7 (6.5)	57 (78)	453	46 (53)
Andhra Pradesh	19,528 (5,371)	21.7 (4.5)	54 (70)	436	37 (49)
West Bengal	**19,314 (5,567)**	**19.2 (3.5)**	**48 (75)**	**389**	**44 (57)**
Maharashtra	27,755 (8,507)	24.2 (9.5)	38 (50)	336	40 (54)
Karnataka	22,612 (5,600)	25.1 (8.1)	43 (65)	450	41 (54)
Tamil Nadu	23,805 (6,262)	19.8 (12.5)	31 (68)	376	33 (48)
Kerala	23,324 (5,687)	9.9 (8.2)	15 (24)	87	29 (29)

Source: Source: State GSDP: Reserve Bank of India; Poverty count: Deaton-Dreze, 2002; IMR, % children undernourished: NFHS-1, 1992-93 and NFHS-3, 2005-06; MMR, The progress of Indian states, UNICEF, 1995

Table 2: Comparative Health Service Coverage and Access Indicators

	% children 12-23 months fully immunized	% mothers who had at least 3 ANC visits for their last birth	% institutional deliveries	% births attended by health professionals	% mothers received postnatal care from a health personnel within 2 days of delivery for last birth
All India	44	51	41	48	36
Andhra Pradesh	46	86	69	74	70
West Bengal	**64**	**62**	**43**	**46**	**38**
Maharashtra	59	75	66	71	59
Karnataka	55	79	67	71	61
Tamil Nadu	81	97	90	93	90
Kerala	75	94	100	100	88

Source: NFHS-III (2005-06); Health system performance indicators, NFHS-3, 2005-06

[1] In the text, we utilize the Deaton-Dreze adjusted poverty estimates, which differ from the official estimates in a number of regards: see Angus Deaton and Jean Dreze (2002), Poverty and Inequality in India: a Reexamination, Economic and Political Weekly, September 7.

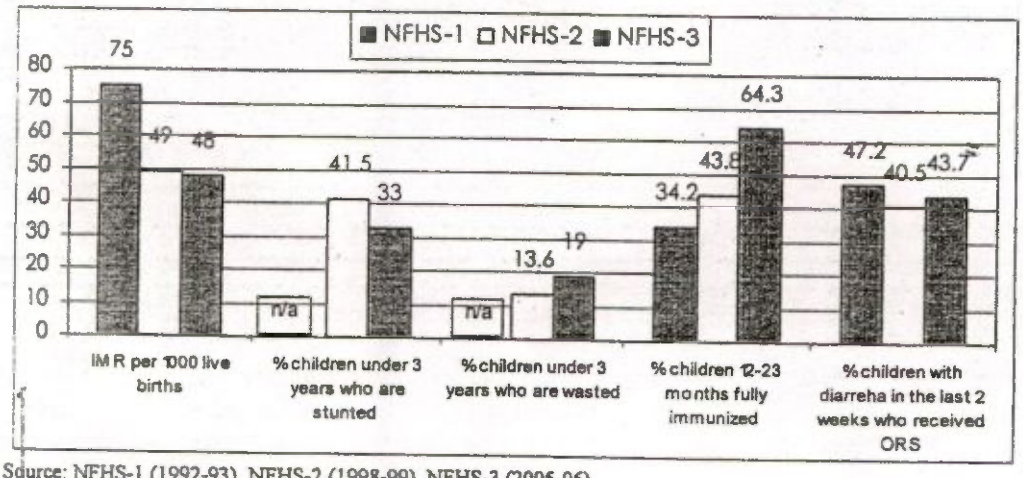
[2] There is no precise data on maternal mortality. The official SRS data (2000) do not seem reliable, since all surveys, including the 1995 study referenced in Table 1, find higher maternal mortality than SRS estimates, particularly in poor districts.

2. Figure 1 and 2 below illustrate progress in some basic maternal and child health care indicators occurred over the last fifteen years. The progress made so far provides evidence that change is indeed possible and that the capacity to generate that change is at hand. However, it also shows that there are still many urgent health problems to address, such as.

- Infant mortality rate is still unacceptably high. Almost 5 children (7 children) out of 100 born alive die before their first (fifth) birthday. *Given that neonatal mortality constitutes a large part of this, greater coverage and better quality of services before, during, and after delivery are required to achieve further improvements.*
- Data on malnutrition suggest that one third of children may be stunted, i.e. short for age. Continuous severe under-nutrition early in life permanently impairs the individual, and thus produces a long-lasting negative social and economic impact.
- It is estimated that a mother dies for every 400 deliveries in the state. As around only forty percent of the deliveries take place in health institutions in the state, this shows the urgency of getting to those families that still deliver at home. *Less than five percent of those who delivered at home were assisted by a doctor or a trained health professional during delivery. In 2005 less than two thirds of pregnant women received at least three ANC visits during their pregnancy, and for women belonging to underprivileged groups coverage was modest (for example it was only 45.7 percent for illiterate mothers).*
- Finally, note that the pace of progress observed during the decade of the '90s seems to have slowed down over the last seven years and IMR and safe delivery have stagnated.

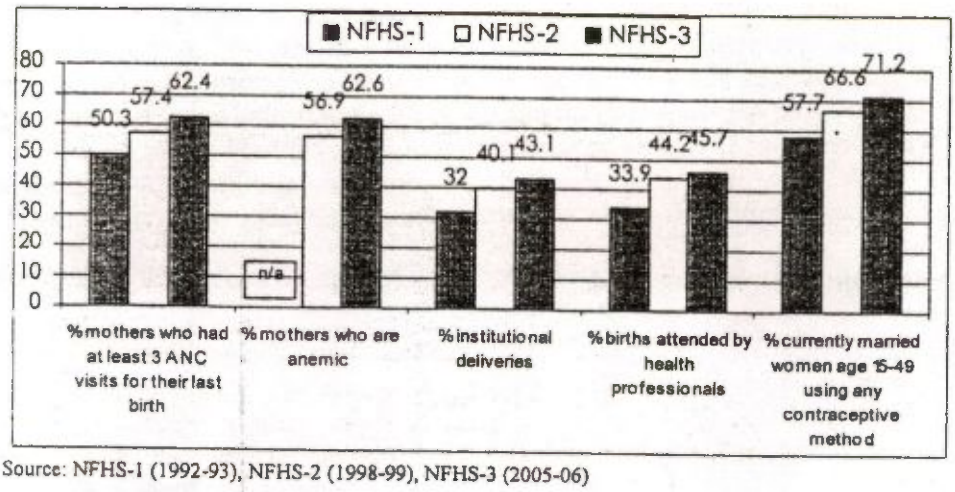
Accelerated progress in the coming years is necessary for West Bengal to reach the Millennium Development Goals (MDG).

Figure 1: Selected Child Health Indicators from NFHS-1 to NFHS-3



Source: NFHS-1 (1992-93), NFHS-2 (1998-99), NFHS-3 (2005-06)

Figure 2: Selected Maternal Health Indicators from NFHS-1 to NFHS-3



Source: NFHS-1 (1992-93), NFHS-2 (1998-99), NFHS-3 (2005-06)

3. The state is characterized by wide disparities in health outcomes between urban and rural areas, and between different socio-economic groups. For example, people with low education and those residing in rural areas tend to deliver more at home, and not to use formal institutions. Overall, 43 percent of total number of births was delivered in formal institutions (NFHS-3); however, while nearly 80 to 90 percent of mothers residing in urban areas or high educational level chose institutional delivery, less than one-fourth of mothers with none or low education or residing in rural areas did (NFHS-3). There are also wide health disparities between the poor and the better off and between rural and urban areas, as Table 3 below indicates (see also Annex 1).

Table 3: Health system performance indicators in West Bengal by socio-economic status and by region

	Wealth Quintile		Region		
Performance indicator	**Lowest**	**Highest**	**Rural**	**Urban**	**Total**
No antenatal check-up (percent)	15.7	0.1	10.8	3.6	10
Institutional deliveries (percent)	21.5	86.3	31.4	79.7	40.1
Children 12-23 months fully immunized(percent)	31.7	70.0	41.4	58.6	43.8
Children with ARI to health care provider (percent)	43.6	76.6	52.2	51.7	52.4

Source: NFHS-II (1998-99)

1.2 Health delivery system

4. The main intervention and response by the Government of West Bengal in the health sector has been the establishment, maintenance and staffing of an extensive network of health facilities at the primary, secondary and tertiary level. While these investments have made a tangible difference to physical infrastructure and delivery capacity, the outcomes in terms of actual improvement in services have not been as obvious.

5. In fact, the performance of this extensive delivery system continues to raise serious concerns about effectiveness, access, and targeting the most vulnerable. Parallel to this and partly as a consequence of it, the private sector is growing and more and more people seek their care from private providers, qualified or unqualified. According to the NSS (2004), the private sector currently accounts for 21 and 35 percent of the total number of hospital stays in rural and urban areas respectively, and approximately 80 percent of all non-hospital cases both in urban and rural areas. Government practitioners increasingly have a dual job holding in the public and in the formal private sector, while a large share of the poorer rural and urban populations continue to seek care from health care providers who have no formal qualifications.

2. Rationale for Bank involvement

6. During the last decade, the World Bank supported West Bengal through the State Health Systems Project II, which closed in March 2004, and focused mainly on secondary services, and through the IPP-VIII and IPP-IX projects, focused respectively on strengthening coverage of essential maternal and reproductive health services in the poorer urban areas of Kolkata, and on infrastructure for delivering maternal and child health services in rural areas. As part of its knowledge activities, in 2004 the World Bank drafted a Health Policy Note for West Bengal, which the state government has fully endorsed. On October 28, 2004 the Bank agreed to support the Government of West Bengal with a new operation for the health sector (the West Bengal Health System Development Project, or WBHSDP) for the following reasons:

2.1 Support Recent Developments in the Context of the Health Sector Strategy

7. In 2003, the GoWB issued a new Health Sector Strategy (HSS) for the period 2004-2013, which describes the mission of the Department of Health and Family Welfare (DHFW), Government of West Bengal "to improve the health status of all the people of West Bengal especially the poorest and those in need" through improved coverage of key health services, especially in the areas of maternal and child health and communicable diseases. In August 2005 the DHFW launched the Health Systems Development Initiative (HSDI), a comprehensive health sector development and reform initiative to implement the HSS, supported by DFID and by other Development Partners (see Annex 1 and 2).

8. DFID has committed a grant of up to GBP 97.5 million to be disbursed as *budget support*[3] (over five years), plus GBP 2.5 million in technical cooperation funds. DFID's assistance is conditional on the achievement by DHFW of a number of milestones, which signal progress in implementation of the HSDI and HSS and are contained in an agreed *Matrix of Milestones* regularly revised together with the DHFW leadership and the other Development Partners. These milestones are organized into eight areas or "themes", namely: Strategic and Policy Framework; Additional Measures to meet HSS targets and MDGs; Organization and Management Systems; Health Financing; Access and Demand for Services; Private Sector; Asset Supplies and Management; and Procurement and Financial Management Systems.

9. The proposed Bank project proposes to support the HSDI together with DFID and the other Development Partners. This is the first time that such partnership is developed at the state level in India. The Bank would support the concrete planning and implementation of the HSDI

[3] What is meant in this context by "budget support" is that DFID would simply transfer its funds to the state's treasury in several installments, rather than against expenditures.

developmental and reform activities envisaged in the Matrix of Milestones [4], and would help develop and implement key innovations, such as rigorous monitoring and evaluation, public-private partnerships (PPPs), and new health financing initiatives.

2.2 Support for Establishing a Results Framework for the DHFW

10. Although the HSS is an ambitious reform strategy and the HSDI provides a comprehensive operational framework to implement it, before the preparation of the WBHSDP started little work was done to develop a Results Framework that sets clear, realistic targets and intermediate quantitative indicators to regularly review progress towards achieving the stated objectives and to strengthen the capacity of the DHFW to do so. The proposed project would address this shortcoming by supporting the preparation of a Results Framework for the DHFW (instead of for Bank-financed activities only), which links the planned reforms and investments to intermediate outputs, and eventually to specific outcomes (see Section B.4 for a description), and by placing specific focus on the activities and incentives necessary to strengthen the DHFW's own monitoring and evaluation system for these areas.

3. Higher level objectives to which the project contributes

11. The proposed project seeks to improve the services of the public sector at lower levels, where the poor are the main clients, and facilitate the interaction between the public and the private sector for general health improvements in the state.
The project fully endorses the HSS 2004-2013 ultimate policy goals of reducing maternal, child mortality, and communicable diseases, and thus improving essential health outcomes especially among the vulnerable groups. The project is also consistent with the strategic principles and the priorities identified by the Country Assistance Strategy (CAS), September 2004:

a) focus on outcomes to ensure that Bank support is geared towards achieving the MDGs,
b) selective support of activities that have greatest impact on the poor,
c) strengthened role of the Bank as knowledge provider and generator.

C. PROJECT DESCRIPTION

1. Lending Instrument

12. The lending instrument for the proposed project would be a Standard Investment Loan (SIL). Disbursements of the IDA credit proceeds would follow the modalities of a traditional investment project, i.e., disbursements would be effected against incremental expenditures associated with a specific set of developmental activities (new activities or expansion of existing ones).

13. While disbursements would be as in a traditional project, as indicated in Section (A) above the proposed project would be supportive of, and linked to the DHFW's overall medium-term development and reform initiative (the Health Sector Development Initiative or HSDI). More specifically, the proposed project would be linked to the HSDI through the following mechanisms and design features: (a) only activities which are fully consistent with, and

[4] So far, the HSDI has focused mostly on designing important structural reform processes (e.g. HR policies, responsibilities for maintenance, increasing accountability to local elected bodies, etc.) but has not yet made much progress on planning and implementing the developmental activities in the health sector that are necessary to improve utilization and quality of priority services. This is evidenced by the partial execution of the increased budget allocation for the DHFW in 2005-06 and 2006-07.

supportive of, the HSDI's *Matrix of Milestones* have been included in the proposed project; (b) in the Results Framework satisfactory progress in the HSDI would be a key indicator for measuring progress in the proposed project; (c) Bank missions to review implementation of the proposed project would be closely coordinated and would overlap as much as possible with HSDI's reviews; (d) the budgeting of DHFW expenditures associated with the proposed project would be a key ingredient in the annual updating of the rolling *Medium-Term Expenditure Framework* to take place in the context of the HSDI; and (e) yet another link to the HSDI would be to include some of the Milestones in the HSDI matrix as *special covenants* in the legal documentation for the proposed project—e.g., in the areas of procurement and financial management.

2. Project Development Objective (PDO) and Key Indicators

14. The PDO is to increase the utilization of both preventive and curative health services, particularly in underserved areas.

15. Key indicators and targets of utilization are the following:

(i) percent of institutional deliveries;
(ii) percent of women having at least 3 ANC visits before delivery;
(iii) percent of women covered by TT (2 shots for first birth, booster for subsequent births if <3 years, 2 shots if >3 yrs);
(iv) number of rural facility outpatient primary attendances (=rural hospital + BPHC + PHC + subcentre);
(v) number of rural facility inpatient attendances (=rural hospital +BPHC);
(vi) annual case detection rate (%) of new sputum positive (NSSP) TB cases;
(vii) percentage of NSSP cases cured out of total NSSP cases detected;
(viii) annual Parasite Incidence for malaria: number of blood smears found positive for malaria parasite in a year per 1000 population;
(ix) prevalence rate of leprosy per 10,000 population;
(x) full immunization.

3. Project Components

16. The project, with an estimated baseline cost of US$113.6 million equivalent, would have three components: Rural Health (US$80.7 million); Urban Health (US$19.5 million); and Project Management, Capacity Building and Monitoring & Evaluation (US$13.5 million). A brief description of the three components follows; further details are given in Annex 4.

17. Component I: Rural Health: This component aims to increase coverage of basic health services in rural areas, with particular emphasis on mother and child care. Component I is composed of four sub-components: (i) Strengthening Government-provided Health Services (US$49.5 million baseline cost); (ii) Strengthening Health Care Access through Public-Private Partnerships (US$8.1 million baseline cost); (iii) Preparation and Initiation of a Health Insurance Pilot (US$12.1 million baseline cost); and (iv) Public Health (US$12.3 million baseline cost). The main activities under each sub-component are discussed below.

18. *Sub-Component I (i): Strengthening Government-provided Health Services.* This sub-component would include the construction of a number of government Sub-centers, and renovation/upgrading, and equipping (through procurement of medical and non-medical goods for the primary health care system) of Sub-centers, Primary Health Centers (PHCs), Block PHCs,

and District/Sub-Divisional Hospitals. These health care facilities would be mostly located in 74 prioritized Blocks which are among the most backward and poor performing Blocks in the State.[5] Three criteria were used to rank Blocks and select those given priority under the project: female literacy, birth rate, and communicable disease burden. This subcomponent would also finance

19. *Sub-Component I (ii): Strengthening Health Care Access through Public-Private Partnerships*. For several years now, the DHFW has been encouraging the establishment of public-private partnerships (PPPs) in an effort to better serve the population with health care services. However, these Public Private Partnership (PPP) agreements have lacked strategic coherence and have been biased toward secondary and tertiary care. This subcomponent will identify roles and opportunities in primary care in rural and urban areas for the private sector (NGOs as well as for-profit) and raise their involvement in the delivery of essential health services in the state. The outcomes expected are higher standards of service and better access to these services among the poor and underserved. The following activities are planned under this subcomponent: (a) the strengthening of the PPP Cell in SPSRC; (b) research and studies on the extent and composition of the private sector; (c) training of private providers in service delivery under Service Agreements with Government; (d) establishing partnerships with NGOs for the provision of services in remote and under-served areas; (e) expanding the PPP model for provision of diagnostic services already in operation in Rural Hospitals to 250 upgraded BPHCs; (f) initiating the contracting-out of non-clinical services (food services, security, cleaning and laundry) at BPHCs; (g) starting a community-managed emergency referral transport scheme in backward/difficult to reach areas, and (h) technical assistance and other capacity building activities to create an accreditation process for private providers.

20. *Sub-Component I (iii): Innovations in Health Financing to enhance accessibility of essential services. The following activities are planned under this subcomponent:* (a) introducing a voucher system for poor patients using privately-operated Diagnostic Units in Rural Hospitals; (b) introducing a voucher system for NGO-operated ambulance services at BPHCs; (c) Preparation and initial implementation of a Health Insurance Pilot. The objective of this component is to improve access to essential services for a subset of the poorer section of society in the state. Several studies have shown health care costs to be one of the main barriers to access health services and causes of impoverishment among low-income people. The health insurance pilot would initially focus on informal economy workers in the Burdwan district, including landless agricultural labourers who are members of the existing provident fund (PROFLAL). The precise number of persons to be covered would depend on a clear identification of the beneficiaries or target group, but it is foreseen to be by the end of the project a reasonably large group of approximately two million individuals. In order to understand what kind of pilot design would be the most appropriate in the Bardwan district, GTZ had agreed to provide technical assistance to the DHFW. GTZ had identified the studies areas as well as the consultants required for this purpose, who have already completed the first preparatory studies. Based on the findings of these studies, GTZ has prepared a first outline of the pilot design. The first year of the project will be devoted to the preparation of the pilot. This would require a definition of the following: a) identification of the target group(s); b) benefit package design and costing of the premiums; c) determination of subsidies, and whether or not to charge equity-adjusted premiums for BPL population; d) implementation arrangements; how to involve PRIs in implementing the pilot, and so forth. It is estimated that it will take six months to finalise these important policy decisions. Before the pilot is launched, considerable preparatory work will be required, including setting up a service providers' network, a quality assurance system and so forth. Taking some of these decisions may require seeking concurrence and support of other departments as well.

[5] The total number of Blocks in the State of West Bengal is 342.

By September 2007 DHFW is expected to have a detailed action plan for implementation of the pilot. Thereafter, in the next 6 to 9 months, DHFW would put the implementation process in place. GTZ is planning to open a Social Security Resource Centre (SSRC) that would facilitate DHFW in implementing the pilot. Overall, the scheme should be ready for enrolling people by April/July 2008.

GTZ has suggested DHFW to form a small working group on health insurance, so that the decision making process on design and implementation of the pilot could be expedited. The formation of this small working group with adequate decision making power is necessary for finalising the design and rolling out the scheme as per the timeline mentioned above. Formation of the working group should be done at the earliest, preferably by April 07.

21. *Sub-Component I (iv): Public Health.* This sub-component comprises a set of activities aimed at improving the effectiveness of West Bengal's *public health services*. These are services which are either *public goods*,[6] such as health education through mass media, or have positive externalities, such as control of tuberculosis and other communicable diseases. This sub-component would seek to strengthen certain ingredients of the state's public health services which are currently neglected but which are critical for its functioning. The activities in the sub-component would complement, but not duplicate, those activities funded under centrally sponsored programs including the Tuberculosis Control and Vector-Borne Disease Control programs, or under other Bank-assisted projects dealing with other aspects of public health (Food and Drugs Quality Improvement Project, Integrated Disease Surveillance Project). Specifically, the following activities would be included in the project under this sub-component: (a) the establishment and operation of a Challenge Fund for Behavior Change Communication (BCC) activities, which would be a mechanism whereby DHFW would invite and evaluate proposals for high-priority BCC activities; (b) epidemiological and other studies; (c) the establishment and operation of four combined food/drug laboratories and the provision of equipment for the State Food Laboratory; (d) the addition of Laboratory Technicians in 76 Designated Microscopy Centers which are part of the National Tuberculosis Control Program; (e) the provision of additional staff and other inputs for the three existing Zonal Entomological Units for the control of malaria and other vector-borne diseases; (f) the introduction of larva-eating fish in 34 Blocks with high malaria prevalence; (g) the establishment and operation of a State Center and an Advisory Group for Non-communicable and Chronic Disease Prevention; (h) a review/updating of public health laws in the State; and (i) the upgrading of two apex State technical institutions related to public health, namely, the School of Tropical Medicine and the State Infectious Diseases Hospitals at Kolkata; and (j) the introduction of a school health program to target primary school children, age 6-10, consisting of promotive and preventive interventions.

Component II: Urban Health

22. Component II is composed of two sub-components: (i) Introducing Community-based Primary Health Care Services for the Slum Population in 63 Municipalities (US$17.2 million baseline cost); and (ii) Adding Public Health Activities in 63 Municipalities with a Dedicated Slum-targeted Primary Health Care Program (US$2.3 million baseline cost).

23. *Sub-component II (i): Introducing Community-based Primary Health Care Services for the Slum Population of 63 Municipalities.* At present, only half of the total 126 municipalities in the

[6] "Public goods" are goods or services where the consumption of one unit of the good or service by a given individual does not preclude consumption of the same unit by other individuals.

State have a dedicated government-funded primary health care program which provides basic maternal and child health services for slum populations. These services were originally introduced through three projects assisted by the World Bank and DFID, the most recent being the Bank-assisted India Family Welfare (Urban Slums) Project (1994-2002). An end-line survey conducted at the completion of that project showed a markedly increased utilization of basic health care services by women and children, together with a notable fertility decline and a decrease in infant mortality among the targeted slum population.[7] The encouraging results in the 63 municipalities where this slum-targeted program is operating have prompted the Government of West Bengal to decide to expand the program to the remaining 63 municipalities in the State (which are all located outside the Kolkata Metropolitan Area). Maternal and child health services would be made available to the slum populations of these municipalities following the same successful service model in use in the municipalities where the program already exists. The service model revolves around the deployment of female "honorary health workers" (HHWs, who are paid a modest honorarium), at the rate of one per 200 families, who function as a link between the slum communities from which they are recruited and government sub-centers. The HHWs are supervised by a cadre of First-Tier Supervisors (FTSs), at the rate of one per sub-center, who are ex-HHWs that have distinguished themselves in their work. The model also includes the contracting-in of private sector Part-time Medical Officers (PTMOs), at the rate of one per sub-center, who complement the services provided by the sub-centers' regular staff of government paramedics.

24. Specific activities under this sub-component would include the establishment and operation (in rented buildings) of 283 Sub-centers. Services provided at these sub-centers would include as a minimum child health care services including immunization; ANC services and counseling for institutional delivery; family planning services for spacing and counseling for terminal methods; and the primary treatment of common ailments. The sub-component would also include the establishment and operation of 15 Urban Health Centers in municipalities where secondary health care facilities are not available.[8] These would be small facilities located in rented buildings. Each Urban Health Center would serve a slum population of about 30,000 and would provide preventive and curative outpatient services not available at the sub-center level.

25. In addition, the range of services supported by the program would be broadened (relative to the current range of services in the 63 Municipalities that already have a dedicated government-funded primary health care program) to include some important *public health aspects*. The benefits of this new public health dimension of the program would not be circumscribed to slum populations but would benefit the entire population of the municipalities. Specifically, Sub-component II (i) would include technical assistance and workshops for the development of Municipality-specific Public Health Action Plans, with a focus on the health determinants in the respective municipalities. The Plans would target improvements in key public health areas including water quality management, solid waste management, sanitation and hygiene, licensing of health facilities, and the tracking of seasonal disease outbreaks (e.g., dengue fever). The project would also fund the introduction of a new cadre of First-Tier Supervisors/Public Health, who would be posted at the Municipality level and work on public health matters only.

26. The Municipality-specific Public Health Action Plans would clearly benefit from the existence of clear guidelines from the State Government specifying the roles and responsibilities

[7] Under the program, each beneficiary slum household maintains a Family Health Card in which services received and other events are recorded.

[8] In 48 of the 63 municipalities to which the program would be expanded, there is already a District or Sub-division Hospital or a State General Hospital in operation.

of different stakeholders/government agencies in addressing the public health issues and determinants. In the absence of such guidelines, important aspects of the Municipality-specific Public Health Action Plans would remain on paper only, because the Municipalities themselves would not have the authority and/or means of taking the corresponding actions.

27. *Sub-component II (ii): Adding Public Health Activities in 63 Municipalities with a Dedicated Slum-targeted Primary Health Care Program.* Under this sub-component, a new public health dimension would also be introduced in the 63 Municipalities where a dedicated primary health care program is already in operation for the slum populations. Activities would include the recruitment and deployment of public health-focused incremental staff at the Municipality level; training on public health for existing staff; and technical assistance and workshops for the development of Municipality-specific Public Health Action Plans, along the lines already discussed under Sub-component II.(i).

28. The service package in the 63 Municipalities already having a dedicated health care program for the slum population has been up to now limited to the reproductive and child health area. The proposed project would be instrumental in broadening this package to include other basic curative services, which is expected to increase the usefulness of the program to slum inhabitants. Refresher training for HHWs and their supervisors would also be introduced in the program, thus remedying an important weakness.

Component III: Project Management, Capacity Building and Monitoring and Evaluation

29. Component III of the proposed project would be composed of four sub-components: (i) Project Management (US$---million baseline cost); (ii) Capacity Building-Rural Health (US$7.2 million baseline cost); (iii) Capacity Building-Urban Health (US$0.7 million baseline cost); and (iv) Monitoring and Evaluation (US$.....million baseline cost).

30. Note that a process of organization development and capacity building both at the central and local levels has already been launched under the HSDI. This process will offer opportunities for learning and exchange of experiences to senior officers at the central and local levels, provide internal reviews of existing organizations structures, and identify bottlenecks and priority areas to be addressed. The proposed project intends to support this ongoing process and contribute to its financing. The objective is to build institutional capacity at all levels, improve governance, and, together with the investments planned under the M&E and public health subcomponents, move the DHFW towards a result-oriented management system.

31. *Sub-component II (i): Project Management.* The activities will include: (i) incremental operational costs including labor costs for project management; (ii) consulting services to cover technical issues, as well as procurement and financial management improvements; (iii) training of project management staff; (iv) provision of necessary office equipment.

32. *Sub-component II (ii): Capacity Building-Rural.* This sub-component would include several capacity-building activities relating to local government, Rogi Kalyan Samitis (RKSs), and government health staff: (a) Strengthening of Gram Panchayat and Block Planning. The project would support the progressive decentralization of the health planning process in rural areas. All Districts in the State would prepare District Health Plans for 2007-08, based on a participative process and bottom-up approach. Preparation of Village Health Plans would precede the preparation of the District plans and feed into the latter. The Village Health Plans would be the responsibility of the Health Standing Committee of each Gram Panchayat. District Health Plans

would include activities related to the provision of drinking water, sanitation, hygiene and nutrition. The project would provide funds at the Block and Gram Panchayat levels for conducting surveys, workshops, studies, consultations, orientation and other activities. (b) Training of PRI members for strengthening their role in health. This activity would consist of training of Panchayat members, especially those in the Health Standing Committees at Gram Panchayat and Panchayat Samiti levels, in order to enhance their role in the health sector, and more specifically so that they are able to perform their duties in the context of decentralization. All the Gram Panchayats would be covered in a phased manner over five years. (c) Capacity-building of Rogi Kalyan Samitis (RKSs). RKSs have been constituted at District Hospitals, Sub-Divisional Hospitals, Rural Hospitals, Block PHCs and PHCs. It is vital that capacities of RKSs be enhanced, so that they can play their envisaged role in the management, monitoring and supervision of these health facilities. To this effect, the project would include two-day capacity building workshops for RKS members of all the facilities where RKSs have been constituted. (d) Exposure visits for health functionaries. This activity would consist of exposure visits for health functionaries within India and abroad, in order for them to learn from national and international best practices. (e) Establishment of five new ANM schools. The present state capacity for nursing training is inadequate to fulfill the demand. Under the project, five new ANM schools would be set up. This would supplement the ongoing DHFW's drive to set up ANM training schools through public-private partnerships. (f) capacity building activities for health supervisors, Anganwadi workers, TBAs and other care providers, in addition to those already being implemented through the RCH-II project.

33. *Sub-component III (iii): Capacity Building-Urban Health.* The proposed project would support capacity building at the level of the State Urban Development Agency (SUDA), the individual Municipalities, and DHFW. SUDA is the technical agency of the State Municipal Affairs Department, and would be the key agency to provide technical backstopping, capacity building and monitoring/supervision support to the Municipalities for the implementation of Component II. To discharge its enhanced responsibilities, SUDA would be provided with a team of professional staff with an adequate skill mix. In addition to the salaries of these incremental staff, the project would fund other operational expenses of the team, and expenses associated with training and staff development. In order to coordinate the program and pay sufficient attention to the new public health aspects, each Municipality would be provided with a Health Team composed of a Health Officer, a Public Health Nurse, four to five First-Tier Supervisors/Public health, and support staff. The costs of establishing and operating these teams would be funded under the proposed project. Moreover, since DHFW would play a key stewardship role in the program—steering policy, formulating standards/norms/operational guidelines, providing technical inputs during epidemics, and holding periodic consultations with DMA and the Municipalities--, the capacity of DHFW to perform these duties also needs to be enhanced. To this effect, an Urban Cell would be established within DHFW, with a nodal officer and supportive staff. In addition, the project would include *a program of training* for staff and other stakeholders at various levels (see Annex 4 for details).

34. This subcomponent will also support all needed activities *for the development of a comprehensive urban health strategy.* The Bank will support the DHFW in the development of a 5 years strategy based on the systematic review of the experience in urban health programs in West Bengal and India. A series of consultative workshops will be organized to engage all relevant partners in the strategy development.

35. *Sub-component III (iv): Monitoring and Evaluation*: The monitoring and evaluation systems of the DHFW have been strengthened significantly by Government over the last few years, increasing in scope and also building an IT infrastructure to allow for more rapid and

accurate transformation of information. However, much of this strengthening has, to date, emphasized tertiary and some secondary facilities. Furthermore, while the government has started to use information for targeting policies (e.g. the use of hospital performance indicators and ranking by these indicators), there is a clear scope and demand to expand this. This component will strengthen the monitoring and evaluation capacity of the DHFW both in terms of the quality of information collected, particularly at the primary level, and promoting the use of this information for policy.

36. This work will take place under four main sets of activities:

(i) *Rationalizing and strengthening the central state monitoring apparatus*. This will include a review of the roles of all central monitoring units in the DHFW (including the State Bureau of Health Intelligence, the Demographic Evaluation Cell of the State Family Welfare Bureau and respective program officers) and the redefinition of roles in order to increase the speed and efficiency of reporting. This organizational review will take place in the first year of the project and the recommended changes will be made in subsequent years. The activities to rationalize the system will also include a reduction and simplification of the forms filled out by front line health workers. A pilot version of this is currently under way in two districts and this initiative will be scaled up as part of this project.

(ii) *Expanding the reach of the health information system*. The activities supported under this subcomponent will include expanding both the depth and breadth of information gathered. In terms of depth, the proposed project would support the roll out of a computerized MIS to the block and district level. This project would support both the hardware (both at the local and state levels) and software development. The software will be designed so as to provide some immediate simple analysis for monitoring and policy at both the block and district levels, as well as providing for the transmission of data to the state level. The project will also support the broadening of the health information system. This will include a household survey to complement the data collected under the regularly programmed NFHS and RCH programs [timing of survey to be determined]. In addition, the project will support the expansion of the existing monitoring system beyond health outcome indicators to include data on personnel and funds accounts and audits. A detailed study of the financial data system will be conducted in the first year and this will serve as the basis for the integration of this with the central MIS in subsequent years. There has been some initial work on building a personnel database for the DHFW, and this activity will be scaled up and integrated with the central MIS. Finally, this set of activities will also support the expansion of the MIS coverage of private and urban primary facilities.

(iii) *Impact evaluation*. To complement the activities that will improve the monitoring of the DHFW, the proposed project will also support a program of rigorous impact evaluations. These evaluations will be used to examine the effects of at least one of the major innovative initiatives of the Department. The design of the impact evaluation will be completed during the first year. Data collection and analysis will take place during subsequent years and results will be available for discussion no later than the fifth year of the project.

(iv) *Increasing the capacity for making data informed policy*. This proposed set of activities will comprise both expanding the set of information for policy formulation but also the skills for analysis. In addition to the activities indicated above (e.g. integrating financial indicators into the MIS), in terms of expanding the set of information the proposed project will include the development of a set of health service quality indicators. During the first year of the project, consultants will be appointed to define suitable indicators for each set of institutions. In terms of

improving the skills for analysis, the proposed project will provide training in data analysis for central and district staff, once the reorganization of the MIS institutional setting is complete.

4. Lessons Learned and Reflected in the Project Design

37. The Bank has been involved in the health sector in West Bengal and other states in India through several projects. From these projects, some of the lessons learned include the following:

i. More funding and inputs alone are not sufficient to produce sustainable changes in the health delivery system. The Bank's work must improve the functioning of the health system to be sustainable, starting from "the basic" requirements, such as building capacity, strengthening the processes of planning, implementation and monitoring, create more efficient and transparent mechanisms for use of all resources available for health.

ii. In order to achieve priority health outcomes for the poor, there is a need for an improved public health system. Traditionally, public health interventions have been addressed by centrally-sponsored schemes with little stewardship from the state DHFWs. This is the first Bank-supported project that is addressing this question explicitly at the state level.

iii. The public sector should seek to crowd-in, rather than crowd-out the private sector, and the private sector should be more engaged in service provision to meet the MDGs. This could be done through contracting-out more services where the private sector can deliver more efficiently and of better quality. PPP schemes are a central strategy of the proposed operation to address private sector engagement. Strengthening the regulatory capacity to oversee the quality of care in the private sector is also part of the reforms supported by the proposed operation in the PPPs subcomponent.

iv. *In Urban Health*: the Urban Health component of the proposed project builds upon the experience of several externally-assisted projects, the most recent being the Bank-funded *Family Welfare (Urban Slums) Project*[9], implemented from 1994 to 2002. This project demonstrated the effectiveness of the model centered on the use of female "honorary health workers" who are drawn from the slums where they serve, backed by supervisors located at sub-centers and part-time medical doctors hired from the private sector. Important lessons learnt and incorporated into the proposed project include: (i) that the program could be made more useful by expanding the service package to include basic curative care beyond reproductive and child health; (ii) that desired health outcomes depend to a large extent on factors outside health care, such as sanitation and other environmental factors, which in turn has led to a decision to introduce a new element of *public health* in the program through the proposed project (and with it, an expansion of the program's beneficiary population beyond slum inhabitants); and (iii) that there is a need for introducing refresher training for the honorary health workers and their supervisors.

5. Alternatives Considered and Reasons for Rejection

38. When the proposed project was at its early conceptualization stage, the alternative of a Development Policy Loan (DPL) was explored. It was thought that a DPL would fit in well with the then starting DFID-assisted operation, the HSDI, which was similar to a DPL. However, at the time no State-level sector-specific DPL had been attempted in India, and in the end it was concluded that a health sector DPL would be too risky for such a new undertaking[10]. The second

[9] Also known as the India Population Project VIII.

[10] The proposal of doing a DPL was rejected for the following reasons: (i) the critical fiscal situation of West Bengal, although improving, does not justify a DPL operation without an agreement with the Bank on

alternative explored was that of a SIL where the modality of disbursement of the IDA credit would be of the "program support" type—i.e., where with some exceptions any expenditures incurred by DHFW, incremental and non-incremental, would have been eligible for Bank reimbursement, up to the value of an annual cap. This second alternative was discarded in favor of a more traditional SIL, where the expenditures eligible for Bank reimbursement are drawn from a narrower set of DHFW activities and are incremental in nature. The reasons for this decision were as follows. Because external support to DHFW already included two different modalities, namely the DPL-type modality in the HSDI and the traditional project modality in operations supported by several other Donors, the introduction of a third modality in the form of a Bank "program support" operation would have further complicated the overall external assistance picture. At the same time, there did not seem to be any distinct advantages from choosing a "program support" modality of disbursement. Unlike other cases where such modality would facilitate the formulation of a sector reform and development program, in this case such a program was already in existence in the form of the HSDI. Finally, there was reluctance to use country fiduciary systems from the beginning, as it would have happened under a program approach, pending an agreement on a time-bound reform process to strengthen them. Thus Bank support could take the form of a traditional SIL and yet be anchored in, and supportive of, that sector program. In accordance with this line of thinking, as noted in Section B.1.above the proposed project would be explicitly linked to the HSDI in both design and supervision.

C. IMPLEMENTATION

1. Partnerships Arrangements

39. The GoWB, DFID and the Bank agreed to jointly support a new "Modus Operandi", based on the formulation of a Medium-Term Program and Annual Programs of Work (APWs). The idea is that DHFW needs to move away from a *modus operandi* of incremental planning and budgeting for its operations on a year-to-year basis, towards a different *modus operandi* whereby annual plans and budgets are formulated in the context of a medium-term reform and investment program.

40. To this effect, DHFW formulated a first *Medium Term Expenditure Framework* (MTEF), which incorporated the DHFW's entire projected budget initially for the five-year period 2007/08 to 2011/12. [11] The DHFW also produced the first *Annual Programs of Work* for the FY 2006-2007. [12] The introduction of a rolling MTEF and APWs are included in the HDSI's *Matrix of Milestones*.

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a fiscal adjustment plan; (ii) the Department of Economic Affairs of the Government of India rejected the option of a sector-specific budget support operation at the state level; (iii) an investment operation would allow to continue supporting the reforms under HSDI and would strengthen the focus on implementation, which has not been a priority of HSDI, and it is a necessary ingredient to achieve the planned milestones.

[11] The MTEF projected public sector expenditure in West Bengal in a broad but comprehensive manner, and would be revised annually on a rolling basis. Expenditures pertaining to the continuation of existing activities as well as those in connection with new activities (or expansion of existing activities), expenditures funded by GoWB, GoI and all the Donors are included in the MTEF. The formulation of the MTEF requires the estimation of a (rolling) Resource Envelope, which acts as a constraint on total projected expenditure and enables the assessments of trade-offs among different categories of expenditures.

[12] Each APW would spell out (in greater detail than in the MTEF) the activities to be implemented in that particular year, the estimated costs of those activities, responsibilities for implementation, timing of various critical actions, and milestones/targets to be achieved by the end of the year. The APWs would also specify how the costs of the activities to be implemented in a given year are to be reflected in DHFW's budget (and

41. The Bank, the DHFW and DFID would work out a common Supervision Strategy by Negotiations The purpose of this common strategy would be to reduce the combined monitoring burden on DHFW staff (e.g., by reducing the number of review missions by the Bank and DFID), while at the same time maximizing the synergism between Bank assistance and the HSDI.

42. The APWs would be the critical link between the MTEF and actual implementation of DHFW's activities. Every fiscal year the APW would be jointly reviewed in draft form by DHFW, DFID, the other Development Partners and the Bank, and based on this review agreement would be reached on any changes to be made in the final version. Soon after the end of each fiscal year, another joint review would be conducted to assess progress towards the WBHSDP PDO and towards implementation of the HSDI's milestones.

2. Institutional and Implementation Arrangements

43. A traditional project approach that foresees execution through an external PMU, such as in the previous State Health System Project II, has been rejected because the Government of West Bengal explicitly requested the Bank for support to strengthen its own planning, implementation and monitoring processes. The Bank agreed to mainstream as much as possible the WBHSDP within regular Department structures in order to reduce transaction costs and the other distortions associated with traditional investment projects. Strengthening the own arrangements of the DHFW not only would result in sustainable changes but its benefits would also reach the resources allocated for health by DFID and by the GoWB.

44. Overall responsibility for project implementation would be with the Strategic Planning and Sector Reform Cell (SPSRC) of the DHFW. The DHFW would appoint a Project Director from the Indian Administrative Service (IAS) cadre and belonging to the rank of Special Secretary, who would be supported by a Deputy Project Director from IAS or senior state cadre and belonging to the rank of Joint Secretary. The PMU will be supported by the various staff in the Directorate. Arrangements for financial management/disbursements and for procurement are described in Annexes 7 and 8 respectively. Implementation arrangements for the individual components/sub-components are described below.

Implementation Arrangements for Component I: Rural Health Component:

45. The first sub-component, *Strengthening Government-provided Health Services*, comprises the construction, renovation and equipping of a number of health facilities, including sub-centers/Block sub-centers, PHCs, and District/Sub-divisional Hospitals, mostly located in 74 backward Blocks. The arrangements for the procurement of equipment and for carrying out civil works are described in Annex 8, *Procurement*. Once operational, the new/renovated facilities would continue to function under the existing State-wide management arrangements for government rural health services described in Annex 6.

46. Implementation of the second sub-component, *Improving Health Care Access through Public-Private Partnerships*, would be coordinated by the PPP Cell in the SPSRC, which would be strengthened for that purpose.

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any other relevant Departments' budgets). This specification would require mapping specific expenditures to specific budget headings in a transparent manner.

47. Implementation of *the Innovations in Health Financing* would require forming a Health Financing Cell. The Cell will be monitored by SPSRC. Other implementation details would be known only after the design and the implementation mechanisms are further elaborated by the DHFW.

48. For the implementation of the fourth sub-component, *Public Health*, arrangements would vary depending on the type of activity implemented. In the case of activities related to the malaria and tuberculosis control programs, implementation would take place through the existing administrative structures for these centrally-sponsored programs. Epidemiological and other studies, as well as the review of public health laws in the State, would be carried out by consultants under the supervision of DHFW. The new State Center for Non-Communicable and Chronic Disease Prevention would be housed in a suitable existing institution not yet identified; this institution would have delegated authority from DHFW to establish and operate the Center. For the establishment and operation of the four new combined food/drug laboratories…[NEED TO SPECIFY WHICH UNIT OF DHFW IS RESPONSIBLE FOR FOOD/DRUG QUALITY CONTROL]. Finally, an important new activity in this sub-component would be the Challenge Fund for Behavior Change Communication Activities, whereby DHFW would invite, evaluate and fund proposals for high-priority behavior change communication activities in the health area [NEED TO FLESH OUT HOW THIS WOULD WORK].

Implementation Arrangements for Component II: Urban Health Component

49. Direct responsibility for implementing activities under the component would rest with the respective Municipalities (Urban Local Bodies), under the overall coordination of the Department of Municipal Affairs.[13] The Municipalities would be provided technical backstopping, capacity building and monitoring/supervision by the State Urban Development Agency (SUDA), the technical agency identified by DMA. DHFW would play a key stewardship role in the program—steering policy, formulating standards/norms/operational guidelines, providing technical inputs during epidemics, and holding periodic consultations with SUDA, DMA and the Municipalities. As already noted in Section B.3, the various agencies involved in implementation of the Urban Health component would be provided with additional staff and resources to fulfill their duties. In order to facilitate coordination with SUDA and DMA, an Urban Health cell has been proposed to be formed in the Secretariat, details of which are currently being worked out.

50. The institutional arrangements for the Urban Health program would also include a series of committees that will help coordinate the program and provide oversight. These would be: (i) at the district level, the Urban Health Committee under the District Health Samity; (ii) at the Municipal level, the Municipal Level Health and Family Welfare Committee and the Municipal Level Management Committee; and (iii) at the ward level, the Health Sub-Committee under the Ward Committee.

Implementation Arrangements for Monitoring and Evaluation

51. The monitoring and evaluation component will be implemented chiefly by the State Bureau of Health Intelligence (SBHI) or its successor organization. One of the initial activities is the streamlining and rationalization of the MIS institutions and as this may include a reorganization of the SBHI, it will be overseen by the SPSRC. The SBHI will take responsibility for subsequent

[13] For the 41 Municipalities in the Kolkata Metropolitan Area, the Kolkata Metropolitan Development Agency would continue to provide oversight of the program.

activities, collaborating with other parts of the DHFW as needed (e.g. on integrating financial and personnel data into the MIS).

3. Monitoring and Evaluation of Outcomes/Results

52. The monitoring systems of the DHFW have been expanded in scope and effectiveness in the recent past. The improvements have included a more timely and comprehensive hospital monitoring system. Indeed, this hospital monitoring system has been used by the DHFW to construct a set of performance indicators to benchmark hospital performance. While there are plans to improve the monitoring of facilities and health services at the primary level, the current system is limited. The chief type of data available for monitoring activities consist of output indicators of the quantity of various services provided, complemented by some surveillance data (e.g for malaria) and some treatment effectiveness measures (e.g for TB). Therefore, these types of indicators will have to form the basis of the monitoring of the WBHDSP.

53. Some types of health data such as health seeking behavior or the incidence of diarrhea are best captured from the point of the population, rather than the point of service, as individuals may not interact with the public health facilities during the course of the illness or while seeking care. These survey indicators will form a complement to the core indicators available from the DHFW's monitoring system. Taken together, these indicators will provide a critical input into the DHFW's push towards results based management.

54. Monitoring. As indicated above, the central base of the monitoring system will come from the output indicators that are regularly monitored by the DHFW. These will allow for regular (e.g. annual) monitoring of the WBHSDP, as well as progress in the sector more generally. However, these indicators do not give us a complete picture of the health of the entire client population. To this end, the set of indicators from the existing DHFW system will be complemented by a second set of indicators from household surveys. The Bank is still discussing with the DHFW the timing of these surveys, but there will be a baseline (either a new survey or existing RCH data), and a second survey to serve as input into the mid-term review. There may also be another survey at the end of the project. These will be coordinated with GoI-sponsored surveys planned during this period in order to avoid duplication.

55. Evaluation. As part of the HSS, the DHFW is undertaking a number of innovative policy experiments. Two of these, health insurance and PPPs, will be supported in part by the WBHSDP. While monitoring data can help us understand the outputs and some of the outcomes of these interventions, it will not allow us to definitively attribute changes in health outcomes to these interventions. As these are interventions that the DHFW is considering scaling up, it is particularly important that their impacts are measured in a way that provides clear evidence on their effectiveness. Hence, impact evaluations of these innovations will provide a key complement to the core monitoring activities.

4. Sustainability

56. Financial sustainability: the proposed project is sustainable from a *financial* point of view. The Draft Mid-Term Expenditure Framework (MTEF) prepared by the Technical Assistance Support Team, DHFW for the five-year period 2006-07 to 2010-11 separately projected: (i) the resources likely to be available to finance government expenditure in the health sector in West Bengal during that period, broken down by source of funding (State Government, GOI, DFID), and (ii) government health expenditure. Projections of expenditure were based on current plans

for upgrading infrastructure and other current or expected development programs, but not taking into account the proposed Bank-assisted project. Similarly, projections of the "resource envelope" took into account current sources of funding excluding the proposed Bank-assisted project. When the latter is added to the picture, the additional State Government funding that would be required over and above the corresponding MTEF projection only amounts to about 1.2%-1.3% per year during project implementation.[14] That is to say, funding the proposed project would either require a small additional contribution to the health sector on the part of the State Government, or a small reduction in some of the other health expenditures projected in the MTEF. Immediately after project completion, the 2012/13 incremental recurrent costs arising from the project, which the State Government would need to fund if project activities are to be sustainable, would amount to about 3.9% of the 2010/11 value of State Government financing as projected in the MTEF. This percentage is sufficiently small that it should be feasible for the State Government to accommodate, provided of course the corresponding activities are accorded sufficient priority.

57. Political sustainability: the proposed project is embedded in a broader reform program, initiated in 2003 by GoWB with the drafting of the HSS and the launch of the HSDI in 2005 (see section A.2.1). Over the last three years the HSS priorities and the HSDI strategic directions seem to have been fully endorsed by the political and bureaucratic leadership. Public voice demanding improvements in governance and better health care services is also strong in the state, and likely to further increase in the future.

58. Institutional sustainability: a Strategic Planning and Sector Reform Cell (SPSRC) headed by a Special Secretary has been created in the DHFW to steer the reform process. At the same time, an Organizational Development (OD) process has been initiated to strengthen the Department capacity to plan, execute and monitor its programs at the central and the local level. The OD process is also focused on fiduciary mechanisms, to strengthen the existent procurement and financial management arrangements.

5. Critical risks and possible controversial aspects

59. Following are the main risks for implementation of the project. The risk ratings is computed taking into account the mitigation measures

Risks	Mitigation Measures	Rating
The HSDI sector development and reform activities will not be carried out because of weak institutional capacity.	Although implementation at the beginning may be slower than expected, the ongoing capacity developed process will ensure more sustainable results over the medium-term. Technical Assistance is available from DFID to help the DHFW effectively absorb additional resources while institutional capacity is developed. The Organization Development activities will focus also on fiduciary mechanisms and strengthen them over time.	M
Coordination with DFID may not continue effectively, and the DHFW may not have the capacity to manage the funds flowing into the health sector from DFID, the other Donors and the World Bank through separate operations.	DFID and the World Bank are committed to work together and take advantage of the respective strengths. The framework adopted by the WBHSDP based on the MTEF and annual POWs is fully consistent with HSDI. The development of a common Results Framework and Monitoring Strategy will also insure harmonization of objectives and focus and minimize *ad hoc* reporting requirement for individual Development Partners.	M

[14] See Annex 9 for details of the calculation.

Weak institutional arrangements between DHFW and Department of Municipal Affairs may lead to fragmented implementation (uneven pace and quality) of the urban health component.	Technical collaboration between departments has been promoted during the preparation of the proposal. It will be further sought during the development of the urban health strategy. Tripartite Agreements between the DoHFW, SUDA and DoMA will be formalized in a Memorandum of Understanding	M
Productive institutional linkages with the private sector and non-governmental organizations may not be scaled up as planned.	Intense capacity building strategies at the state level have been developed to increase NGOs and other private providers' involvement in delivery of essential services. The DHFW has already financed successful PPPs in the past, although very few on the delivery of primary health care services. A new PPPs Policy has been prepared by the DHFW and has been approved by Cabinet. A dedicated PPP Cell will be strengthened to implement the various PPP activities in the state.	M
The health insurance experiment and the voucher schemes may not be successfully carried out, or the experiment may be terminated at the end of the project.	GTZ has been providing regular and high-quality technical assistance for health insurance. The first year will be devoted to the preparation of the pilot. The voucher schemes are assisted also by GoI through different national programs. The health Financing Cell will support the preparation, implementation and M&E to assure a feasible and sustainable design as well as evaluation. The design process will incorporate lessons learned from the current health insurance efforts in the recently negotiated health project in Karnataka and other states in India.	S
Overall risk rating		*M*

6. Loan/credit conditions and covenants

[NOT AVAILABLE YET]

D. APPRAISAL SUMMARY

1. Economic and financial analyses

60. The proposed project will contribute to reducing the burden from communicable disease, maternal and child morbidity and mortality and set the foundations for implementing preventive policies on non-communicable diseases. Its objectives and strategies are aligned with the International consensus which set the attainment of the Millennium Development Goals (MDGs) as priority objectives for International assistance and government action in low-income countries.

61. Equity. With regard to *equity aspects* of government health expenditure, existing studies based on data from the mid-1990s suggest that such expenditure disproportionately benefits the rich. The ratio of subsidy to richest versus poorest 20 percent of the population in West Bengal at that time was 2.73 (Mahal et al. 2001), mainly because expenditure on public hospitals was pro-rich. For inpatient care, while 43.9 percent of the population was estimated to be below the poverty line, they utilized only 29.9 percent of inpatient bed-days. These figures would rank West Bengal as average in terms of equity in India, worse than most Southern and Western Indian states, but better than most Northern and Eastern states. Moreover, the studies suggest that hospital care is pro-rich even with regard to their outpatient component. NSS-based (1995-96) evidence shows that hospital-based outpatient care favored those above the poverty line, while PHC-based outpatient care favored those below the poverty line (Mahal, Yazbeck, Peters and Ramana, 2001). It is important to note, however, that the above results are based on data that is

already ten years old. In the meantime, there has been rapid growth of the private hospital sector in West Bengal, especially in urban areas, so it is likely that many of the more affluent households have switched to using private rather than government hospitals. However, public resources' allocation continues to be largely based on historical expenditure and the existing health inputs, so that more funds tend to reach urban and developed areas where more facilities and personnel are already in place (see PER, 2005).

62. The proposed project will contribute to expand coverage of essential services in rural and underserved areas. Its focus on primary care services and rural areas will contribute to improve the redistributive impact of government health expenditure. Most of the activities planned under the proposed WBHSDP target the socially and demographically vulnerable on a priority basis, because these are the main groups who are at present not able to use even basic health services of decent quality (see social analysis).

63. Efficiency. With regard to *efficiency aspects* of government health expenditure, all conclusions are by necessity very tentative, since there is no systematic information on a facility-level activity levels in the public or the private sectors. Thus, it is impossible to compute unit or average costs of service provision. However, there are several symptoms of problematic areas:

- there is no mechanism to track the linkages between the received funds and the consequent performance at all levels;
- convoluted operational procedures persist, particularly in the relationship between different levels of government and different Departments;
- a high proportion of SGEHFW is spent on salaries (see point above), whiles operational expenses are under-funded;
- poor attendance in primary and secondary care rural facilities is common. [15] Because of the large gaps still existing in coverage of prevention and of basic care services, and the absence of a referral system, performing secondary and tertiary care hospitals tend to be overcrowded.

64. To improve allocative efficiency[16], the proposed project will contribute to progressively move the government away from an almost exclusive focus on private goods (curative care) and towards greater emphasis on public goods, through scaling up prevention activities, M&E, and creating capacity in the State Government for stewardship of the whole sector. To improve productive efficiency, the WBHSDP will introduce a results-based approach to planning and service delivery, and stimulate more competitive allocation of resources.

65. Financial and fiscal analyses. The proposed project supports this renewed government financial commitment to the health care sector, and at the same time provides explicit incentives to shift focus away from tertiary care and towards public health and primary care services, particularly in underserved urban and rural areas where some of the potential health gains from additional health coverage are largest. As indicated in section C3, the project will generate recurrent costs which seem totally sustainable by DHFW in the long run.

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[15] At the grass-root level absenteeism, especially of doctors but also of other staff, is high (in 2003, 43 percent of staff who were supposed to be present in PHC facilities, were not there on a day of an unannounced visit (Source: Chaudhury and others; see World Development Report, 2004, Chapter 2, Table 1.2b. The World Bank).

[16] An allocation of resources is defined as efficient if it is not possible to further enhance benefits for anybody without reducing benefits for others. In order to be efficient, public expenditure needs to give priority to the correction of market failures (allocative efficiency). It should also be productively efficient. Productive efficiency is measured as the units of output per unit cost of inputs. Any good or services is produced efficiently if costs are minimized.

66. All Departments have been negatively affected by the fiscal readjustment process initiated after 2000 (see Annex 9)[17], and growth of state health care expenditure has been low in recent years. The annual compound rate of growth of this expenditure was about seven percent in the period from 1999-00 to 2005-06, but adjusted for inflation it was only slightly higher than one percent.

67. More recently, GoWB has recognized that the observed stagnation of social and health expenditure occurred over the last few years needed to be reversed. Table 4 below shows actual state health expenditure for 2004-05 and 2005-06, and the budget estimates for 2006-07, by major heads of the budget's (functional) classification. As shown in the table, a large (nominal) increase of 25.6 percent is budgeted for 2006-07. The increase reflects in part expected budget support from DFID, but the state's own resource commitment is also planned to go up by a very substantial 22 percent between 2005-06 and 2006-07.[18] Actual execution of this sharply higher budget will undoubtedly be a challenge.[19]

68. In addition to the expenditures which are budgeted in the DHFW budget, there are also substantial government health expenditures not reflected in that budget. These are expenditures funded by GOI as grants, mainly executed through the Health and Family Welfare Societies. They include expenditures funded under NRHM (including RCH II), NACO, and some other categories such as GOI funding for the cancer control program. In 2006-07 these off-budget health expenditures in West Bengal would probably amount to about Rs. 430 crores (of which three-fourths from NRHM). These expenditures are not included in the table below. Hence, adding on-budget and off-budget expenditures, the total government health expenditure expected in 2006-07 would be about Rs. 2,300 crores.

Table 4, West Bengal, DHFW Expenditure, 2004-05 to 2006-07 (in Rs. Crore)

	2004-05 (actual)	***Share (%)***	***2005-06 (actual)***	***Share (%)***	***2006-07 (BE)***	***Share (%)***
Rural Health Services	246.14	18.3	351.44	23.7	450.74	24.2
ISM&H (rural and urban)	46.26	3.4	46.82	3.2	54.16	2.9
Urban Health Services	639.65	47.6	635.09	42.8	774.21	41.5
Medical Education and	115.85	8.6	140.99	9.5	212.49	11.4

[17] The overall fiscal situation of West Bengal has been difficult in recent times. The state sustained a sharp deterioration in its fiscal situation in the 1990s, with the gross fiscal deficit reaching a peak of around 10 percent of the state Net Domestic Product by 1999-2000. In the current decade West Bengal has been striving to bring its fiscal deficit down.

[18] By "the state's own resource commitment" we mean the portion of DHFW budget that is not funded from either GOI grants or bilateral donors' grants. In 2006-07, out of a total DHFW budget of Rs. Crore 1,865.76, about 13 percent is expected to be funded by DFID, and about seven percent from the GOI (the latter for Family Welfare).

[19] In 2005-06, actual DHFW expenditure (Rs. 1,485 crores) represented about 87 percent of the BE figure (Rs. 1,709 crores). The level of execution had been higher in the previous two years, at about 94 percent of the BE figures.

Research						
General	15.18	1.1	26.20	1.8	32.97	1.8
Public Health	121.98	9.1	114.72	7.7	156.71	8.4
Family Welfare	157.01	11.7	168.58	11.3	181.68	9.7
Hill Areas	0.60	0.04	1.50	0.1	2.80	0.2
Total	1,342.68	100.0	1,485.34	100.0	1,865.76	100.0

Source: DHFW MTEF

69. Note that the labels assigned to the above different budget headings can be misleading[20], and that from the budgetary classification presented above one cannot draw firm conclusions on the total and the distribution of spending by type of services.[21]

70. In conclusion, the above analysis indicates that in order to achieve the ambitious health outcomes the GoWB has committed to achieve in the HSS, there is a need to increase as well as reallocate public expenditure in favor of priority areas in terms of potential health impact, and improve performance of the public sector. These are precisely the two main strategic directions chosen for the project.

2. Technical

71. The proposed operation is fully consistent with the recently discussed HNP Sector Strategy, which argued that the Bank should pursue a combined strategy of accelerating achievement of health-related MDG outcomes and of assisting India in developing new strategies characterized by:

- focus on public health and preventive activities;
- focus on the primary care level and on the more remote underserved areas rural areas, and the sprawling poor urban areas;

[20] For example, under the heading "Public Health" we can find categories of expenditure which can be considered as part of public health, such as IEC activities, but also expenditure on central level functions which in economic terms would be better classified as "overhead" costs (mainly salary costs of central level staff). At the same time, other important public health functions are not included in the "public health" heading. For example, monitoring and evaluation costs are included under subcategory "80 – General", or other important public health services are classified under family Welfare.

[21] For example, Table 4 could suggest that the 70% of the population in West Bengal who lives in rural areas received only 25% of the total DHFW expenditure, whilst the urban population took up almost 50% of the benefits. However, one needs to consider also that: a) most of the National programs classified under Family Welfare in fact principally benefit rural populations; b) in the absence of a functioning primary care level, rural populations largely seek care in urban hospitals (or, more precisely, the wealthier rural population –see point under Equity in the main text, and finally c) the category "Urban Health Services-Allopathy" in fact mainly includes tertiary care services which do not benefit the vast majority of the poorer urban population. Thus, the budget classification masks the fact that basic urban health services are one of the most neglected areas, and that is the reason why it is one of the areas where the WBHSDP intends to focus.

- exploration of innovative ways of financing and delivering health care services for the poor;
- clear focus on results, with few clearly identifiable and measurable objectives to measure performance, and rigorous monitoring and evaluation arrangements;
- focus on fiduciary reforms to improve availability of medicines at all levels, but particularly at the primary and secondary care levels;
- as much as possible, use of country systems and institutional mechanisms conducive to institutional strengthening of the DoHFW.

72. The proposed project design also builds upon the lessons learned in previous Bank-financed projects in the health sector in India, and on best practices in other Indian states and elsewhere;

73. Finally, the focus on essential cost-effective services relevant for the MDGs is consistent with findings of the Disease Control Priorities study for India.

3. Fiduciary

74. In the context of the proposed WBHSDP and the ongoing Donors' supported HSDI, sound and transparent fiduciary processes are seen as key to achieving significant efficiency, transparency, accountability and governance improvements in the system.

75. The work on fiduciary arrangements for the WBHSDP builds on the assessments made during the design of HSDI and the plans to improve both financial management and procurement arrangements in the state that have been agreed by the DHFW and DFID and expanded/strengthened to incorporate comments and suggestions by the Bank team.

76. The financial management and procurement arrangements are described more in detail in Annexes 7 and 8 and the most important milestones will also be included in the table of intermediate indicators in the Results Framework.

[THIS IS TO BE DONE AS PREPARATION CONTINUES]

Financial Management (to [redacted])

Disbursements will be based on the basis of Financial Management Reports, and adjusted for annual audited financial statements.

Fiduciary risks and Mitigation Measures

In assessing the fiduciary risk and determining the mitigating measures, the Bank will work in complete alignment with DFID's HSDI program. The financial management capacity assessment of the DoHFW as has been undertaken by DFID, serves as a good starting point. Based on the identified risks and the mitigating measures, a set of up-front Financial Management improvement measures have been agreed and documented in the HSDI matrix of milestones and prior actions.

Financial Management Issues

Issues related to financial management that will need to be addressed are:

- Defining the different expenditure units (DHFW, District Samitis, PRIs, ULBs, other Line Departments etc.) for each component, the fund flow and accountability mechanisms for the various components and the manner the end use of funds will be confirmed;
- In this context, where funds are transferred to other institutions as grants-in-aid, specific financial reporting mechanisms will need to be agreed to ensure that DoHFW maintains adequate levels of oversight;
- Addressing issues of year-end fund transfers to off-Treaury Samithi bank accounts or PLA accounts, while reflecting the same as in-year expenditures;
- Integration and aligning financial information with performance monitoring mechanisms;

Auditing Arrangements

The State Auditor General's Office will certify the annual financial statements for the operation, within six months of the close of each financial year. For health program funds transferred to other sectors, including PRIs, ULBs, Urban Development etc. auditing arrangements will need to be separately determined.

Procurement ([redacted])

The adequacy of the existing procurement framework and processes of the DHFW for program support has been studied by a DFID-appointed consultant who presented its findings to the DHFW. The recommendations are being examined by the DHFW and will be implemented gradually.

With regard to institutional development, the mission was informed that GOWB has considered various alternative institutional models and has decided to set up a Corporation on the Tamil Nadu model. A team of officers have visited Tamil Nadu and had discussion with the responsible officials. The proposed Corporation in West Bengal will however have some differences with regard to scope of coverage of services and structure. The proposed Corporation is envisaged to broadly cover: (a) procurement of drugs and medical supplies; (b) procurement of equipment; (c) finalizing contracts for annual maintenance; and (d) repair and maintenance of civil works.

Procurement of civil works will be done by the engineering wing of the DHFW. The new organization will develop its own procurement manual and bidding documents to ensure transparent and effective public procurement and will be empowered with adequate authority within the framework of state financial rules.

The Bank is of the view that procurement under the DHFW can be effectively done through National Competitive Bidding (NCB) for civil works and equipment. Therefore, a satisfactory NCB procedure of the DHFW is essential for the proposed project. In light of that, the Bank has requested the DHFW to build some specific conditions into the NCB procedure for wider acceptance in line with available best practices.

Procurement reforms are an essential dimension of the needed reforms in the health sector, which the proposed project would contribute to, in line with its objective of linking its activities and objectives to the ongoing sector-wide reforms under the HSDI program (see above section A). The proposed Health Sector Procurement Reform Action Plan (from now on referred to as the Action Plan) is presented in Annex 8. The intent of the Action Plan is to increase transparency and efficiency in procurement, and to guarantee greater availability and higher quality of pharmaceuticals. The main reform initiatives proposed in the plan are the same as those proposed in the National GAAP, agreed by GoI and the Donors' community, and now under

implementation by GoI and the state governments through RCH-II, TB-II and the Disease Control Project. They concern institution strengthening for procurement, enhancing transparency and efficiency of procurement procedures, enhancing drug quality, strengthening complaint handling procedures, improving management including strategies to strengthen the drugs controllers' organization and drug testing laboratories.

Drug procurement. DHFW is planning major changes in its drug procurement procedures. Existing procurement of drugs is decentralized, wherein the consuming centers are responsible for placement of orders and receiving supplies and releasing payments. On setting up of the Corporation, the procurement and payment for drugs will be centralized. Drugs will be delivered to the District Reserve Stores (DRS). It will be the responsibility of the consuming centers down the line to pick up supplies from DRS. The centralized operation will need a strong management information system. Computerization and linking of the DRS with the Corporation will be essential to a successful operation. Bidding methods of drugs would depend on packaging of drugs to be finalized and on quality requirements in accordance with the recommendations of the Detailed Implementation Review (DIR) that is currently being undertaken for operations in the health sector in India.

4. Social

The main social issues in the project are related to equity and gender concerns, and to consultations with and the participation of those who are expected to benefit from the project or contribute to the achievement of its goals in other ways. The project aims to ensure that maternal and child health outcomes improve especially among the poor and disadvantaged in the state. The project would monitor progress on this objective through data on outcomes that are disaggregated by age, gender, social group (particularly Scheduled Caste (SC) and Scheduled Tribe (ST) status), economic level (below or above poverty line), and geographical areas (see section on M&E). It would also examine public expenditure by areas (districts) (especially tribal areas) and by services, relating these to benefit incidence data. It is expected to carry out studies that would examine the reach and quality of services to ensure greater equity as well as gender-sensitivity in service provision. Reviews of data and studies of outreach care, maternal and child health services, and public health interventions will also assist in determining the project's progress on the equity and gender dimensions.

About 5.5 percent of the population of West Bengal is ST, somewhat dispersed throughout the state, with some districts and blocks having high concentrations. The key aim under the UCS pilot will be to ensure that these disadvantaged people get their fair share of benefits from the project, that they are adequately consulted and participate in it, and that their culture and resources are not harmed in any way.

In relation to the IR safeguard, the project will ensure that any persons affected in any way by land or assets severed for health program purposes will be fairly compensated, provided adequate notice, consulted regarding their resettlement plan in a timely manner and have access to an adequate grievance redressal mechanism.

5. Environment

This project is a Category B project, because its potential adverse impacts on the environment and public health are well identified and site-specific and the required management measures are well defined and implementable. Hospitals and healthcare facilities generate hazardous biomedical

waste which if inadequately treated and managed can have adverse impact on the environment and on public health through air, land and water pollution. Therefore institutionalizing effective waste management systems in all health care facilities is a key prerequisite to improving efficiency and effectiveness of health care. Proper management of such healthcare waste is also a legal requirement under the Government of India's Bio-Medical Waste Management Rules (1998 and amended in 2000) and GOWB's state regulations. The State Pollution Control Board in West Bengal is the prescribed authority for monitoring and enforcing the implementation of the national regulatory framework.

Under the recently completed State Health Systems project in West Bengal, a Healthcare Waste Management Plan had been prepared and implemented. This had supported capacity building of healthcare workers, enhanced awareness of waste management issues, supported linkages with the State Pollution Control Board and allowed for dissemination of equipment and establishment of a waste management system in selected project facilities. Currently, GTZ is in process of developing a waste management strategy for primary healthcare facilities. At the national level the Government of India has developed national policy frameworks and guidelines for implementation of infection control and healthcare waste management systems through its centrally sponsored projects, including Reproductive and Child Health (RCH-II), National AIDS Control Programe (NACP-III) and Tuberculosis Control Program (RNTCP-II).

The Infection Control and Healthcare Waste Management System to be established under the proposed new WBHSD project will build on existing guidelines and frameworks and complement and strengthen previously existing systems. DHFW is expected to develop an Action Plan to implement, support and monitor such a system. Consultation and disclosure of the Action Plan is scheduled for appraisal (May 2007).

6. Safeguard policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[X]	[ ]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[X]	[ ]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[X]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[X]

7. Policy Exceptions and Readiness

[NOT AVAILABLE YET]

Annex 1: Country and Sector or Program Background

INDIA: West Bengal Health Sector Development Project

I. HEALTH STATUS IN WEST BENGAL

West Bengal demonstrates a similar or slightly better health performance compared to the Indian average (Table 1.1), with exception of IMR and full immunization coverage rate among children under two years of age, which are part of the MDG indicators and in West Bengal record significant more positive outcomes in comparison to the national average.

Table 1.1: Selected health indicators for West Bengal and all India average from NFHS-3 (2005-06)

	Name of Indicator	West Bengal	All India
Demography	Infant mortality rate (IMR; per 1000 live births)	48	57
	Total fertility rate (TFR; children per women)	2.3	2.7
Child Nutrition	% children aged 6-35 months who are anemic	69.4	79.1
	% children under 3 years who are stunted	33.0	38.4
	% children under 3 years who are wasted	19.0	19.1
	% children under 3 years who are underweight	43.5	46.0
Child Health	% children 12-23 months fully immunized	64.3	44.0
	% children with diarrhea in the last 2 weeks who received ORS	43.7	26.2
	% children with ARI in the last 2 weeks taken to a health facility	48.0	64.2
Reproductive Health	% mothers who had at least 3 ANC visits for their last birth	62.4	50.7
	% mothers who are anemic	62.6	57.8
	% institutional deliveries	43.1	40.7
	% births attended by health professionals	45.7	48.2
	% currently married women age 15-49 using any contraceptive method	71.2	56.3

Source: NFHS-3 (2005-06)

However, the state is still lagging behind the most advanced states in the South and West in terms of health outcomes.

Table 1.2: Comparative Health Service Coverage and Access Indicators

% children 12-23 months fully immunized	% mothers who had at least 3 ANC visits for their last birth	% institutional deliveries	% births attended by health professionals	% mothers received postnatal care from a health personnel within 2 days of delivery for last birth	% currently married women age 15-49 using any contracep tive method

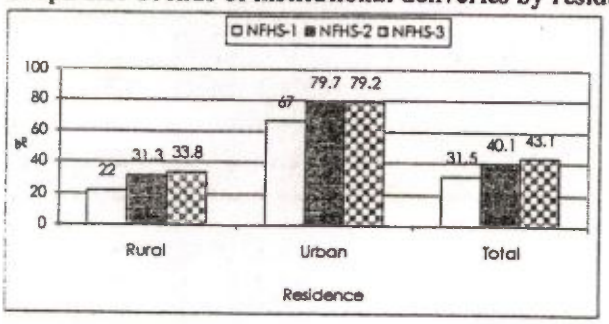
All India	44	51	41	48	36	56
West Bengal	**64**	**62**	**43**	**46**	**38**	**71**
Andhra Pradesh	46	86	69	74	70	68
Karnataka	55	79	67	71	61	64
Kerala	75	94	100	100	88	69
Maharashtra	59	75	66	71	59	67
Punjab	60	73	50	69	55	63
Tamil Nadu	81	97	90	93	90	61

Source: NFHS-3 (2005-06)

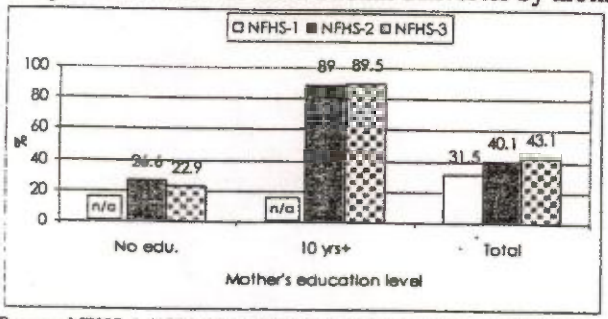
Health inequalities

West Bengal is still a predominantly agrarian state, with 72 percent of its estimated 80.78 million population (fiscal year 2001-02) living in rural areas, and one of the highest proportions of citizens designated as belonging to Scheduled Castes, Scheduled Tribes and contextually disadvantaged groups (5.5 percent of the population in West Bengal is tribal and 23 percent belongs to Schedule Caste). The state is characterized by wide disparities in health outcomes between urban and rural areas, and between different socio-economic groups. For example, people with low education and those residing in rural areas tend to deliver more at home, and not to use formal institutions. Overall, 43 percent of total number of births was delivered in formal institutions (NFHS-3); however, while nearly 80 to 90 percent of mothers residing in urban areas or high educational level chose institutional delivery, less than one-fourth of mothers with none or low education or residing in rural areas did (NFHS-3).

Graph 1.1: Trends of institutional deliveries by residence



Graph 1.2: Trends of institutional deliveries by mothers' education level



Source: NFHS-1 (1992-93), NFHS-2 (1998-99), NFHS-3(2005-06)

A tribal district study found that MMR was equal to 711 per 100,000 among tribal groups in the district, almost four times the estimated state-level average (194 per 100,000) (SIP, European Commission).

Table 1.3 below indicates the *burden of disease* by type of disease at the beginning of the 1990s. The table indicates that in rural areas, West Bengal in the early 1990s still suffered mostly from communicable diseases. The DALY lost due to communicable diseases in rural areas were about 70 percent higher compared to urban population. Urban populations enjoyed much better health outcomes for all types of diseases. However, the epidemiological transition was under way, and the burden of disease was shifting towards non-communicable diseases in urban populations. More recent studies of the burden of disease in West Bengal are not available, but if West Bengal followed the same trend as other Indian states, it is likely that the importance of non-communicable diseases has increased substantially since the early 1990s.

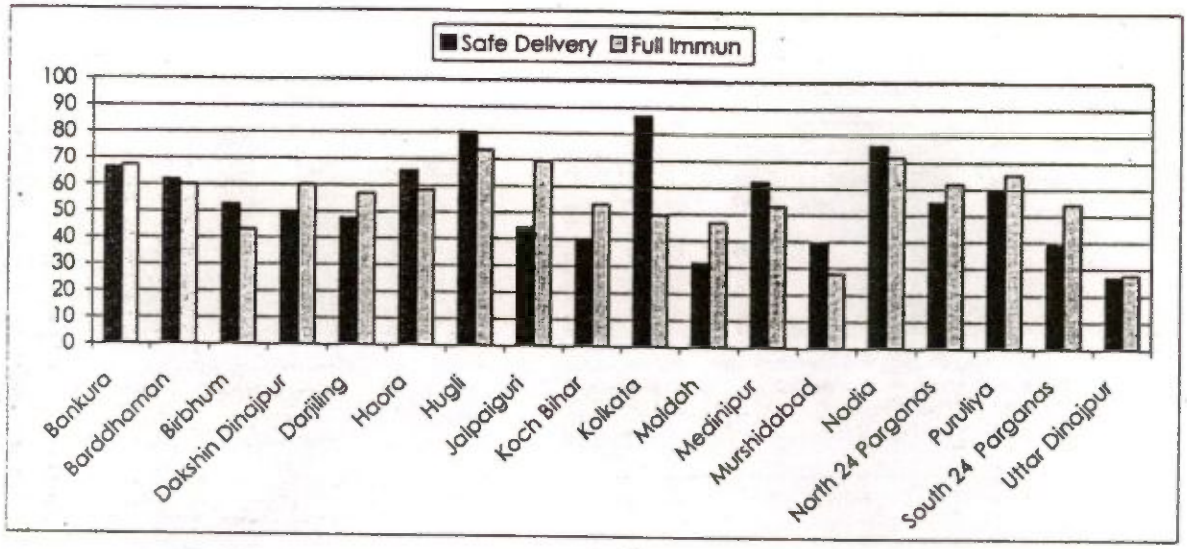
Table 1.3: DALYs (Disability adjusted life years) lost per 1,000 population by major cause groups in rural and urban areas, 1991-92

	DALYs lost per 1,000 pop. *Rural*			DALYs lost per 1,000 pop. *Urban*		
State	Group I	Group II	Group III	Group I	Group II	Group III
Punjab	134.41	73.51	43.86	114.39	56.15	32.08
Maharashtra	148.29	72.25	41.54	100.74	47.87	18.31
Karnataka	165.56	72.78	43.24	109.90	50.27	22.13
West Bengal	**164.6**	**69.14**	**44.03**	**96.66**	**53.84**	**20.29**
Andhra Pradesh	160.04	81.46	47.23	97.67	74.25	30.45

Source: ASCI 2001
Note:
Group I: diseases including pre-epidemiological transition disorders such as communicable diseases, maternal, peri-natal and nutritional deficiency
Group II: diseases including non-communicable diseases
Group III: injuries and accidents

Considerable disparities in performance within the state remain; more than 80 percent of deliveries were recorded as "safe delivery" in Kolkota and Hugli, while only around 30 percent in Uttar Dinajpur and Maldah, according to RCH-II (2002-04) (see Graph 2.1). A similar level of disparity is seen in full immunization coverage for children aged 12 to 23 months.

Graph 1.3: Selected health service indicators from RCH-2 by district

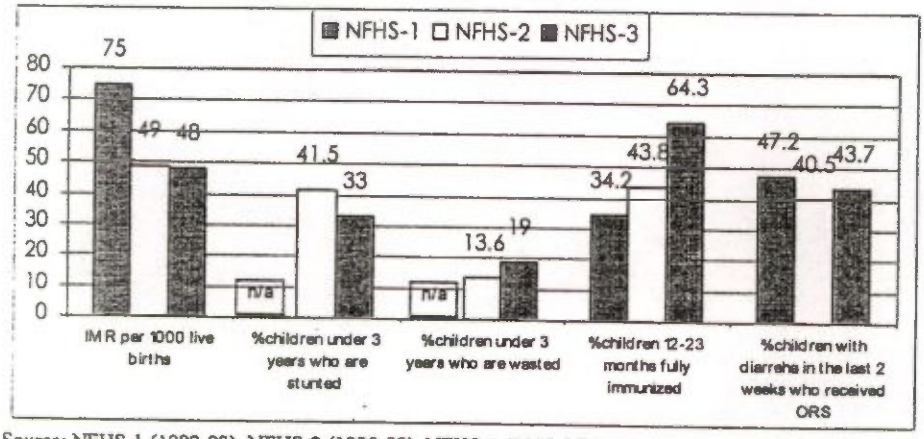


Source: RCH-2 (2002-04)

Progress over the last fifteen years

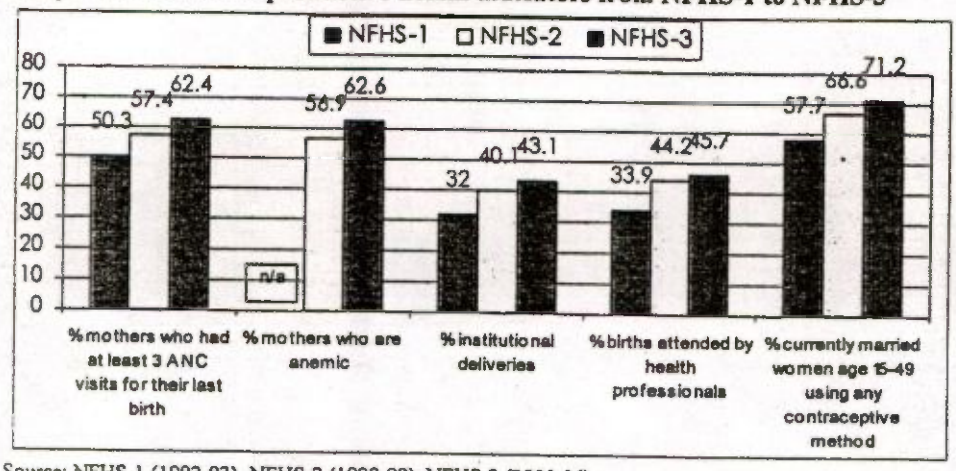
By comparing the NFHS-1 (1992-93) to NFHS-3 (2005-06), one can see that all health indicators in reproductive and child health have greatly improved since the early 1990s. However, the pace of progress between NFHS-2 (1998-99) and NFHS-3 has been slower than between NFHS-1 (1992-93) and NFHS-2 (1998-99), and the progress for some important indicators such as IMR and safe delivery has stagnated in more recent years (Graphs 1.4 and 1.5).

Graph 1.4: Selected child health indicators from NFHS-1 to NFHS-3



Source: NFHS-1 (1992-93), NFHS-2 (1998-99), NFHS-3 (2005-06)

Graph 1.5: Selected reproductive health indicators from NFHS-1 to NFHS-3



Source: NFHS-1 (1992-93), NFHS-2 (1998-99), NFHS-3 (2005-06)

Table 1.4 below illustrates the relationship between the initial level of coverage of institutional, safe delivery and immunization, and their change by district over the period from 1998 to 2002. Some of the most backward districts in terms of the level of service coverage in 1998 also struggled to make a significant change over time; these districts include Murshidabad, Uttar Dinajpur and Maldah. Meanwhile, some districts that started with very low coverage, such as Barddhaman, Dakshin Dinajpur, and Puruliya, made a great progress between 1998 and 2002. Among the districts who started with relatively high coverage, some such as South Parganas, Darjiling, and Jalpaiguri, worsened their level of coverage over the period. Others among the initial "good performers", such as Hooghli and Bankura, further improved their coverage over the period between RCH-1 and RCH-2.

Graph 1.5: relationship between the initial level of coverage of institutional, safe delivery and immunization, and their change by district over the period from 1998 to 2002.

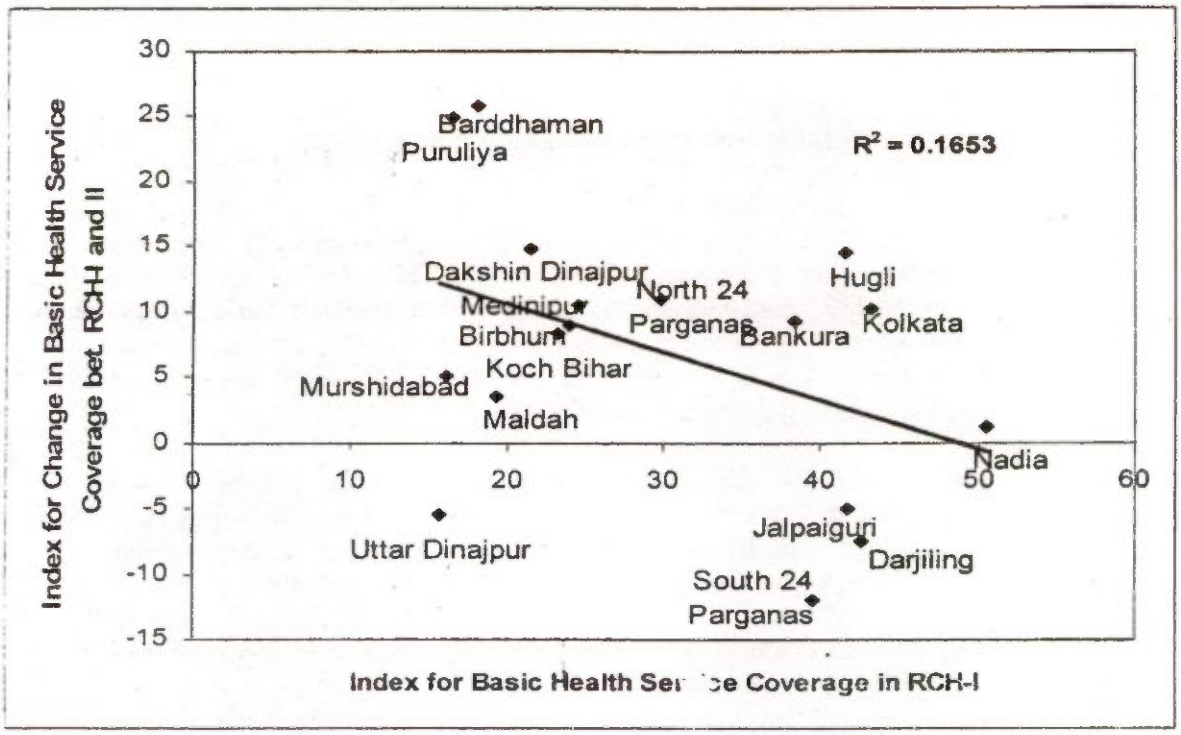


Table 1.4: Change in health service coverage and service coverage status by district

		Health service coverage at RCH-I (1998/99)	
		Low initial coverage	**High initial coverage**
Change in health service coverage between RCH-I and II	**Improved greatly (more than 8.8 change in the composite coverage index)**	Barddhaman	Bankura
		Birbhum	Hooghli
		Dakshin Dinajpur	Kolkata
		Puruliya	Medinipur
			North 24 Parganas
	Did not improve much or further worsened coverage of immunization and delivery services	Koch Bihar	Darjiling
		Maldah	Jalpaiguri
		Murshidabad	Nadia
		Uttar Dinajpur	South 24 Parganas

Source: RCH-1 and RCH-2

Note:

The index was constructed based on the four main service indicators available from RCH-1 and 2: % of institutional deliveries, % of safe deliveries, % of full immunization coverage and % of no immunization coverage. Based on the index ranking, all 18 districts were grouped into four categories: high/low service coverage status, and vast/little progress made between RCH-1 and 2.

Haora district is excluded from the ranking process as the reported percentage change of institutional and safe delivery for Haora district from RCH-1 to RCH-II (from 95 to 56 and 65 percent respectively for institutional and safe delivery) was considered unreliable.

The overall disparities in performance by each district in selected maternal and child health related activities have decreased since RCH-1. However, it should be noted that the gap in the coverage of institutional deliveries and safe deliveries has been widened, while the disparity in full immunization coverage and no immunization decreased. In fact as seen in NFHS1-3, West

Bengal as a whole has made only a marginal progress over the time in delivery related performance. Therefore, reducing disparities in performance among districts needs to be the first priority to accelerate the overall progress as a state.

II. Delivery System and Health Seeking Behavior

The public sector has a large number of health facilities at all levels. The government of West Bengal runs 15 District hospitals, 31 State general Hospitals, 44 sub-divisional hospitals, 95 Rural Hospitals (RH), 252 Block Primary Health Centers (BPHC), 922 Primary Health Centers (PHC), and 10,356 small sub-centers at the village level staffed by Multi-purpose Workers (MPWs). In addition, there are a few urban tertiary hospitals attached to the Medical Colleges. The total number of beds in the public sector is estimated to be equal to 71,074, (58,721, excluding those at the primary care level).

The current GoWB's strategy is to consolidate and upgrade existing infrastructure, rather than further expanding it. While the government would increase the number of sub-centers, it does not intend to add new PHCs/BPHCs. Instead, the plan is to upgrade about one-third of the existing PHCs into BPHCs, and converting all BPHCs into Rural Hospitals.

Primary care sector institutions often lack basic inputs. For example, the results from a recent inventory of services in three districts of West Bengal (Hooghly, Purulia, and Kochbihar) shows that lower level facilities lack critical inputs: about half of the PHCs and one-fifth of the First Referral Units (FRUs) do not have a continuous supply of water, 19 percent of PHCs do not have electricity, in 84 percent a telephone is missing, and in 92 percent a vehicle for emergencies is missing.

The majority of public hospitals are in urban areas. Only 26% of the public hospitals and 11.7% of the public hospital beds (Sub District level hospital downwards) are in rural areas while 74% of the public hospitals and 88.3% public hospital beds are in urban areas, reflecting a disproportionate distribution of facilities since the rural population accounts for 72 percent of the total population.

Currently in rural areas there is one doctor per 4500 population compared to urban area's average of one doctor per 808 population. Critical gap, in staff, persists at the peripheral level, even if availability of doctors to the rural population has improved significantly compared to the position in 1983, when there was only one doctor per 5,386 populations.22

A severe dearth of specialists exists in the rural areas, particularly in respect of the anaesthetists and gynecologists.

The lower level hospitals are technically less efficient. While the bed occupancy rate at District hospitals is pretty high, the same at referral levels (BPHC) is significantly low. It is found that in BPHCs average bed occupancy is 51% whereas the same is 72% in case of RH (Source: Data for January 2004-December2004, Health on the March 2004-05).

[22] Data as on 2004, Source: Health on March 2004-05 – Calculations based on total number of registered allopathic practitioners having recorded their address in the State as on 31.12.04)

Absenteeism appears to be quite high particularly in primary care institutions. A recent study commissioned as part of the World Bank World Development Report 2004 (Chaudhury et al, 2003, Habyarimana et al., 2003, and NRI and World Bank, 2003) found absenteeism rates equal to 43 percent in primary care centres.[23]

There is a broad range of *private providers*, including private (for-profit and charitable) hospitals, modern solo private practitioners, qualified providers of Indian System of Medicine (ISM), small nursing homes (polyclinics) and medical diagnostic centers, traditional birth attendants, known as dais, and unqualified or not-fully qualified providers (e.g. rural medical practitioners, or RMPs). Detailed information is not available on the size of the private sector delivery system, or on its break-down among different types of providers. Most people in West Bengal seek care from the private for profit sector for outpatient care, but utilize public hospitals for inpatient care. NSS data from 2004 revealed that about 80 percent of outpatient care was catered for in the private sector. A different pattern prevailed with respect to inpatient care, where the public sector still dominates: 65 percent of inpatient cases in urban and 79 percent in rural areas were catered for in the public sector.[24] However, the utilization of private facilities has been increasing steadily since the previous NSS in urban areas (28 percent in the NSS 52nd round and 35 percent in the NSS 60th round).

Table 1.5: Percentage distribution of outpatient care by type of facility and geography

		NSS 42nd (1986-87)	NSS 52nd (1995-96)	NSS 60th (2004)
Rural	Government	16	15	19
	Private	84	85	81
Urban	Government	20	19	20
	Private	80	81	80

Table 1.6: Percentage distribution of hospitalized care by type of facility and geography

		NSS 52nd (1995-96)	NSS 60th (2004)
Rural	Government	82	79
	Private	18	21
Urban	Government	72	65
	Private	28	35

Source: NSSO, 1995-96 and 2004-05 survey rounds

The same pattern is observed for deliveries. According to the information from RCH-II, in 2002 34 percent of total number of births took place at public institutions, 52 percent at home, and 14 percent of total number of delivery occurred in private institutions.

The evidence also indicates that the poor use private sector providers for outpatient care as well. Formal private sector providers are utilized more for major ailments, and informal private providers for minor ailments. According to the study in three districts cited before (reported in HFWB, 2002), among the poorest 25 percent of the population 38.6 percent used private

[23] Absenteeism is measured as the percentage of staff who are supposed to be present but are not on the day of an unannounced visit. It includes staff whose absence is "excused" and "not excused".

[24] The national average demonstrated the different trend in inpatient care – only around 40 percent both in rural and urban areas utilized public sector hospitals (NSS 2004).

providers for major ailments (both inpatient and outpatient care), while 57.7 percent used informal providers (RMPs) for minor ailments.

III. Health Expenditure and Financing

Households' Out-of-Pocket Expenditure

The two main types of expenditure on health goods and services by source of financing are households' out-of-pocket (OOP) expenditure and government expenditure. A 2002 study by the Indian Institute of Health Management Research (IIHMR) estimated OOP in West Bengal at about Rs. 480 per capita (Rs. 694 in urban areas, and Rs. 242 in rural areas), or about two-thirds of total per capita health expenditure. Data from NSS 2004-05 would indicate a higher per capita OOP expenditure, equal to Rs. 716. According to the NSS survey more than two/thirds is spent on outpatient care services and drugs, since the latter are normally utilized much more frequently than hospital inpatient care.

Table 1.7 Per capita OOP expenditure on health care-West Bengal, 2004-05, Rs.

Total per capita expenditure	2004	1996	Implicit annual rate of medical inflation-1996-2004
HOSP	166.8	50.8	0.158
Non-HOSP	550.1	204.6	0.13
Total	716.9	255.4	0.136

Source: NSS 2004-05 and 1995-96

Government Expenditure

Government expenditures on health goods and services in West Bengal are mostly reflected in the state budget under the DHFW, but there is also a substantial component of off-budget financing from GOI. The information for this section was extracted from the Draft Mid-Term Expenditure Framework (MTEF), Technical Assistance Support Team, DHFW, February 2007.

Table 1.8 below shows actual state health expenditure for 2004-05 and 2005-06, and the budget estimates for 2006-07, by major heads of the budget's (functional) classification. West Bengal in 2003-04 ranked fourth in the nation in terms of the share of health in total state budget.[25] Nonetheless, growth of state health expenditure has been low in recent years. The annual compound rate of growth of this expenditure was about seven percent in the period from 1999-00 to 2005-06, but adjusted for inflation it was only slightly higher than one percent.[26] However, as shown in Table 1.8, a large (nominal) increase of 25.6 percent is budgeted for 2006-07. The

[25] The share of DHFW budget in total state budget has been rising in the past three years, from 4.48% in 2004-05 (actual expenditure) to 5.07% in 2006-07 (as per budget estimates).

[26] The overall fiscal situation of West Bengal has been difficult in recent times. The state sustained a sharp deterioration in its fiscal situation in the 1990s, with the gross fiscal deficit reaching a peak of around 10 percent of the state Net Domestic Product by 1999-2000. In the current decade West Bengal has been striving to bring its fiscal deficit down.

increase reflects in part expected budget support from DFID, but the state's own resource commitment is also planned to go up by a very substantial 22 percent between 2005-06 and 2006-07.[27] Actual execution of this sharply higher budget will undoubtedly be a challenge.[28]

In addition to the expenditures which are budgeted in the DHFW budget, as already noted there are also substantial government health expenditures not reflected in that budget. These are expenditures funded by GOI as grants, mainly executed through the Health and Family Welfare Societies. They include expenditures funded under NRHM (including RCH II), NACO, and some other categories such as GOI funding for the cancer control program. In 2006-07 these off-budget health expenditures in West Bengal would probably amount to about Rs. 430 crores (of which three-fourths from NRHM). These expenditures are not included in Table 1.8. Hence, adding on-budget and off-budget expenditures, the total government health expenditure expected in 2006-07 would be about Rs. 2,300 crores.

Table 1.8: West Bengal, DHFW Expenditure, 2004-05 to 2006-07 (in Rs. Crore)

	2004-05 (actual)	Share (%)	2005-06 (actual)	Share (%)	2006-07 (BE)	Share (%)
Rural Health Services	246.14	18.3	351.44	23.7	450.74	24.2
ISM&H (rural and urban)	46.26	3.4	46.82	3.2	54.16	2.9
Urban Health Services	639.65	47.6	635.09	42.8	774.21	41.5
Medical Education and Research	115.85	8.6	140.99	9.5	212.49	11.4
General	15.18	1.1	26.20	1.8	32.97	1.8
Public Health	121.98	9.1	114.72	7.7	156.71	8.4
Family Welfare	157.01	11.7	168.58	11.3	181.68	9.7

[27] By "the state's own resource commitment" we mean the portion of DHFW budget that is not funded from either GOI grants or bilateral donors' grants. In 2006-07, out of a total DHFW budget of Rs. Crore 1,865.76, about 13 percent is expected to be funded by DFID, and about seven percent from the GOI (the latter for Family Welfare).

[28] In 2005-06, actual DHFW expenditure (Rs. 1,485 crores) represented about 87 percent of the BE figure (Rs. 1,709 crores). The level of execution had been higher in the previous two years, at about 94 percent of the BE figures.

Hill Areas	0.60	0.04	1.50	0.1	2.80	0.2
Total	1,342.68	100.0	1,485.34	100.0	1,865.76	100.0

Source: DHFW MTEF, September 2006

The functional classification in Table 1.8 does not make it immediately apparent what expenditures can be considered to be for primary, secondary and tertiary health care respectively. In the above-mentioned MTEF, however, the data have been reshuffled into a more transparent functional classification which is shown in Table 1.9 below. It can be seen that the share of the Primary sector has gone up by three percentage points since 2004-05 and is now about 43 percent, while the share of the Secondary sector has fallen by about the same number of percentage points and is now about 28.5 percent. The share of the Tertiary sector (which includes the main medical colleges and hospitals as well as expenditures on Medical Education and Research) is currently about 22 percent. The remaining 6 percent (in 2006-07) is accounted for by Direction and Administration and miscellaneous expenditures under the major heading "General".

Table 1.9: West Bengal, Functional Classification of DHFW Expenditure, 2004-05 to 2006-07 (In Rs. Crores)[29]

	2004-05 (actual)	Share (%)	2005-06 (actual)	Share (%)	2006-07 (BE)	Share (%)
Primary Sector	544.35	40.54	650.97	43.83	805.80	43.19
Secondary Sector	426.31	31.75	432.12	29.09	532.85	28.56
Tertiary Sector	293.46	21.86	312.52	21.04	415.92	22.29
Direction and Administration	63.37	4.72	63.55	4.28	78.22	4.19

[29] In arriving at the sector allocation in this table, the following grouping of the budget items was followed by the authors of the West Bengal MTEF:

Primary sector: (i) rural health services excluding hospitals and dispensaries; (ii) ISM&H, both urban and rural; (iii) public health excluding direction and administration; (iv) family welfare, excluding direction and administration; (v) hilly areas; and (vi) 40 percent share in medical store depots.

Secondary sector: (i) hospitals and dispensaries under RHS; (ii) hospital and dispensaries under UHS, excluding main medical colleges and hospitals; (iii) other UHS, excluding direction and administration; and (iv) 60 percent share of medical store depots.

Tertiary sector: (i) main medical colleges and hospitals (Medical CH, NRSM, SSKM, KNM, RGKM, TB hospital, and Mental Hospital); and (ii) MERT.

Direction & Administration: to keep the calculations simple, Direction & Administration was not apportioned among the three sectors (primary, secondary and tertiary).

General: likewise, expenditure under the budget head "General" was not apportioned among the three sectors.

General	15.18	1.13	26.20	1.76	32.97	1.77
Total	1342.68	100.0	1485.34	100.0	1865.76	100.0

Source: DHFW Draft MTEF, September 2006

DHFW expenditure by object category (i.e., "economic" or "object" classification) for the period 2004-05 to 2006-07 is shown in Table 1.10 below. It may be noted that the share of Salaries & Wages has declined by about 10 percentage points during the period, from 71.6 percent in 2004-05 to 61.3 percent in 2006-07, though in absolute terms there would be an increase in this category from 2004-05 to 2006-07 of about 19 percent in nominal terms. The share of Drugs has gone up marginally and is now 6.6 percent. The share of Non-Salary Grants has been rising rapidly, from 1.3 percent in 2004-05 to 6.6 percent in 2006-07, reflecting greater transfers to Gram Panchayats and Health and Family Welfare Societies (Samitis) at different levels. However, a significant part of such grants remains unspent and is kept in the respective bank accounts.

With regard to *equity aspects* of government health expenditure, existing studies based on data from the mid-1990s suggest that such expenditure disproportionately benefits the rich. The ratio of subsidy to richest versus poorest 20 percent of the population in West Bengal at that time was 2.73 (Mahal et al. 2001), mainly because expenditure on public hospitals was pro-rich. For inpatient care, while 43.9 percent of the population was estimated to be below the poverty line, they utilized only 29.9 percent of inpatient bed-days. These figures would rank West Bengal as average in terms of equity in India, worse than most Southern and Western Indian states, but better than most Northern and Eastern states. Moreover, the studies suggest that hospital care is pro-rich even with regard to their outpatient component. NSS-based (1995-96) evidence shows that hospital-based outpatient care favored those above the poverty line, while PHC-based outpatient care favored those below the poverty line (Mahal, Yazbeck, Peters and Ramana, 2001).

It is important to note, however, that the above results are based on data that is already ten years old. In the meantime, there has been rapid growth of the private hospital sector in West Bengal, especially in urban areas, so it is likely that many of the more affluent households have switched to using private rather than government hospitals.

Table 1.10: West Bengal, Object Classification of DHFW Expenditure, 2004-05 to 2006-07 (In Rs. Crores)

	2004-05 (actual)	Share (%)	2005-06 (actual)	Share (%)	2006-07 (BE)	Share (%)
Salaries and Wages	960.89	71.6	1013.17	68.2	1144.0	61.3
Office expenses	48.80	3.6	50.07	3.4	60.25	3.2
Rent, rates and taxes	2.59	0.2	2.98	0.2	5.82	0.3
Maintenance	9.99	0.7	12.60	0.8	15.16	0.8

Materials and Supplies	126.55	9.4	121.68	8.2	177.62	9.5
Of which Drugs	(83.68)	(6.2)	(92.06)	(6.2)	(123.14)	(6.6)
Works	65.16	4.9	62.35	4.2	166.14	8.9
Machinery and Equipment	36.39	2.7	45.97	3.1	76.24	4.1
Vehicles	7.31	0.5	1.91	0.1	14.73	0.8
Grants	22.08	1.7	116.73	7.8	128.86	6.9
Of which Non-salary	(16.90)	(1.3)	(110.34)	(7.4)	(122.66)	(6.6)
Other Expenditure	62.93	4.7	57.89	3.9	76.86	4.1
Total	1,342.68	100.0	1,485.34	100.0	1,865.76	100.0

Source: DHFW Draft MTEF, September 2006.

IV. Previous Bank-assisted projects in West Bengal's health sector

In recent years the state has introduced some health improvements through projects with various donors. These have lead to renovation and upgrading of selected hospitals and health centers, introduction of quality improvement programs for hospitals, some improvements in the efficiency of hospital management, and introduction of certain reforms in governance at the district level. There has been an increase in utilization of secondary and tertiary public facilities, and some perceived enhancement in quality of care. However, the evidence shows that, despite progress, much remains to be done to improve the performance of the public institutions. The situation is more problematic in the rural areas, because in those areas the private formal sector is less capable of filling the gaps left by the public sector. Moreover, new infrastructure investments and increased staff numbers have led to increases in recurrent costs by as much as 8percent.

The State Health Systems Development Project (SHSDP II)

The World Bank funded a State Health Systems Development Project (SHSDP II), from June 1996 to March 2004, through an IDA Credit of US$...million equivalent. The project strengthened the infrastructure for the government's secondary care sector and introduced a series of significant managerial innovations.

Facility upgrading. Facilities upgraded included 214 hospitals (18 district hospitals, 61 sub-divisional/ state general hospitals, and 95 rural hospitals) and 36 health centres (8 BPHCs and 28 PHCs) in the remote areas of Sunderbans.

Health management information system (HMIS). The project introduced significant changes in HMIS. A HMIS manual was developed, and a system of *monthly report* of performance indicators for all hospitals in the state and *quarterly report* of performance and efficiency for district/state government/sub-divisional/rural hospitals and BPHCs was introduced. Prior to the project's establishment, there was no performance culture in the DHFW. Without computerization of records and a strong MIS system, records were irregular and erratic. The new HMIS has made possible a better record-keeping of inputs and outputs, and could help managers set basic targets for their facilities. Unfortunately, the lack of initiative and the lack of managerial capacity have so far hindered the full utilization of the HMIS analysis to improve accountability and hospital management.

Establishment of Quality Assurance Programme in Secondary and Tertiary Hospitals. The project was instrumental in establishing a system for grading the performance of hospitals. To this effect, 14 quality indicators have been selected[30], and each hospital has been graded according to its performance on those 14 quality indicators. This has created positive peer pressure and increased awareness of performance among service providers.

Other managerial reforms. Several other management reforms were introduced together with the project. First, greater autonomy has been introduced at the facility level, with delegation of administrative and financial powers to Principals of medical Colleges, Chief medical Officers, Superintendents of hospitals and Assistant Chief Medical officer for health. Second, the DHFW committed to introduce a more rational and transparent transfer policy for medical staff. Third, doctors have been hired on a contract basis. Fourth, non-clinical services, such as scavenging, security, diet, and cleaning, have been contracted out to the private sector. Progress is also been made in establishment of diagnostic facilities in hospital premises in joint venture with the private sector.

Introduction of bio-waste management techniques. The DHFW also improved bio waste management techniques separating hospital waste into three categories of (i) hazardous materials, (ii) infectious waste and (iii) generic waste. This system is working fairly well, with the exceptions of a few facilities that were identified in a recent health audit.

Outputs. The project led to some positive developments in the management of the government's secondary and tertiary care institutions, which were reflected in a larger volume of outputs. Table 1.11 summarizes the improvements in key performance indicators observed during the first seven years of the project. The improvement in performance is higher in Rural Hospitals, and for lab tests and other diagnostic tests.

The number of deliveries performed by public hospitals has also increased (more in DH and RH than in SDH/SGH hospitals). However, these hospitals seem not to have been able to take on the lead role of providers of emergency obstetric care, which is one of the most important functions they were meant to fulfill. Presently, only about one fourth of the total number of deliveries is estimated to take place in the facilities rehabilitated by the project. Lack of key specialist staff, such as anesthesiologists and gynecologists, lack of support staff, lack of key medicines and other supplies, dual-job holding by most doctors, all these factors hamper the full utilization of the secondary care facilities for obstetric cases.

[30] These include: emergency admission rate, use and content of display board at entrance, bed turn-over rate, filling of Bed Head Tickets, referred patients (in and out), new-born death rate, segregation of waste, number of major and minor surgeries, testing of drinking water quality, cleanliness of hospital, doctor's attention to patients' queries.

According to the patient satisfaction surveys (which were repeated three times over the period 2000-02), significant improvements have also been achieved in availability and courteousness of doctors and nurses. For inpatient care, nursing care was reported as the most important contributing factor to patient's satisfaction/dissatisfaction in 30 percent of the cases; second factor was doctors' attention (26 percent of cases). The latter was by far the most important factor for OPD (80 percent of cases). Some of the more problematic indicators at the time of the first survey have shown improvements in subsequent surveys. Over 83 percent of the patients reported to be satisfied of the services received.

The surveys also show that outsourcing sanitation and other non-clinical services has lead to significant improvements in facilities' cleanliness and appearance. The more recent patient survey indicated 76 percent of patients were satisfied with the cleanliness of the facilities, compared to 61 percent two years before. Finally, the surveys show that the hospitals have been able to attract an increasing number of people belonging to the poorest 20 percent of the population (an estimated additional 0.2 million).

Lack of broad ownership of the reforms. The project has been less effective in promoting change and in being a spearhead for systemic/structural reforms. For example, the project intended to promote innovations in health financing, protect and increase the share of the state public expenditure for health or reallocate resources in favour of non-salary expenditures. By and large, these objectives were not achieved. The project has hardly had any influence at the level (mostly in the Department of Finance) where decisions concerning the size and composition of health expenditure are taken. Also, its influence on the Department of Health and Family Welfare as a whole has not been decisive. Managerial improvements have been largely limited to the secondary and tertiary sector and in the facilities supported by the project, and so to some extent controlled by the Project Management Unit. The rest of the system does not seem to have been improved. For example, the primary sector, where the problems of absenteeism, lack of medicines, etc are more severe, does not seem to have been influenced by the changes occurring in hospitals.

Table 1.11 Key performance indicators 1997 – 2003

Performance Indicators	Type of facility	1997 (baseline)	2003	Rate of Increase 2003 over 1997
OPD per month per hospital	DH[31]	15,348	19,632	27.9%
	SDH/SGH[32]	7,998	10,967	37.1%
	RH[33]	6,081	9,113	49.9%
IP per month per hospital	DH	2,338	3,045	30.2%
	SDH/SGH	1,104	1,243	12.6%
	RH	257	402	56.4%
Bed occupancy rate (%)	DH	81.2	90.1	11.0%
	SDH/SGH	74.2	85.0	14.6%
	RH	47.9	82.3	71.8%
Average length of stay	DH	5.30	4.22	-20.4%
	SDH/SGH	4.10	4.06	-1.0%
	RH	3.30	2.91	-11.8%
Average monthly X-rays done	DH	779	1273	63.4%
	SDH/SGH	321	473	47.4%
	RH	40	129	222.5%
Percentage of inpatients and outpatients receiving laboratory tests	DH	10.50	15.09	43.7%
	SDH/SGH	5.65	9.67	71.2%
	RH	3.54	5.64	59.3%
Percentage of major surgeries to admissions	DH	7.81	10.27	31.5%
	SDH/SGH	6.78	7.98	17.7%
Percentage of deliveries to admissions	DH	17.20	18.09	5.2%
	SDH/SGH	18.68	18.66	-0.1%
	RH	22.29	19.7	-11.6%

Source: DHFW, Government of West Bengal

The ownership of reform programs has remained weak and their implementation has lacked vigor. The existing style of governance and the overall culture in which the bureaucracy operates does not provide strong incentives for creative thinking or innovation. The general tendency among many is to protect the status quo, and top level bureaucrats do not have interest in addressing sector policy or strategic issues, also because of short tenures. There is a very limited scope for mutual learning or for taking decisions which may be politically risky. In this context, the reforms and the managerial improvements implemented in the state in the last few years have been achieved mainly thanks to the extensively hard work of few key but isolated individuals.

Under utilization of the secondary care facilities. Although the secondary sector oversaw a tremendous increase in the number of in-patient and outpatient cases, there are signs that capacity is still not being fully utilized, particularly in rural hospitals. The overall impression is that the new facilities are being run as successful OPD centers that also cater for minor surgeries such as

[31] District Hospitals
[32] Sub-Divisional Hospitals/State General Hospitals
[33] Rural Hospitals. Rural hospitals correspond to Community health Centers of other states in India

appendectomy and surgical sterilization, whereas due to lack of specialists and other support staff they are not fully utilized for more complicated treatment, or utilized after-hour. The facilities which are functional are well utilized between 9.00am and 3.00pm. In the late afternoon, patients disperse as all but one doctor leaves the building and a skeleton staff is left to run the facility.

Increased capacity has not yet led to a sufficient increase in institutional deliveries. Partly due to the problems outlined above, the secondary and tertiary hospitals currently attend roughly 23-24 percent of the total births in the state[34]. The secondary facilities have not yet been able to take a more significant role as providers of emergency obstetric care. The district and sub-district hospitals are doing better than the sub-division and rural hospitals.

In conclusion, the experience of the State Health Systems' project shows that progress in performance is directly linked not only to capital investment, but to better human resource management, and to increased recurrent inputs (maintenance, drugs, skilled manpower, etc.). Improving primary care is also essential to create a well-functioning referral system which could lead to a better utilization of secondary and tertiary care facilities. The qualitative aspects of working force, especially motivation and attitude, still remain an area of concern.

The India Population VIII project

West Bengal also benefited from the World Bank-supported India Population VIII project, which sought to bring family welfare services to urban slums. In West Bengal it covered a population of 3.8 million in three municipal corporations and 38 municipalities. The project has brought about significant improvements in the health system coverage of slum populations, and has produced important innovations in the engagement of NGOs in service provision. The successful grass-root service delivery model initiate during IPP-VIII could be used as an example to be replicated to the rest of the state (which would be the case under the proposed project).

V. HEALTH SECTOR POLICIES AND REFORMS

The Health Sector Strategy 2004-2013

In 2003, the GoWB (through the DHFW) formulated a *Health Sector Strategy* for the ten-year period 2004-2013 (HSS 2004-13). The concept was that the Department would adopt a ten-year strategic planning framework for its activities, from which more detailed operational plans (initially annual plans, and later three-year rolling plans) would be specified and reflected in the annual budgets. The new approach was expected to introduce a greater rationality to the process of allocating resources for the government health services, which hitherto was dominated by a year-by-year incremental approach. The approach was also expected to ensure that all significant external funding in health was in line with the state government's views of health priorities and strategies. The HSS also highlighted several other broad policy goals/principles: (i) to ensure that

[34] Hospitals, Sub Divisional Hospitals, State General Hospitals and Rural Hospitals in the State attended 391,097 deliveries in 2003, 24% of estimated annual total no. of births (1,666,139) in West Bengal.

the whole population has access to a range of evidence-based and affordable health promotion and prevention services; (ii) to promote appropriate health-seeking behavior by all citizens; (iii) to ensure universal *equity of access* to simple curative and emergency services; (iv) to ensure that quality Primary Health Care remains pre-eminent as the central strategic health priority for the state, and that this is reflected in the budgets over the next ten years; (v) to ensure that the health systems necessary to provide such services in an accountable and cost-effective manner are developed and strengthened in line with international best practice; and (vi) actively engage in partnerships with Panchayati Raj institutions, civil society groups, NGOs, donor agencies, the private sector, and other development partners to assist in realizing the Department's mission.
The HSS also set a range of health outcome indicators and goals, mostly pertaining to maternal and child health (lowering neonatal and infant mortality, lowering maternal mortality, raising the proportion of deliveries by skilled attendants, raising the proportion of institutional deliveries, lowering the total fertility rate, raising the couple protection rate, raising the percentage of fully immunized children, and containing the spread of HIV/AIDS in the state). DHFW established a Strategic Planning and Sector Reform Cell (SPSRC) to guide the further development of the strategy and operational plans. Moreover, DHFW recognized from the outset that the HSS ought to be a "living document".

The Health Sector Development Initiative (HSDI)

Subsequent to issuing the HSS 2004-2013, the DHFW worked with DFID in developing the Health Sector Development Initiative (HSDI). The HSDI is *a sector reform and development program* to be implemented over the five-year period 2005-06 to 2009-10. It seeks to translate key aspects of the HSS into specific activities and policy/institutional reforms, which are specified in the HSDI's Matrix of Milestones. The Matrix, which is revised on an annual basis, contains a set of "Expected Outcomes by End of Program", the *milestones* for the corresponding year, and a brief summary of progress achieved in reaching the milestones of the previous year.

The HSDI has financial and technical assistance support from DFID. The financial support is in the form of a budget support grant of GBP 97.5 million over five years, to be released in five annual tranches, with release of each tranche conditional on satisfactory progress by the GoWB in achieving the corresponding set of annual milestones. DFID has released the first two tranches of its support. DFID has also agreed to provide funds for technical assistance for up to a value of GBP 2.5 million over five years.

The *HSDI Matrix of Milestones for 2006-07* is attached at the end of this Annex. Below, an attempt has been made to re-group the various strategies/developmental activities in the Matrix along six "reform goals", in order to provide a more straightforward picture of the logic of the program:

Reform Goals	Strategies/Developmental Activities
1. Get more money (resources) for government-funded primary health care services.	-Increase share of DHFW in state budget. -Increase share of primary sector in DHFW's budget. -Allow health facilities to retain and spend revenue from user charges.
2. Ensure better value for public money spent on health, including	-Improve procurement and financial management. -Improve preventive maintenance of buildings and equipment. -Introduce better inventory management system for drugs.

foreign assistance.	-Improve monitoring and evaluation of health services (develop HMIS system, link primary and secondary data, strengthen capacity for data analysis at DHFW). -Improve planning/budgeting [develop the capacity of the SPSRC, conduct rolling MTEFs, prepare overall DHFW Annual Plans, prepare evidence-based District Plans, prepare annual budgets consistent with Annual Plans]. -Ensure that all donor assistance, whether loans or grants, is in line with the state government's health sector priorities and strategies. -Conduct periodic Public Expenditure Tracking Surveys.
3. Improve capacity for the provision of government-funded primary health care services, especially in maternal and child health, and improve the quality of government services.	-Upgrade one PHC in each block into a 10-bed facility (a total of 342 PHCs to be upgraded). -Upgrade each BPHC into a 30-bed facility, except for those in localities where there are already Rural Hospitals or Sub-Divisional Hospitals/State Government Hospitals (a total of 242 BPHCs to be upgraded). -Establish Neonatal Care Centers at all District Hospitals and "stabilization units" for neonates in all BPHCs and Rural Hospitals. -Make Rural Hospitals able to function as First Referral Units, including for obstetric care. -Expand mobile health care services in remote areas (Health Camps to be held on a fixed day and fixed time each week at all Gram Panchayat Headquarters in the state). [Note: though not mentioned in the HSDI Matrix, the government also plans to add 4,800 non-Gram Panchayat sub-centers and 2,091 Gram Panchayat sub-centers in the period 2006-07 to 2010-11]. -Increase budget for medicines at the primary level. -Develop an overall strategy and action plan for improving access to health services by the poor/disadvantaged. -Improve management of human resources by DHFW, inter alia to reduce absenteeism and better staff rural health facilities (where many vacancies exist). -Introduce supervision of health functionaries by PRIs. -Develop Public-Private Partnerships. -Conduct periodic User Satisfaction Services. -Develop a service quality index, design total quality framework, initiate measurement of service quality.
4. Enhance demand for basic health services by underserved population groups.	-Develop and implement Behaviour Change Communication Strategy. -Design/implement voucher schemes for safe delivery, NGO-managed ambulance service.
5. Reduce households' financial risk associated with disease episodes.	-Pilot health insurance program, scale up if successful/sustainable.
6. Improve value for money for consumers of privately-provided, privately-financed health services.	-Improve accreditation and regulation systems for quality assurance in the private sector.

The HSDI starts with the premise that for health outcomes in the state to improve further, more resources would be needed for publicly-funded primary health care (reform goal number 1 in the table above). To this effect, the program seeks a higher priority for DHFW in the overall state budget as well as a higher priority for primary health within the DHFW budget. Provided total state government expenditure grows in real terms (or at least does not decline), the above adjustments in priority would lead to increased resources for primary health care. This would be complemented by revenues from user charges.[35]

Second, the program highlights the importance of spending public resources in the health sector more efficiently (reform goal number 2). Such greater efficiency is to be pursued through certain basic management reforms (in procurement, financial management, drug management), better information collection for decision-making (HMIS improvements, tracking of public expenditure surveys), and an overhaul of the planning and budgeting processes that would introduce a medium-term perspective and give the districts a greater say in resource allocation.

Third, the additional resources accruing to DHFW would be used to increase the capacity of the government's primary health sector to serve the public, by providing better access to services and achieving better quality (reform goal number 3). This would entail not only deploying additional inputs of infrastructure and staff, but also improvements in personnel management and supervision (inter alia to reduce absenteeism and reduce vacancies in less desirable locations), and the systematic measurement of service quality in both its technical and non-technical aspects (the latter through user satisfaction surveys). A special effort would be made to improve access to essential services by the poor/disadvantaged.

Fourth, improvements on the supply side would be complemented by an enhanced demand for essential health services by underserved population groups (reform goal number 4), by improving these groups' knowledge of health issues and services and by lowering financial barriers to using services trough experimentation with voucher schemes.

Fifth, the HSDI would entail the piloting of health insurance programs. If successful and scaled up, such programs would help reduce the financial risk households face on account of expenses associated with episodes of disease (reform goal number 5).

And, finally, in recognition of the large and increasing share of health services which are provided in the private sector, the HSDI would include measures in the areas of regulation and accreditation of private providers.

The HSDI entails a rich and ambitious program of reform and development for the health sector. Significant progress has been made so far in a number of areas, as summarized in the attached *HSDI Matrix of Milestones for 2006-07.*

[35] As of February 2006, government health facilities in the state of West Bengal are allowed to retain and spend 40% of revenues from user charges they collect. The remaining 60% is to be deposited with the District Health and Family Welfare Societies (Samitis), which in turn will allocate these funds to various health care facilities in the district on the basis of need.

Other Assistance for the Health Sector from DFID

In addition to its support for HSDI, DFID is also providing funding for Urban Health Services (about Rs. 116 crores for the four-year period 2006-07 to 2009-10), and for Medical Education and Research (about Rs. 87 crores for the same period).

Assistance for the Health Sector from Other Donor Partners

The EC-supported *Sector Investment Program* is scheduled to close in March 2007. The anticipated funding for 2006-07 is about Rs. 25 crores.

The KfW-funded Basic Health Project is scheduled to close by the end of 2007-08. Anticipated funding is about Rs. 70 crores for 2006-07 and Rs. 106 crores for 2007-08.

Annex 1 -Continued

HSDI Matrix of Milestones for 2006-07

Key Issues	Measures planned 2005/6	Progress from 2005/6	Milestones for 2006/7	Expected Outcomes by end of programme
1 Strategic and Policy Framework	Action Plan linked to DHFW Budget for 2005-6 developed which reflects SF priorities	A Core Group of Officers identified in the Department to carry forward the process on long term basis. Annual Plan for 2006-2007 prepared	**1. Annual Plan 2007/8 prepared; flows from MTEF; uses information from District Plans 2007/8 ; feeds into national and state budget cycle and is linked to measurable performance indicators - Use of funds by the District Health Societies (Base year – 2005-2006)**	1. Annual DHFW plans and budgets operate within a rolling sector strategy framework.
	SPSRC role and vision established Capacity building plan agreed by Mar. '05 & implementation started	GO on establishment of SPSRC has been issued on 31 March. Staffing in progress.	**2. Health Reform Communication Strategy framed and initiated for better communication with the health care providers. Mainly through Newsletter, periodic workshops and discussions.**	2. DHFW playing a stewardship role in overseeing implementation of the strategy.
	New donor assistance for 2006-07 aligned with the strategic priorities	Joint-reviews taken place with DFID and World Bank	**3. Donors support a common performance monitoring framework for HSS.**	3. New donor programmes are harmonised around the DHFW strategy.
	Evidence-based health plans produced for 4 of the poorly performing districts, reflecting priority actions in HSS and linked to devolved finances (ref Human Development Report for poor-performing districts) Capacity building plan for district Health, PRI and other stakeholders developed and initiated	ToR for supporting district planning process agreed and EOI has been placed. District Planning framework developed as part of Annual Planning process. TOR for field testing of district template approved and TAST network partner begins assignment.	**4. All District Plans 2007/8 include an evidence based Maternal and Neonatal care plan, with interventions prioritised according to the district situation**	4. District planning processes well established and responding to local health priorities. DoHFW uses the district plans for allocation of resources.
2. Additional measures to meet HSS targets & MDGs	Detailed reviews carried out and implementation plans developed & initiated for: • Upgrade one PHC in each block into a 10 bedded facility & each BPHC into a 30 bedded facility • Neonatal Care Centres at all District Hospitals and stabilisation units in all BPHCs / RHs. • Functional Basic Obstetric Care Centres at Rural Hospitals • Expansion of Mobile health care system in remote areas	*Facility upgradation* In progress. BPHCs are being upgraded under different health programmes (HSDI - 40, NRHM - 42 & Basic Health Project - 67). The work is in different stages of progress. Some of the BPHCs, PHCs and Sub Centres where up-gradation was taken up under BHP (Phase-I); and RIDF-IX have been handed over. Rest are in advanced stage of completion. *Maternal & Neonatal*	**5. 26 Rural Hospitals operationalised as First Referral Units and their functioning monitored.** **6. Progress on key indicators** • Percent of pregnant women delivering in a public health facility • Percent of children fully immunised • TB Case detection and treatment success rate • Malaria Prevalence Rate • Number districts where Leprosy is eliminated	1. IMR reduced from baseline of 51 to 35 by eop (2010 target: 21). 2.MMR reduced from baseline of 250 to 150 by eop (2010 target: 70) 3. 50% increase in institutional deliveries in poorer districts (baseline < 35%). 4. 50% increase in child immunisation rates in poorer districts (baseline < 30%).

Key Issues	Measures planned 2005/6	Progress from 2005/6	Milestones for 2006/7	Expected Outcomes by end of programme
		care Birbhum Neonatal unit has been made operational. Sanction given to Coochbehar, Uttar Dinajpur, Nadia and Bankura. Inspection has been done for Malda. 27 Rural Hospitals and 9 Sub-Divisional Hospitals have been identified based on potentiality and geographical distribution. Medical Officers, who would undergo anaesthesia training for emergency obstetric care in five Medical Colleges of West Bengal – Medical College Kolkata, RG Kar Medical College, Bankura Medical College, Medinipur Medical College & North Bengal Medical College have been selected. TOT completed and training of Medical Officers underway. *Mobile Healthcare* i. Procurement being processed. ii. Identification of NGOs and 90% Screening process completed.		
3. Organisation and Management Systems – HMIS, HRM/D, and decentralisation	The Organisational Review in three identified priority areas completed. The institutional / Organisational Review of H & FW Deptt. From RH/BPHC/PHC perspective completed. Organisational Review of Health Dept. (management structure) initiated.	Both District OD and HQ OD review in Progress.	***Organisational Development*** **7. DoHFW in-house review of management structure conducted.** **8. Reforms implemented on the basis of review studies and other actions taken by the department.** ***Human Resource Management*** **9. HRM policy and plan developed and implementation initiated.**	1. Stronger oversight role provided by DHFW to the functioning of public and private health systems. 2. Public sector has a strong results-based management system in place. 3. 50% reduction in absenteeism levels by eop (baseline: 43% absenteeism in PHCs). 4. At least 90% of the RH/ BPHC/PHC fully staffed (baseline: 16% vacancies for PHCs).

Key Issues	Measures planned 2005/6	Progress from 2005/6	Milestones for 2006/7	Expected Outcomes by end of programme
	Extend and refine transfer policy to link staff to vacancies in poorer districts. 25% of Obs/Gyn specialist in post in 94 rural hospitals (*staff records*)	No attempt yet to give any concrete shape to this.	*Quality* **10 . Design of total quality framework for health systems and measurement of quality begun – would mainly focus on the service delivery from different hospitals and health centres.** - During the year conduct a baseline study on two aspects as part of the overall quality assessment system: **- Public Expenditure Tracking Survey** **- User satisfaction survey**	5. Qualitative surveys show significant improvement in attitudes of care providers.
	Introduce supervision of health functionaries by PRIs.	i. Sub-Centre Health Committee has been constituted with PRI functionary as the Chairman for better supervision. ii. Similarly, Rogi Kalyan Samities for PHCs constituted with PRI functionary as the Chairman.	*Decentralisation* **11. Institutional strengthening of district and block administration (eg. Funds utilised by RKS, funds from dept for maintenance use by PRI, positions filled)**	
	HMIS Systems linking primary-level data and secondary-level data implemented by June 2005 Service quality index developed by the Department & implementation assessed through user satisfaction surveys	The entire IT enabled HMIS of DHFW is conceived as two component, Hospital data and Public Health Data. DHFW has developed a Health Intranet linking entire Primary level Hospital data from the Sub-division level upwards up to Medical College using Web based HMIS system, where by on-line tracking of Hospital performance and generation of Hospital Indicators are possible. This component is developed & implemented. Regarding Public Health Data Primary Data from the Sub-Center upwards are consolidated at the BPHC, using integrated	*HMIS* **12. State Bureau Health Information strengthened with additional personnel to enhance capacity for analysis of data. This would also include sensitisation of the district and below.**	6. Integrated disease surveillance and health statistics developed and informing planning and budgeting.

Key Issues	Measures planned 2005/6	Progress from 2005/6	Milestones for 2006/7	Expected Outcomes by end of programme
		software encompassing all the public health programmes. The electronic HMIS data is further linked with the District and State Head Quarters using the same Health Intranet. This scheme is been conceived and developed, a dedicated Public Health Web Portal has been commissioned, the field testing of the software being done at the nine pilot blocks of three districts.		
4. Health Financing	**Share of DHFW budget in "developmental services" expenditure to reach 9.5%. (without DFID support).** **Where user charges exist, ensure that resources can be kept at facility level (*GO permitting funds to be retained. Facility budget*?)**	**G.O. on User Charges issued and made effective from 1.4.2006.**	13. DoHFW's actual spending, (excluding external aid) increase by 10% compared to 2005-06. 13 B Evidence allotted funds effectively spent based on findings from Public Expenditure Tracking survey, Utilisation Certificates, Internal Audit report etc.	**Health spend as share of GoWB 7% by 2010 (cf 3.9% in 2004-05) – to be confirmed once the fiscal reform programme is developed.**
	Resources to primary sector at least 40% of DHFW budget in 2004-05	Met	**14. Resources to primary sector at least 46% of DHFW budget in 2007-08.**	2. Primary health as share of health spend at 55% by 2010 (cf 35 2003-04)
	Public Expenditure Review for government health sector produced, Budget reorientation to reflect priorities, Progress in developing a sector MTEF. (*PER report produced, Budget reorientation to reflect priorities*)	In progress	**(included in milestone1)**	3. Sector rolling MTEF providing the framework for annual budgets.
	Budget for medicines at primary level to increase from 1% in 2003 to 2% by 2005-06 (*Dept budget*	Met	**15. Evidence of increased stocks of approved essential drugs at health facilities (e.g. user perceptions; public**	4. Essential drugs are available in all the RH/BPHC/PHC by 2008

Key Issues	Measures planned 2005/6	Progress from 2005/6	Milestones for 2006/7	Expected Outcomes by end of programme
	statements)		**expenditure tracking study, drugs management information system)**	
	Decisions on next steps for Health insurance / risk pooling agreed	In progress. As a part of the process for design of Health Insurance Scheme targeted for Landless Agricultural Labourers, 6 Studies have been commissioned and will be completed by end of July 2006. On the basis of the Studies, the product and system will be designed in August and September 2006 through intensive consultations with stakeholders. A workshop is scheduled in October 2006 to discuss the system and product options and prepare a draft design.	**16. Design of health insurance scheme finalised**	5. Pilots for community health insurance schemes completed and being scaled up. Out of pocket expense for primary care reduced among target community (baseline oop exp 65% of total health exp)
5. Access and demand for Services	Scale up of Basic Health Care Facilities plans developed in detail (strengthening primary care facilities: Memo HF/0/MS/107/W-17/2001 of 8/3/02) (same as in key issue no.2)	Covered in 2 above	**17. Current efforts reviewed, overall access strategy developed, including identification of barriers to access and action plan for the un-reached implemented and monitored.**	1. Reduction in share of BoD from communicable/ maternal/neonatal / nutritional deficiency from the current 50% baseline.
	Plans for education, awareness raising, communication aimed at increasing demand in place by March 2005 (*surveys of demand generation, knowledge monitoring*) **To be taken up under RCH II**	TOR agreed and procurement initiated	**18. BCC strategy developed and evidence of implementation.** **19. Safety net (Voucher based) for ambulance services introduced on a pilot basis and monitored.** **20. Review implementation of Janani Suraksha Yojana/referral transport and improve its delivery across the state especially in 6 poor performing districts. Initiate appropriate action and monitor.**	2. Pilots for new service delivery models in remote districts completed, and scaled up with plans and resources. 3. Health Seeking Behaviour Survey in poor performing districts shows over x% increase in number of people seeking treatment from both public and good quality private providers (baseline and target to be developed by Yr 2).
	Design for a voucher scheme for safe delivery in 2 Districts completed	Arrangements have been made with KfW to design voucher schemes for safe deliveries between April 18 and April 29, 2006. Consultants already identified. Funding to be done by KfW. Another Voucher Scheme being		

Key Issues	Measures planned 2005/6	Progress from 2005/6	Milestones for 2006/7	Expected Outcomes by end of programme
		designed for NGO Managed Ambulances Scheme. The Draft Scheme expected to be finalised by April 12, 2006.		
6. Private Sector	Prepare Action Plan for improving accreditation & regulation systems for quality assurance in public and private sectors A Unit within DHFW for Private Sector issues identified by Dec. 2004	With the Technical Assistance of GTZ, Terms of Reference has been prepared for Study on review of the implementation mechanism of Clinical Establishment Act. Consultants have been short listed and the Study will be commissioned shortly. GTZ is also providing support for developing a quality framework for the Department that will include scope for developing minimal and optimal standards for regulation and accreditation.. A draft concept paper has also been prepared. The review of the Clinical Establishment Act will pave the way for development of standards. Discussions have been held with Quality Council of India on Accreditation. Preliminary discussions have also been held with TAST for developing SQI.	**21. Set up a unit (or outsource) to regulate the PPPs for mobile ambulances, diagnostic centres and drug outlets.**	Regulatory system for private and public sector health sector providers fully functional.
	PPP schemes reviewed and next steps agreed		**22. Appropriate safeguards for the poor in PPPs (diagnostic and ambulance) developed and initiated and evidence of improved service delivery.** **-pilot voucher for increased access to diagnostic services in 1 district** **- GOs on safeguards for the poor issued for enhanced access to ambulance services and monitored (proactive information flows,**	PPPs leading to improved service delivery for all especially the poor

Key Issues	Measures planned 2005/6	Progress from 2005/6	Milestones for 2006/7	Expected Outcomes by end of programme
			measuring usage etc).	
7. Asset & Supplies Management	Producing alternative pilot tested models for maintenance of buildings & equipments.	There is some progress with regard to delegation of maintenance budget (for sub centres and PHCs) to PRIs	**23. Guidelines for Preventive Maintenance issued (including to PRIs) and funds disbursed to PRIs for maintenance.**	O&M systems are fully functional.
	The new inventory management systems for drugs linked with HMIS implemented upto district level	Not done.	**Included in milestone 12**	Basic Drugs are available in PHCs/Rural Hospitals.
8. Procurement and Financial Management Systems	Financial management assessment Action Plan completed by Dec 2004 • Functioning Audit Committee • Strengthening of Internal audit systems. • Phased filling up of all the 18 Accounts Officer Post. Snr. Managers respond to audit findings • Improved budgeting system developed • Implementation of PER findings • Review and strengthen the procurement system.	Established and running Internal auditors have been engaged for conducting internal audit of all district hospitals and CMOH offices. For health institutions in Kolkata area offer letters have been issued to 25 CA firms for conducting internal audit of the equal number of health institutions including hospitals and teaching colleges and non-teaching institutions. Hospitals and teaching colleges in districts have also been brought under internal audit. Panel for CA firms has been prepared in consultation with the Finance (Internal Audit) Department, GoWB. Not sure how many are in post. DoHFW has got permission to recruit staff on contract. No progress. Review has been done. DoHFW now need to start implementing the recommendations	**24. FRA of the DoHFW including the District Societies and Block Societies.** **25. Drugs and equipments Supply Corporation established and staffed with agreed procurement policy.** **26.Networked HMIS system between HQ and district DRS.** **27. Strengthening the directorate of drugs control and application of schedule M revised** **- staffing** **- evidence of post supply quality testing of drugs.**	1. FRA in 2006 shows reduction in fiduciary risks compared to the 2004 baseline.

Annex 2: Major Related Projects Financed by the Bank and/or other Agencies

INDIA: West Bengal Health Systems

[*Guideline:*
(Recommended length 1 page)

This annex should summarize recent projects supported by the Bank and other international agencies in the country in the same sector or related sectors. For each project listed, indicate which of the sector issues discussed in A.1 have been or would be addressed. For Bank-financed projects completed in the last five years, OED's rating should be provided. For ongoing Bank-financed projects, the IP and DO ratings from the latest Project Status Report should be shown.]

Annex 3: Results Framework and Monitoring

INDIA: West Bengal Health Sector Development Project

The strategy to prepare the Results Framework is built around a core of key monitoring indicators, complemented by rigorous impact evaluations for innovative policies. This strategy has been chosen to build on and reinforce the recent progress the DHFW has made in capacity and processes for monitoring through the implementation of the Health Sector Strategy. The Bank team is currently working with the DHFW and other donors to build a unified results framework for the sector, of which this will be part. The results framework of the WBHSDP will constitute a subset of the overall monitoring framework of the DHFW, and provide input into the results-based management approach of the DHFW.

Monitoring

The information for tracking the PDO indicators is already being collected by the DHFW through the DHFW's existing monitoring system. These data are available on an annual basis and thus will be used for year to year monitoring. These indicators will be complemented by less frequent household survey data. These survey data will be used for four purposes: 1) to provide an alternate source for indicators measured through the HMIS, 2) to provide disaggregated information about given groups (e.g. scheduled castes/scheduled tribes), 3) to capture health information that the HMIS is not designed to cover (e.g. incidence of diarrhea), and 4) to provide a picture of overall health trends in the entire health sector of the state by capturing trends in the volume of services provided by *all* health care providers in the State. The latter figures (on overall services provision) could then be converted to *ratios* where the denominator is the relevant population (e.g., all children 12-23 months when it comes to immunization, all pregnant women in the case of maternity services, etc.). Such state-wide ratios would provide an indication of the progress being made in the health sector as a whole, at least in terms of volume of essential services utilized by the population.

The survey data needed for this more infrequent monitoring would come from two sources. The first source would be the RCH household surveys. The second source would be household surveys funded by the project [the inclusion of these surveys as an activity in the monitoring and evaluation component is under discussion]. In order to have comparable data over time, it is essential that these surveys include the relevant questions verbatim from the RCH survey instruments.

The indicators described above are primarily quantity indicators. While these will provide insight into the expansion of activities of the DHFW under WBHSDP, they do not provide information on the quality of services individual clients receive. At present the Bank team is engaging with the DHFW about the possibility of including quality indicators through additional survey instruments (either the panel survey of households that builds on the RCH or a set of patients' satisfaction and facility surveys) which will provide periodic insights into the trajectory of service quality during the project. The set of indicators, their target values and the data collection process will be identified before appraisal.

Impact Evaluation

The planned arrangements for the Results Framework also refer to carrying out *impact evaluation* of selected interventions. This is important given that the project includes certain innovative initiatives, especially in the areas of health insurance and PPPs. While impact evaluation would only provide insights into a small fraction of the activities included in the project, it would nonetheless be a key component of the Results Framework, as these evaluations would enable DHFW and its development partners to establish a clear causal link between project activities and health impacts.

RESULTS FRAMEWORK

PDO	Project Outcome Indicators	Use of Project Outcome Information
To increase the utilization of essential health services, both preventive and curative, particularly in under-served areas.	Percent of institutional deliveries	These indicators will be regularly monitored and will be a key input into annual progress monitoring. In addition, these indicators will be systematically reviewed and compared to survey data indicators as part of the mid-term review. Based on the findings, the strategies and the project support to achieve the desired improvements will be continued or modified.
	Percent of women having at least 3 Antenatal care (ANC) visits before delivery	
	Percent of women covered by Tetanus Toxioide (TT)	
	Number of rural facility outpatient primary attendances (=rural hospital + BPHC + PHC + subcentre)	
	Number of rural facility inpatient attendances (=rural hospital + BPHC)	
	Annual case detection rate (%) of new sputum positive (NSSP) TB cases	
	Percentage of NSSP cases cured out of total NSSP cases detected	
	Annual parasite incidence for malaria	
	Prevalence rate of leprosy per 10,000 population	
	Percentage of children (12-23mos) fully immunized	

Arrangements for results monitoring

PDO Indicators	Baseline (2007)	Target Values					Data Collection and Reporting		
		YR1 (2008)	YR2 (2009)	YR3 (2010)	YR4 (2011)	YR5 (2012)	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
Percent of institutional deliveries	49	51	53	55	57	60	Annual	HMIS	DHFW
Percent of women having at least 3 ANC visits before delivery	66	68	70	72	74	76	Annual	HMIS	DHFW
Percent of women covered by at least two tetanus toxoid injections during pregnancy	84	86	88	90	92	95	Annual	HMIS	DHFW
Number of rural facility outpatient primary attendances	81,205,492	84,314,796	87,424,099	90,533,403	93,642,707	96,752,010	Annual	HMIS	DHFW
Number of rural facility inpatient attendances	986,597	1,040,429	1,094,261	1,148,092	1,201,924	1,255,756	Annual	HMIS	DHFW
Annual case detection rate (%) of new sputum positive (NSSP) TB cases	81	81	82	83	84	85	Annual	HMIS	DHFW
Percentage of NSSP cases cured out of total NSSP cases detected	85	86	87	88	89	90	Annual	HMIS	DHFW
Annual Parasite Incidence for malaria	2.6	2.4	2.2	2	1.8	1.5	Annual	HMIS	DHFW
Prevalence rate of leprosy per 10,000 population	1.2	1.1	1	0.9	0.7	0.5	Annual	HMIS	DHFW
Percentage of children (12-23mos) fully immunized	90	91	92	93	94	95	Annual	HMIS	DHFW

Results Indicators for Each Component	Baseline (2007)	Target Values					Data Collection and Reporting		
		YR1 (2008)	YR2 (2009)	YR3 (2010)	YR4 (2011)	YR5 (2012)	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection
Component 1: Rural Health									
Sub-Component I (i): Strengthening Government-provided Health Services									
Sub-Component I (ii): Strengthening Health Care Access through Public-Private Partnerships									
Sub-component: Health Financing pilots	0	Offering health insurance to 20% of the target population	Offering health insurance to 50% of the target population, including 20% of population for whom HI contract is renewed	Offering health insurance to 100% of target population	Renewing contracts of the existing members	Renewing contracts of the existing members	Six-monthly reports, special mid-term report after 3 years, on enrolment and scope—geographical and demographic, surveys on participation	Household surveys, midline community survey on how health insurance is impacting on vulnerable groups	Director, Project management unit.
Sub-Component I (iv): Public Health.									
Component II: Urban Health									
Sub-component II (i): Introducing Community-based Primary Health Care									

Services for the Slum Population in 63 Municipalities									
Sub-component II (ii): Adding Public Health Activities in 63 Municipalities with a Dedicated Slum-targeted Primary Health Care Program.									
Component III: Project Management, Capacity Building and Monitoring and Evaluation									
Sub-component III (i): Project Management									
Sub-component III (ii): Capacity Building-Rural Health									
Sub-component III (iii) Capacity Building-Urban Health									
Sub-component III (iv): Monitoring and Evaluation									

Data comparison for different source of data for selected PDO indicators

PDO key indicator	Latest survey data	Projected 2007 value	YR1 (projected 2008 value)	YR2 (projected 2009 value)	YR3 (projected 2010 value)	YR4 (projected 2011 value)	YR5 (projected 2012 value)
Percent of institutional deliveries							
RCH-surveys -1998-2002	46.3	53.2	55.1	57.1	59.1	61.2	63.3
NFHS surveys 1998-2005	43.1	44.0	44.5	44.9	45.4	45.8	46.3
Percent of women having at least 3 ANC visits before delivery							
RCH-surveys -1998-2002							
NFHS surveys 1998-2005	62.4	63.9	64.7	65.5	66.2	67.0	67.8
Percent of Percent of women covered by at least two tetanus toxoid (TT) injections during pregnancy							

RCH-surveys -1998-2002	86.5						
NFHS surveys 1998-2005							
Percentage of children (12-23mos) fully immunized							
RCH-surveys -1998-2002	51.5	56.8	57.5	58.1	58.7	59.4	60.0
NFHS surveys 1998-2005	64.3	71.8	75.8	80.1	84.6	89.4	94.4

Note: RCH-II (2002 data), NFHS-III (2005 data), Department figures (DHFW HMIS 2005 data)

Supplemental service indicators from survey data

While these indicators will not comprise PDO indicators, these data will be used at the midterm review to provide a comparison with HMIS data (where feasible), data on sub-populations of interest as well as a picture of overall health trends in the state. These indicators include the following:

Supplemental indicator (For each indicator, this table will have total, and then separate values by SC/ST, literate/illiterate, urban/rural)	Latest survey data	Projected 2007 value	YR1 (projected 2008 value)	YR2 (projected 2009 value)	YR3 (projected 2010 value)	YR4 (projected 2011 value)	YR5 (projected 2012 value)
Mothers who received postnatal care from medical personnel within 2 days of delivery for their last birth							
RCH-surveys -1998-2002							
NFHS surveys 1998-2005	37.8						
Children with diarrhea in the last two weeks who received ORS							
RCH-surveys -1998-2002	44						
NFHS surveys 1998-2005	43.7	44.7	45.1	45.6	46.1	46.6	47.2
DPT 3 vaccination (children between 12-23 mths)							
RCH-surveys -1998-2002	69.8						
NFHS surveys 1998-2005	71.5	75.8	78.0	80.3	82.7	85.2	87.7
Polio 3 vaccination (children between 12-23 mths)							
RCH-surveys -1998-2002	67.7						
NFHS surveys 1998-2005	80.7	87.1	90.5	94.1	97.8	100	100
BCG vaccination (children between 12-23 mths)							
RCH-surveys -1998-2002	67.6						
NFHS surveys 1998-2005	74.7	82.7	87.0	91.5	96.2	100	100
Measles vaccination (children between 12-23 mths)							
RCH-surveys -1998-2002	67.6						
NFHS surveys 1998-2005	74.7	82.7	87.0	91.5	96.2	100	100

Health outcome indicators

Health outcome indicator (For each indicator, this table will have total, and then separate values by SC/ST, literate/illiterate, urban/rural)	Actual	Baseline (projected 2007 value)	YR1 (projected 2008 value)	YR2 (projected 2009 value)	YR3 (projected 2010 value)	YR4 (projected 2011 value)	YR5 (projected 2012 value)
Infant Mortality Rate (IMR: per 1000 live births)							

RCH-surveys -1998-2002							
NFHS surveys 1998-2005	48	47.8	47.7	47.6	47.5	47.4	47.3
Under-five Mortality Rate (U5MR: per 1000 live births)							
RCH-surveys -1998-2002							
NFHS surveys 1998-2005							
Maternal Mortality Ratio (MMR: per 100,000 live births)							
RCH-surveys -1998-2002							
NFHS surveys 1998-2005							
Underweight (children between 12-23 mths)							
RCH-surveys -1998-2002							
NFHS surveys 1998-2005	43.5	42.1	41.4	40.8	40.1	39.5	38.9
Stunted (children between 12-23 mths)							
RCH-surveys -1998-2002							
NFHS surveys 1998-2005	33	30.9	29.9	28.9	28.0	27.1	26.2
Wasted (children between 12-23 mths)							
RCH-II survey							
NFHS-III survey	19						
Children age 6-35 mths who are anemic							
RCH-surveys -1998-2002							
NFHS surveys 1998-2005	69.4	67.0	65.9	64.8	63.7	62.6	61.5

Annex 4: Detailed Project Description

INDIA: West Bengal Health Systems

4.01 The proposed project, with an estimated baseline cost of US$113.6 million, would have three components: (i) Rural Health; (ii) Urban Health; and (iii) Project Management, Capacity Building and Monitoring and Evaluation. A detailed description of each component follows.

Component I: Rural Health (Baseline Cost: US$80.7 million)

4.02. Component I is composed of four sub-components: (i) Improving Government-provided Health Services (US$49.5 million baseline cost); (ii) Improving Health Care Access through Public-Private Partnerships (US$8.1 million baseline cost); (iii) Health Financing Pilots (US$12.1 million baseline cost); and (iv) Public Health (US$12.3 million baseline cost). The main activities under each sub-component are discussed below.

Sub-Component I.(i): Improving Government-provided Health Services

4.03. The health care facility infrastructure for the delivery of government-provided health care services in rural areas of West Bengal comprises 16 District Hospitals, 44 Sub-divisional Hospitals, 31 State General Hospitals, 95 Rural Hospitals, 251 Block Primary Health Centers, 922 Primary Health Centers, and 10,356 Sub-centers (data as of the end of 2005).[36] District Hospitals (average number of beds: 437), Sub-divisional Hospitals (average number of beds: 175), State General Hospitals (average number of beds: 110), and Rural Hospitals (average number of beds: 36) provide both outpatient and inpatient services. PHCs and Sub-centers provide outpatient services. Block PHCs have an average of about 14 beds and in addition to outpatient care provide some limited inpatient care.[37] Sub-centers located at Gram Panchayat Headquarters are designated as Headquarter Sub-centers.[38]

4.04. The project would finance construction, renovation and equipping of a number of health facilities, mostly located in 74 prioritized Blocks which are among the most backward and poor performing Blocks in the State.[39] Three criteria were used to rank Blocks and select those given priority under the proposed project: female literacy; birth rate; and communicable disease burden. More specifically, the proposed project would finance:

(i) The construction of buildings for 700 new non-Headquarter Sub-centers, and the provision of the corresponding equipment. In addition, the project would finance cold chain equipment for 675 Headquarter Sub-centers. This investment would be part of a broader program for expanding and upgrading the Sub-center network in the State, with parallel investments being funded from other sources (HSDI, NRHM); the total number of Sub-centers in the State is expected to reach about 15,000 by 2010-11. Additional staff is also envisaged at the Sub-center level: under NRHM, it is planned to deploy a second ANM in all Sub-centers in the country, in a phased manner through 2010 (with first priority given to Headquarter Sub-centers). In order to further strengthen the lowest level of service, under NRHM a

[36] District, Sub-divisional and State General hospitals serve urban populations as well.
[37] BPHCs typically have a female ward, male ward, observation ward, delivery room and laboratory facilities for carrying out blood tests.
[38] There are 3,354 Gram Panchayats in the State. However, no Headquarter Sub-centers are required in those Gram Panchayats that have either a PHC (922 GPs) or a BPHC (251 GPs).
[39] The total number of Blocks in the State is 342.

new cadre of Accredited Social Health Activists (ASHAs) will be deployed in the 74 prioritized Blocks (and elsewhere in the country) to act as a bridge between the ANMs and the villages.

(ii) The upgrading of 142 PHCs (building upgrading and equipment provision). This investment would also be part of a broader program for upgrading 342 PHCs (i.e., one per Block) into 24-hour, seven-days-a-week facilities, with the balance of 200 PHCs scheduled to undergo similar upgrading with funding from other sources (HSDI, NRHM).

(iii) The construction of residential quarters for doctors and nurses at 82 BPHCs now lacking such facilities, and the addition of Blood Storage Units at 75 BPHCs, as part of a broader plan to upgrade all BPHCs in West Bengal to the status of Rural Hospitals over five years.[40]

(iv) The upgrading/expansion of 20 District Hospitals/Sub-Divisional Hospitals currently having bed-occupancy rates consistently over 100%.

Sub-component I. (ii): Improving Health Care Access through Public-Private Partnerships

4.05. For several years now, the DHFW in West Bengal has been encouraging the establishment of public-private partnerships in an effort to better serve the population with health care services. As of mid-2006, a number of public-private partnerships were already in place.[41] Among the most promising such partnerships are the following.

- A number of partnerships with NGOs and CBOs in the area of HIV/AIDS prevention and care.
- Diagnostic units set up through PPPs in 13 Rural Hospitals, with four more such units in the pipeline. Expressions of interest have been invited by DHFW for the remaining 78 Rural Hospitals (as previously noted, there are 95 Rural Hospitals in the state).
- Operation of 133 ambulances for emergency transport at BPHC level, under management of NGOs/CBOs. Expressions of interest have been invited for the rest of the BPHCs.
- Outsourcing of food services, security, cleaning and laundry in a number of secondary and tertiary hospitals.
- NGO-run Mobile Health Clinics in under-served areas of the Sunderbans.
- Contracting-in of specialists such as gynecologists, obstetricians and anesthetists in Rural Hospitals, allowing these hospitals to function as First Referral Units for obstetric and other cases.
- For the training of ANMs and other paramedical staff, DHFW has invited expressions of interest from NGOs and Municipal Corporations for the provision of training venues and student housing, with the faculty and other inputs to be provided by DHFW.

4.06. Under the proposed project, DHFW's drive towards an enhanced use of PPPs would be given further impetus through the following activities:

(i) *The strengthening of the PPP Cell in the SPSRC.* PPP initiatives so far have been undertaken on a pilot basis. Now that a number of such initiatives are under way, and some are being scaled up, specialized manpower and capacity development are required within DHFW for facilitating the core

[40] A Rural Hospital typically has 30-40 beds, an operation theater, labor room and X-ray facilities. In addition to a medical officer who functions as Superintendent, Rural Hospitals have 2-3 Medical Officers and other health care personnel such as Dental Surgeon, nurses, Ophthalmic Assistants, and X-ray technicians.

[41] Guidelines for public-private partnerships in health were formulated in *Policy for Public-Private Partnerships in the Health Sector*, DHFW, Government of West Bengal, January 2006.

processes of PPPs. Under the proposed project, the PPP Cell would be expanded and capacity building activities would be undertaken for key staff.

(ii) *Research & studies*. The project would fund certain basic studies which are needed to provide the PPP drive with a better analytical basis, including a cost study of services already being provided through PPPs; a mapping of all public and private facilities in all Districts; and a study of different options for improving access to MCH services in rural and urban areas, comparing the feasibility and sustainability of vouchers, health insurance and social franchising.

(iii) *Training of private providers*. The project would fund the training of private providers who would participate in a pilot project in two districts. The pilot would attempt to integrate private providers into some key national health programs. Assistance for the pilot would also be provided by GTZ.

(iv) *Partnerships with NGOs for the provision of services in remote and under-served areas*. Following on the above-mentioned successful experience with provision of mobile health care services through NGOs in the Sunderbans region, DHFW under the proposed project would seek to greatly expand the provision of services through NGOs in remote and under-served areas—including coal mining areas in Bardhaman and Puruliya, tea-growing and forest areas in Jalpaiguri, and a broader coverage of the Sunderbans region. In the process, the Sunderbans model would be refined, *inter alia* to ensure that the PPPs are an integral part of Block and District plans.

(v) *Diagnostic services in 250 upgraded BPHCs*. This initiative would expand the PPP model for provision of diagnostic services already in operation for Rural Hospitals to 250 upgraded BPHCs. As in Rural Hospitals, a voucher scheme would be introduced for BPL patients to enable them to pay for the services. The cost of this initiative over the next five years would be partly funded from the proposed project.

(vi) *Contracting-out of non-clinical services*. It was mentioned under paragraph (4.05) above that one of the PPPs under implementation consists of the contracting out of various non-clinical services in secondary and tertiary hospitals. DHFW now plans to expand this initiative to the level of BPHCs. The proposed project would fund technical assistance costs for the initiative. Payments to contractors would be from the state's own resources.

(vii) *Community-managed emergency referral transport in backward/difficult to reach areas in 675 Gram Panchayats*. Under this initiative, to be supported by the proposed project, local self-help groups would be organized to operate and manage means of transportation such as van rickshaws to provide emergency transport for women during pregnancy and delivery, and other emergencies. The scheme would be phased in over the next five years in 675 Gram Panchayats (about 20% of the total).

4.07. It should be noted that, in addition to the above, DHFW would also be pursuing several other important PPP initiatives to be funded from sources other than the proposed project. These include: contracting-in of specialists for First Referral Units; a voucher system for MCH services in urban areas and rural areas, in selected districts; private clinics by local General Practitioners at the Gram Panchayat level; emergency transport services in 460 10-bedded PHCs; contracting out of PHCs to private providers; public health competitive fund for innovative projects; and training schools for ANMs and other paramedical staff.

Sub-Component I.(iii): Health Financing Pilots

4.08. DHFW has been thinking about a few health financing pilots to improve risk protection of the poor against health risks and increase utilization of essential health services.

(i). *Pilot on health insurance.* Since this is being done for the first time, the DHFW is understandably cautious in moving forward on this component. Several studies have shown health care costs to be one of the main causes of impoverishment among low-income people. DHFW, with the World Bank support, would pilot a health insurance scheme for the low-income people in the Burdwan district, which being a relatively better off district has better implementation capacity. The pilot is foreseen to be reasonably large—covering a group of 2 million individuals. At this stage when major design issues are open, the pilot can take several different forms. The pilot can be designed to include different benefit packages, which would include different inpatient and/or outpatient care services. Similarly, the pilot could be managed by the government itself, or by an insurance company, or directly under a network of healthcare providers. Under GTZ's technical assistance to DHFW, good amount of preparatory work has been done to understand what kind of pilot design would be the most appropriate in the Bardwan district. Based on this understanding, GTZ has prepared an outline of the pilot design. A few rounds of consultation may be required before DHFW is able to take a policy decisions on certain core issues in the design of the pilot, such as identification of the target group(s), scale of the proposed intervention, whether or not to charge equity-adjusted premiums, how to involve PRIs in implementing the pilot, and so forth. Once these decisions are taken, considerable preparatory work including setting up a service providers' network and a quality assurance system and so forth, will be required before the launch of the pilot. The project would fund the initial set up costs of the pilot and would also provide premium subsidy to the BPL population. Estimate of these costs would depend on the design of the pilot.

(ii). *Voucher system for poor patients in need of diagnostic services in Rural Hospitals.* It was mentioned above that DHFW is in the process of setting up Diagnostic Units in all 95 Rural Hospitals. Patients using these services pay user charges to the private providers. In order to ensure that the services would be available to poor patients (BPL patients), DHFW also plans to introduce a voucher system for the benefit of these patients—i.e., the BPL patients would be able to use the vouchers to pay for the diagnostic services. The cost of this voucher system over the next five years would be partly funded from the proposed project.

(iii). *Voucher system for NGO-operated ambulance services at BPHCs.* This initiative would enable poor (BPL) patients to pay with vouchers for the emergency transport services being operated by NGOs at the BPHC level. The cost of this voucher system over the next five years would be partly funded from the proposed project.

Sub-Component I. (iv): Public health

4.09. This sub-component comprises a set of activities aimed at improving the effectiveness of West Bengal's *public health services*. These are services which are either *public goods*,[42] such as health education through mass media, or have positive externalities, such as control of tuberculosis and other communicable diseases.[43] The activities in the sub-component would complement, but not duplicate, those activities funded under centrally sponsored programs including the Tuberculosis Control and

[42] "Public goods" are goods or services where the consumption of one unit of the good or service by a given individual does not preclude consumption of the same unit by other individuals.

[43] It should be noted that some key types of public health services fall outside the purview of the DHFW; an example would be any services that promote a cleaner environment. The activities in this sub-component, however, are limited to activities which are within the purview of the DHFW.

Vector-Borne Disease Control programs, or under other Bank-assisted projects dealing with other aspects of public health (Food and Drugs Quality Improvement Project, Integrated Disease Surveillance Project).

4.10. Specifically, the following activities would be funded under this sub-component:

(i) *A Challenge Fund for Behavior Change Communication (BCC) activities.* Under this Challenge Fund, the DHFW would invite and evaluate proposals for high-priority BCC activities. A budget of Rs. 100,000/block/year would be allocated to the Challenge Fund. [THIS NEEDS TO BE FLESHED OUT—WHO WOULD PREPARE AND SUBMIT THE PROPOSALS, ETC. ETC.—NOT DISCUSSED WITH DHFW AT PRE-APPRAISAL].

(ii) *Epidemiological and other studies.* This activity would comprise the commissioning by DHFW of disease burden studies (e.g., on diabetes, hypertension, hepatitis, road traffic accidents), and other studies such as a survey of informal private health sector providers and the mapping of private health facilities.

(iii) *Food and drug laboratories.* The project would fund the establishment and operation of combined food/drug laboratories at Jalpaiguri, Behrampur, Burdwan and Bankura. [NO FURTHER DETAILS ARE PROVIDED IN THE DHFW'S PUBLIC HEALTH PROPOSAL—SHOULD BE ABLE TO SAY SOMETHING ABOUT WHAT THESE LABORATORIES WILL DO, WHY THEY ARE NEEDED]. The project would also provide for the strengthening of the State Food Laboratory through supply of laboratory equipment and reagents. This laboratory conducts routine water bacteriology and statutory food analysis.

(iv) *Tuberculosis control.* A total of 866 Designated Microscopy Centers have been set up under the Tuberculosis Control Program to provide accessible microscopy services to communities. At present, however, 76 of these centers are unable to provide services for lack of Laboratory Technicians. The project would fund the provision of a Laboratory Technician in each of the 76 centers. Also, an additional 100 reserve binocular microscopes would be provided for the rapid replacement of damaged microscopes.

(v) *Malaria control.* The project would fund the strengthening of the three existing Zonal Entomological Units for control of malaria and other vector-borne diseases. This would include the provision of additional staff, renovation of laboratory space, equipment, supplies and mobility support. The project would also fund the introduction of larva-eating fish in 34 Blocks with high malaria prevalence (this intervention is currently in operation in five Blocks in the state).

(vi) *Non-communicable disease prevention.* Under the project, a suitable institution would be identified for the establishment of a state Center for Chronic Disease Prevention. The Center would develop protocols for health promotion programs to reduce the incidence of premature deaths and disability from chronic diseases such as cardiovascular disease and diabetes.

(vii) *Review of public health laws in the State.* Many of the Public Health Acts, which constitute the legislative framework for public health service provision, have not been revisited since the colonial era. Under the proposed project, the DHFW would commission a review of all public health legislation in the State with a view to its updating/rationalization.

(viii) *Upgrading of apex technical institutions.* The proposed project would fund the upgrading of two apex state technical institutions related to public health: the School of Tropical Medicine and the State Infectious Diseases Hospital (Kolkata). In the case of the former, upgrading would focus on modernizing laboratories, establishing a bio-safety level-3 unit, provision of technical assistance, provision of equipment, development of a quality assurance program for laboratory work, and mobility support. In the

case of the State Infectious Diseases Hospital, upgrading would focus on the strengthening of training facilities, renovation of laboratories, renovation of OT, provision of equipment, and library facilities.

Component II: Urban Health (Baseline Cost: US$19. 5 million)

4.11. Component II is composed of two sub-components: (i) Introducing Community-based Primary Health Care Services for the Slum Population in 63 Municipalities (US$17.2 million baseline cost); and (ii) Adding Public Health Activities in 63 Municipalities with a Dedicated Slum-targeted Primary Health Care Program (US$2.3 million baseline cost).

Sub-Component II.(i): Introducing Community-based Primary Health Care Services for the Slum Population in 63 Municipalities

4.12. At present, out of a total of 126 municipalities in the State, 63 municipalities (41 Kolkata Municipal Area municipalities, plus 22 other municipalities) have a dedicated government-funded primary health care program which provides basic maternal and child health services for slum populations.[44] These services were originally introduced through three projects assisted by the World Bank and DFID, the most recent being the Bank-assisted India Family Welfare (Urban Slums) Project (1994-2002). An end-line survey conducted at the completion of that project showed a markedly increased utilization of basic health care services by women and children, together with a notable fertility decline and a decrease in infant mortality among the targeted slum population.[45]

4.13. The encouraging results in the 63 municipalities where this slum-targeted program is operating have prompted the Government of West Bengal to decide to expand the program to the remaining 63 municipalities in the State, which are all located outside the Kolkata Metropolitan Area and have a combined population of about 3.4 million people. Maternal and child health services would be made available to the slum populations of these municipalities following the same successful service model in use in the municipalities where the program already exists. The service model revolves around the deployment of female "honorary health workers" (HHWs, who are paid a modest honorarium), at the rate of one per 200 families, who function as a link between the slum communities from which they are recruited and government sub-centers. The HHWs are supervised by a cadre of First-Tier Supervisors (FTSs), at the rate of one per sub-center, who are ex-HHWs that have distinguished themselves in their work. The model also includes the contracting-in of private sector Part-time Medical Officers (PTMOs), at the rate of one per sub-center, who complement the services provided by the sub-centers' regular staff of government paramedics.

4.14. Specifically, the proposed project would fund the establishment and operation of 283 Sub-centers (in rented buildings), including the salaries of incremental staff (283 FTSs, 283 PTMOs, and 1,270 HHWs), equipment, furniture, drugs, training, rent, and other operational expenses. Services provided at the sub-centers would include as a minimum child health care services including immunization; ANC services and counseling for institutional delivery; family planning services for spacing and counseling for terminal methods; and the primary treatment of common ailments (which would broaden the package of services offered beyond reproductive and child health). The various services would not be available daily but rather in specified days only—e.g., immunization would be provided once a week, and the PTMO would also be available once a week.

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[44] The urban population of West Bengal amounts to about one-fourth of the total population of the State. It is spread over 126 Municipalities and 252 census towns. Of the 126 Municipalities, 41 lie within the Kolkata Municipal Area and the remaining 85 lie outside that area.

[45] Under the program, each beneficiary slum household maintains a Family Health Card in which services received and other events are recorded.

4.15. The project would also fund the establishment and operation of 15 Urban Health Centers in municipalities where secondary health care facilities are not available.[46] These would be small facilities located in rented buildings and staffed with a full-time Medical Officer, one Public Health Nurse, 2-4 GNMs, and a laboratory assistant. Each Urban Health Center would serve a population of about 30,000 and would provide preventive and curative outpatient services not available at the sub-center level.

4.16. In addition, the range of services supported by the program would be broadened to include some important *public health aspects*. The benefits of this new public health dimension of the program would not be circumscribed to slum populations but would benefit the entire population of the municipalities. To this effect, the proposed project would fund technical assistance and workshops for the development of Municipality-specific Public Health Action Plans, with a focus on the health determinants in the respective municipalities. The Plans would target improvements in key public health areas including water quality management, solid waste management, sanitation and hygiene, licensing of health facilities, and the tracking of seasonal disease outbreaks (e.g., dengue fever). The project would also fund the introduction of a new cadre of First-Tier Supervisors/Public Health, who would be FTSs posted at the Municipality level and focusing on public health matters only.

4.17 The Municipality-specific Public Health Action Plans would clearly benefit from the existence of clear guidelines from the State Government specifying the roles and responsibilities of different stakeholders/government agencies in addressing the public health issues and determinants. In the absence of such guidelines, important aspects of the Municipality-specific Public Health Action Plans would remain on paper only, because the Municipalities themselves would not have the authority and/or means of taking the corresponding actions. In this connection, the State Government, with DHFW in the lead, is in the process of formulating a comprehensive Urban Health Strategy for the state, which would provide the guidelines referred to above.

Sub-component II (ii): Adding Public Health Activities in 63 Municipalities with a Dedicated Slum-targeted Primary Health Care Program

4.18. A new *public health dimension* would also be introduced in the 63 Municipalities where a dedicated primary health care program is already in operation for the slum population. The project would fund the provision of incremental staff at the municipality level (72 Public Health Nurses, 540 First-tier Supervisors/Public Health, and 63 Data Assistants); training on public health for existing staff (HHWs, PTMOs, FTSs); and technical assistance and workshops for the development of Municipality-specific Public Health Action Plans, along the lines already discussed under Sub-component II.(i).

4.19 The service package in the 63 Municipalities already having a dedicated health care program for the slum population has been up to now limited to the reproductive and child health area. The proposed project would be instrumental in broadening this package to include other basic curative services, which is expected to increase the usefulness of the program to slum inhabitants. Refresher training for HHWs and their supervisors would also be introduced in the program, thus remedying an important weakness.

Component III: Project Management, Capacity Building and Monitoring and Evaluation (Baseline Cost: US$13.5 million)

4.20. Component III of the proposed project would be composed of four sub-components: (i) Project Management (US$---million baseline cost); (ii) Capacity Building-Rural Health (US$7.2 million baseline

[46] In 48 of the 63 municipalities to which the program would be expanded, there is already a District or Sub-division Hospital or a State General Hospital in operation.

cost); (iii) Capacity Building-State Urban Development Agency (US$0.7 million baseline cost); and (iv) Monitoring and Evaluation (US$.....million baseline cost).

Sub-component III.(i): Project Management

4.21. The activities will include: (i) incremental operational costs including labor costs for project management; (ii) consulting services to cover technical issues, as well as procurement and financial management improvements; (iii) training of project management staff; (iv) provision of necessary office equipment.

Sub-component III.(ii): Capacity Building-Rural Health

4.22. In the area of rural health, the project would support several capacity-building activities relating to local government, RKSs, and government health staff.

(i) *Strengthening of Gram Panchayat and Block Planning.* The project would support the progressive decentralization of the health planning process in rural areas. All Districts in the State would prepare District Health Plans for 2007-08, based on a participative process and bottom-up approach. Preparation of Village Health Plans would precede the preparation of the District plans and feed into the latter. The Village Health Plans would be the responsibility of the Health Standing Committee of each Gram Panchayat. District Health Plans would include activities related to the provision of drinking water, sanitation, hygiene and nutrition. The project would provide funds at the Block and Gram Panchayat levels for conducting surveys, workshops, studies, consultations, orientation and other activities.

(ii) *Training of PRI members for strengthening their role in health.* The proposed project would fund training of Panchayat members, especially those in the Health Standing Committees at Gram Panchayat and Panchayat Samiti levels, in order to enhance their role in the health sector, and more specifically so that they are able to perform their duties in the context of decentralization. All the Gram Panchayats would be covered in a phased manner over five years. Some of the topics to be included in this training would be the role of PRI members in community mobilization for preventive and promotion health activities, awareness generation and related IEC activities to bring about positive changes in the health seeking behavior of communities, supervision and monitoring of grass-roots health functionaries, and the supervision of construction, repair and maintenance of primary health care facilities.

(iii) *Capacity-building of Rogi Kalyan Samitis (RKSs).* RKSs have been constituted at District Hospitals, Sub-Divisional Hospitals, Rural Hospitals, Block PHCs and PHCs. It is vital that capacities of RKSs be enhanced, so that they can play their envisaged role in the management, monitoring and supervision of these health facilities. To this effect, the proposed project would fund two-day capacity building workshops for RKS members of all the facilities where RKSs have been constituted.

(iv) *Exposure visits for health functionaries.* The project would fund exposure visits for health functionaries within India and abroad, in order for them to learn from national and international best practices.

(v) *Establishment of five new ANM schools.* The present state capacity for ANM training is inadequate to fulfill the demand. Under the project, five new ANM schools would be set up. This would supplement DHFW's drive to set up ANM training schools through public-private partnerships (paragraph 4.05) above).

Sub-component III.(iii): Capacity Building-Urban Health

4.23. The proposed project would support capacity building at the level of the State Urban Development Agency (SUDA). SUDA would be the key agency to provide technical backstopping, capacity building and monitoring/supervision support to the Municipalities for the implementation of the activities in Component II of the project. To discharge its enhanced responsibilities, SUDA would be provided with a team of professional staff with an adequate skill mix (Technical Advisor, Project Officer, Assistant Project Officer, 12 Medical Officers, Finance Officer, three Accounts Assistants, two MIS officers, three computer assistants, and support staff). In addition to the salaries of these incremental staff, the project would fund other operational expenses of the team, and expenses associated with management training and staff development.

4.24. In order to coordinate the program and pay sufficient attention to the new public health aspects, each Municipality would be provided with a Health Team composed of a Health Officer, a Public Health Nurse, four to five First-Tier Supervisors/Public health, and support staff. The costs of establishing and operating these teams would be funded under the proposed project.

4.25 DHFW would play a stewardship role in the program—steering policy, formulating standards/norms/operational guidelines, providing technical inputs during epidemics, and holding periodic consultations with DMA and the Municipalities. To fulfill this role, an Urban Cell would be established within DHFW, with a nodal officer and supportive staff.

4.26 In addition, capacity building in Urban Health would include *capacity building/training* for staff and other stakeholders at various levels of the program's structure, as summarized in the matrix below:

Category	Period of training	Skill areas
HHW	45 days	Primary health care services; Antenatal and postnatal care, promotional of institutional delivery, immunization , promotion of breast feeding and proper weaning, growth monitoring of under 5 children, family welfare programs, reproductive tract infections, adolescent health care, treatment of minor ailments, conduction of various awareness program. Public health Surveillance of communicable diseases, basics of major communicable diseases like identification of danger signs, assisting in vector control measures, collection of data relating to communicable diseases etc.
FTS	30 days	Refresher on above issues and training on aspects related to monitoring and evaluation i.,e data collection, recording and preparation of HMIS reports
TOT	2-3 days	Training of trainers for HHWs and FTS by MOs for 2-3 days
Public Health Nurse	2 weeks	Orientation on the program and public health
MOs		Technical training for 1 day each, intermittently, on different topics viz., STD/HIV, disease surveillance, public health , HMIS, National programs like DOTS/NLEP etc.
Exposure visit		For MOs and PHN of ULBs – at the national level or state level.
FTS PH	2 weeks	Capsule training exclusively on public health issues
Key ULB functionaries	1 day	State level orientation of ULBs by SUDA – 1 day for all 63 ULBs on the program
All ULB stakeholders	1 day	Sensitization of key stakeholders i.,e , members in council, ward councilors, CDS members, at each ULB about the program
For SUDA:		
Medical Officers, Project Officers	1 week	Training on technical aspects viz. MCH, disease surveillance, Public health issues, HMIS, National programs etc.

Category	Period of training	Skill areas
Project and administrative team	1 week	Managerial training – on aspects related to MIS, human resource management, health administration, supervision and monitoring, equipment and logistic support
Exposure Visit		For senior members of SUDA to other nationally/internationally recognized programs .

Sub-component III.(iv): Monitoring and Evaluation

4.27. The monitoring and evaluation systems of the DHFW have been strengthened significantly by Government over the last few years, increasing in scope and also building an IT infrastructure to allow for more rapid and accurate transformation of information. However, much of this strengthening has, to date, emphasized tertiary and some secondary facilities. Furthermore, while the government has started to use information for targeting policies (e.g. the use of hospital performance indicators and ranking by these indicators), there is a clear scope and demand to expand this. This component will strengthen the monitoring and evaluation capacity of the DHFW both in terms of the quality of information collected, particularly at the primary level, and promoting the use of this information for policy.

4.28 This work will take place under four main sets of activities:

(i) *Rationalizing and strengthening the central state monitoring apparatus.* This will include a review of the roles of all central monitoring units in the DHFW (including the State Bureau of Health Intelligence, the Demographic Evaluation Cell of the State Family Welfare Bureau and respective program officers) and the redefinition of roles in order to increase the speed and efficiency of reporting. This organizational review will take place in the first year of the project and the recommended changes will be made in subsequent years. The activities to rationalize the system will also include a reduction and simplification of the forms filled out by front line health workers. A pilot version of this is currently under way in two districts and this initiative will be scaled up as part of this project.

(ii) *Expanding the reach of the health information system.* The activities supported under this subcomponent will include expanding both the depth and breadth of information gathered. In terms of depth, the proposed project would support the roll out of a computerized MIS to the block and district level. This project would support both the hardware (both at the local and state levels) and software development. The software will be designed so as to provide some immediate simple analysis for monitoring and policy at both the block and district levels, as well as providing for the transmission of data to the state level. The project will also support the broadening of the health information system. This will include a household survey to complement the data collected under the regularly programmed NFHS and RCH programs [timing of survey to be determined]. In addition, the project will support the expansion of the existing monitoring system beyond health outcome indicators to include data on personnel and funds accounts and audits. A detailed study of the financial data system will be conducted in the first year and this will serve as the basis for the integration of this with the central MIS in subsequent years. There has been some initial work on building a personnel database for the DHFW, and this activity will be scaled up and integrated with the central MIS. Finally, this set of activities will also support the expansion of the MIS coverage of private and urban primary facilities.

(iii) *Impact evaluation.* To complement the activities that will improve the monitoring of the DHFW, the proposed project will also support a program of rigorous impact evaluations. These evaluations will be used to examine the effects of at least one of the major innovative initiatives of the Department. The

design of the impact evaluation will be completed during the first year. Data collection and analysis will take place during subsequent years and results will be available for discussion no later than the fifth year of the project.

(iv) *Increasing the capacity for making data informed policy.* This proposed set of activities will comprise both expanding the set of information for policy formulation but also the skills for analysis. In addition to the activities indicated above (e.g. integrating financial indicators into the MIS), in terms of expanding the set of information the proposed project will include the development of a set of health service quality indicators. During the first year of the project, consultants will be appointed to define suitable indicators for each set of institutions. In terms of improving the skills for analysis, the proposed project will provide training in data analysis for central and district staff, once the reorganization of the MIS institutional setting is complete.

{END OF ANNEX 4 OF PAD}

Annex 5 – Project Costs

INDIA: West Bengal Health Systems

In US$ Million

Components/Sub-components	Costs
Component I: Rural Health	
1.1. Improving Government-provided Health Services	48.2
1.2. Improving Health Care Access through Public-Private Partnerships	8.1
1.3. Health Financing Pilots	12.1
1.4. Public Health	12.3
Sub-total Component I	**80.7**
Component II: Urban health	
2.1. Introducing Community-based Primary Health Care Services in 63 Municipalities	
2.2. Adding Public Health Activities in 63 Municipalities with a Dedicated Slum-targeted Primary Health Care Program	17.2
Sub-total Component II	2.3
	19.5
Component III: Project Management, Capacity Building and Monitoring & Evaluation	
3.1. Project Management	??
3.2. Capacity Building-Rural Health	7.2
3.3. Capacity Building- Urban Health	0.7
3.4. Monitoring & Evaluation	5.6
Sub-total Component III	**13.5**
Total Baseline Cost	**113.6**
Physical Contingencies	**2.3**
Price Contingencies	**7.3**
Total Project Cost	**123.2**

Annex 6: Implementation Arrangements
INDIA: West Bengal Health Systems

The WBHSDP would be planned, implemented and monitored through the existing structures of the DHFW, with strengthening as required. Under this framework, activities of the WBHSDP will be not be implemented by an external PMU but by the executing units of the GoWB in charge of executing state and national funds, thereby granting flexibility and better tailoring to local needs and decentralized plans. A common Results Framework, which is built on the HSDI Matrix of Milestones, would be used to monitor implementation of the overall reform and investment program of the DHFW in priority areas.

Overview of Key Institutions in the State's Health Services

6.01 The Department of Health & Family Welfare (DHFW), Government of West Bengal (GoWB), is responsible for maintaining and developing the public component of the health care system in the state. DHFW operates an extensive network of health care facilities, including 10,356 Sub-centers, 922 Primary Health Centers (PHCs), 251 Block Primary Health Centers (BPHCs), 95 Rural Hospitals (RHs), 18 District Hospitals (DHs) and 65 Sub-divisional/State General Hospitals (SDH/SGHs). DHFW also operates a number of *centrally sponsored health programs*.[47] The DHFW is headed by the Principal Secretary, and overseen by the Minister in Charge, who also heads the Panchayats and Rural Development Department.

6.02 At the *state* level, the DHFW is comprised of the Secretariat, which is the administration and policy-making body, and the Directorate, which is the technical body responsible for service delivery. The Directorate has four divisions: Health Services; Medical Education and Training; Homeopathy; and Drug Control, each headed by a Director. Health Services is the key division within the Directorate. The entire district and sub-district health delivery system falls under the Director of Health Services. Health Services is also responsible for managing the various centrally sponsored programs. As in other states, each of these programs has its own management structure at the state level, though the provision of services under the programs is integrated with all other health services at the district, Block and facility levels. The Strategic Planning & Sector Reform Cell (SPSRC) takes the lead on most of the policy issues relating to the sector. The SPSRC is headed by a senior Indian Administrative Service (IAS) officer, who reports directly to the Principal Secretary.

6.03 At the *district* level, the Chief Medical Officer of Health (CMOH) heads the entire district health administration. The CMOH is assisted by a number of Deputy Chief Medical Officers of Health (DCMOHs) and other officers such as the Zonal Leprosy Officer and the District Tuberculosis Control Officer. All these officers (including DCMOHs) are known as *program officers*, looking after specific types of services or programs. In addition, the CMOH is assisted by a number of Additional Chief Medical Officers of Health (ACMOHs), generally one for each sub-division. The role of the ACMOH is supervisory and his responsibility is not linked to any specific program. Instead, he looks after the entire health administration and service delivery within the territorial boundary of a sub-division. The ACMOHs report directly to the CMOH.

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[47] The national programs are the Revised National Tuberculosis Control Program, the National AIDS Control and Blood Safety Program, the National Anti-Malaria Program, the Diarrhea and Enteric Disease Control Program, the National Program for the Control of Blindness, the National Leprosy Elimination Program, the National Cancer Control Program, and the National Mental Health Program and the Family Welfare Program.

6.04 At the *block* level, the Block Medical Officer of Health (BMOH) functions as head of health administration. All BMOHs working in a particular sub-division administratively report to the corresponding ACMOH. However, for program-specific matters, they report to the respective Program Officers. The BMOH is assisted by a Block Public Health Nurse, a Block Sanitary Inspector, and a Social Welfare Officer.

6.05 Local rural self-government institutions, i.e. the Panchayati Raj Institutions (PRIs) also play a role in health. The Panchayat Raj system in West Bengal is based on a three-tier structure: the Panchayat level (around 8-10 villages), the Block level (around 100-120 villages) and the district level. At the district level, key bodies include a council of elected representatives, the Zilla Parishad; Standing Committees on various development sectors, including health; and an assembly, the Zilla Sansad, comprised of all elective representatives in the district. Similarly, at the Block level, key institutions include a council of elected representatives, the Panchayat Samiti; Standing Committees; and an assembly, the Block Sansad. At the lowest, Panchayat level, key institutions include a council of elected representatives, the Gram Panchayat; Standing Sub-Committees; and, for each village, an assembly of all voters in the village, the Gram Sansad. Gram Panchayats promote public health through community mobilization and participation. Moreover, they supervise the work of Health Assistants in the sub-centers and help in identifying beneficiaries for various health, nutrition and sanitation schemes. District and Block Standing Committees and Panchayat level Standing Sub-Committees supervise the execution of health schemes, especially for health infrastructure development and maintenance.

6.06 *Urban Areas.* Government health services in urban areas include those provided at facilities (hospitals, health centers and sub-centers) which belong to the State DHFW; those provided at facilities owned by various other government departments; and services provided by the Municipalities (ULBs). In addition, the private sector provides an important share of both outpatient and inpatient services. A recent study estimated that 53 percent of all beds in urban areas belong to the State DHFW, 13 percent to other government departments, 29 percent to the private sector, and only five percent to the Municipalities. Fifty-one percent of all qualified medical doctors and 59 percent of trained nurses in urban areas belong to the State DHFW, while only six percent of qualified medical doctors and four percent of trained nurses work for municipal facilities.

6.07 Moreover, 63 out of a total of 126 Municipalities in the state currently have a dedicated government-funded outreach primary health care program which provides basic maternal and child health services for slum populations. The service model revolves around the deployment of female "honorary health workers" (HHWs, who are paid a modest honorarium), at the rate of one per 200 families. The HHWs function as a link between the slum communities from which they are recruited and government sub-centers. The HHWs are supervised by a cadre of First-Tier Supervisors (FTSs) operating out of sub-centers, at the rate of one per sub-center, who are ex-HHWs that have distinguished themselves in their work and have been given additional training. The model also includes the contracting-in of private sector Part-time Medical Officers (PTMOs), at the rate of one per sub-center, who complement the services provided by the sub-centers' regular staff of government paramedics.

Implementation Arrangements for the Proposed Project

6.06 Overall responsibility for project implementation would be with the Strategic Planning and Sector Reform Cell (SPSRC) of the DHFW. The DHFW would appoint a Project Director from the Indian Administrative Service (IAS) cadre and belonging to the rank of Special Secretary, who would be supported by a Deputy Project Director from IAS or senior state cadre and belonging to the rank of Joint Secretary. The PMU will be supported by the various staff in the Directorate. Arrangements for financial

management/disbursements and for procurement are described in Annexes 7 and 8 respectively. Implementation arrangements for the individual components/sub-components are described below.

Implementation Arrangements for Component I: Rural Health Component

6.07 Implementation arrangements for each of the four sub-components in Rural Health are as follows:

(i) Improving Government-provided Health Services:

This sub-component comprises the construction, renovation and equipping of a number of health facilities, including sub-centers/Block sub-centers, PHCs, and District/Sub-divisional Hospitals, mostly located in 74 backward Blocks. The arrangements for the procurement of equipment and for carrying out civil works are described in Annex 8, *Procurement*. Once operational, the new/renovated facilities would continue to function under the existing State-wide management arrangements for government rural health services described above.

(ii) Improving Health Care Access through Public-Private Partnerships:

Implementation of this sub-component would be coordinated by the PPP Cell in the SPSRC, which would be strengthened for that purpose. [Note: we need more details on how the various types of PPP initiatives would be implemented, e.g., the training of private providers, the partnerships with NGOs for the provision of services in remote and under-served areas, the voucher schemes. Such details are not to be found in the documentation we have received from DHFW so far].

(iii) Health Insurance Pilot:

[TO BE COMPLETED]

(iv) Public Health:

The arrangements for implementation of this sub-component would vary depending on the type of activity implemented. In the case of activities related to the malaria and tuberculosis control programs, implementation would take place through the existing administrative structures for these centrally-sponsored programs. Epidemiological and other studies, as well as the review of public health laws in the State, would be carried out by consultants under the supervision of DHFW. The new State Center for Chronic Disease Prevention would be housed in a suitable existing institution not yet identified; this institution would have delegated authority from DHFW to establish and operate the Center. For the establishment and operation of the four new combined food/drug laboratories...[NEED TO SPECIFY WHICH UNIT OF DHFW IS RESPONSIBLE FOR FOOD/DRUG QUALITY CONTROL]. Finally, an important new activity in this sub-component would be the Challenge Fund for Behavior Change Communication Activities, whereby DHFW would invite, evaluate and fund proposals for high-priority behavior change communication activities in the health area [NEED TO FLESH OUT HOW THIS WOULD WORK].

Implementation Arrangements for Component II: Urban Health Component

6.10 Direct responsibility for implementing activities under the component would rest with the respective Municipalities (Urban Local Bodies), under the overall coordination of the Department of

Municipal Affairs.[48] In order to implement the program and pay sufficient attention to the new public health aspects, each Municipality would have a Health Team composed of a Health Officer (assisted by an Assistant Health Officer where the population of the Municipality is over 300,000), a Public Health Nurse, four to five First-Tier Supervisors/Public Health, and support staff.

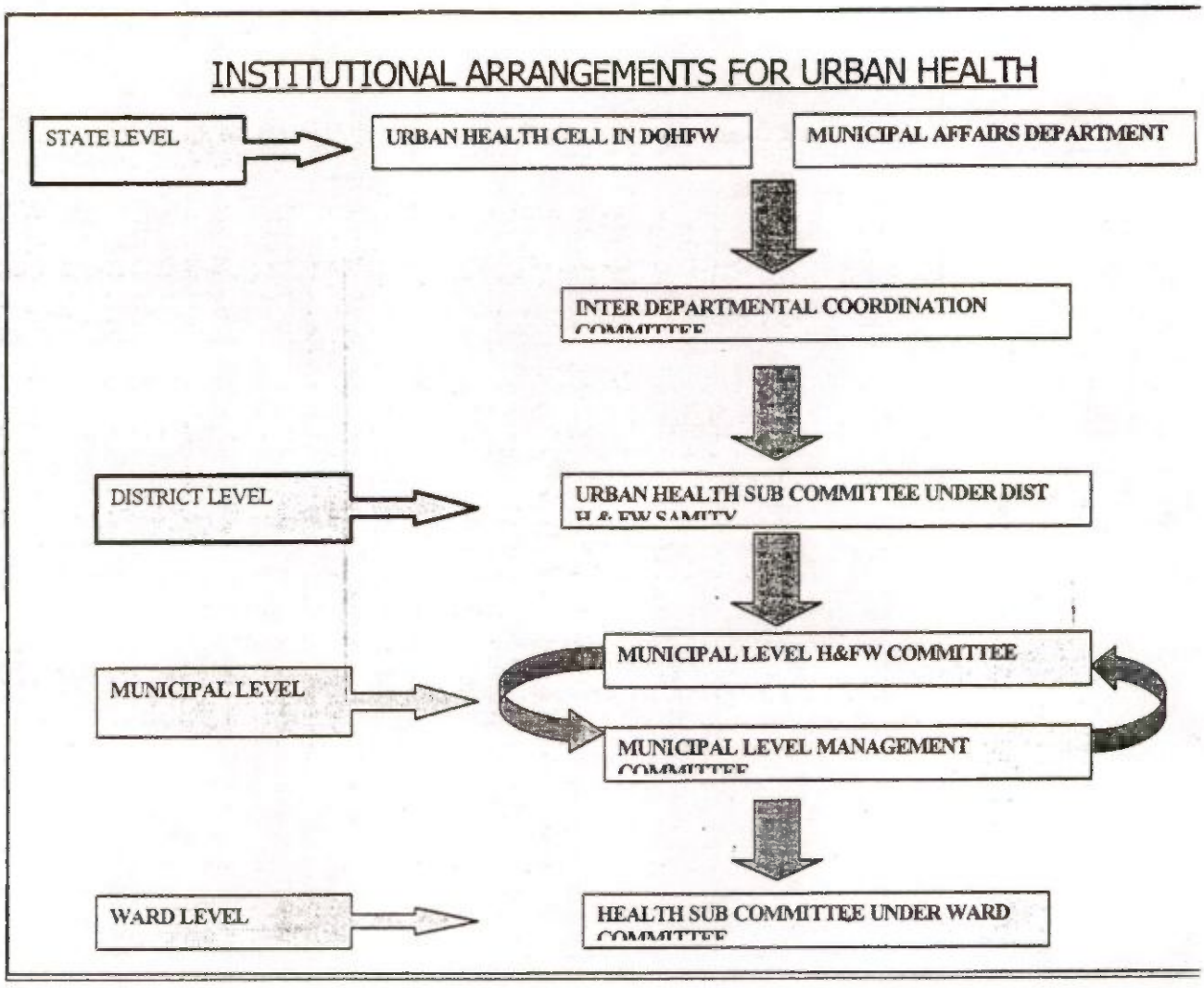
The Municipalities would be provided technical backstopping, capacity building and monitoring/supervision by the technical agency identified by DMA, called the State Urban Development Agency (SUDA). To discharge its enhanced responsibilities, SUDA would be strengthened with a team of professional staff with an adequate skill mix—Technical Advisor, Project Officer, Assistant Project Officer, 12 Medical Officers, Finance Officer, three Accounts Assistants, Monitoring and Evaluation Officer, and support staff.

6.12 DHFW, through the proposed Urban Health Cell, would play a stewardship role in the program—steering policy, formulating standards/norms/operational guidelines, providing technical inputs during epidemics, and holding periodic consultations with DMA and the Municipalities. To fulfill this role, an Urban Cell would be established within DHFW, with a nodal officer and supportive staff.

6.13 The institutional arrangements for the program would also include a series of committees that will help coordinate the program and provide oversight. These would be: (i) at the district level, the Urban Health Committee under the District Health Samity; (ii) at the Municipal level, the Municipal Level Health and Family Welfare Committee and the Municipal Level Management Committee; and (iii) at the ward level, the Health Sub-Committee under the Ward Committee chaired by the Ward Counsellor.

[48] For the 41 Municipalities in the Kolkata Metropolitan Area, the Kolkata Metropolitan Development Agency would continue to provide oversight of the program.

The diagram below explains the institutional arrangement for Urban Health component:

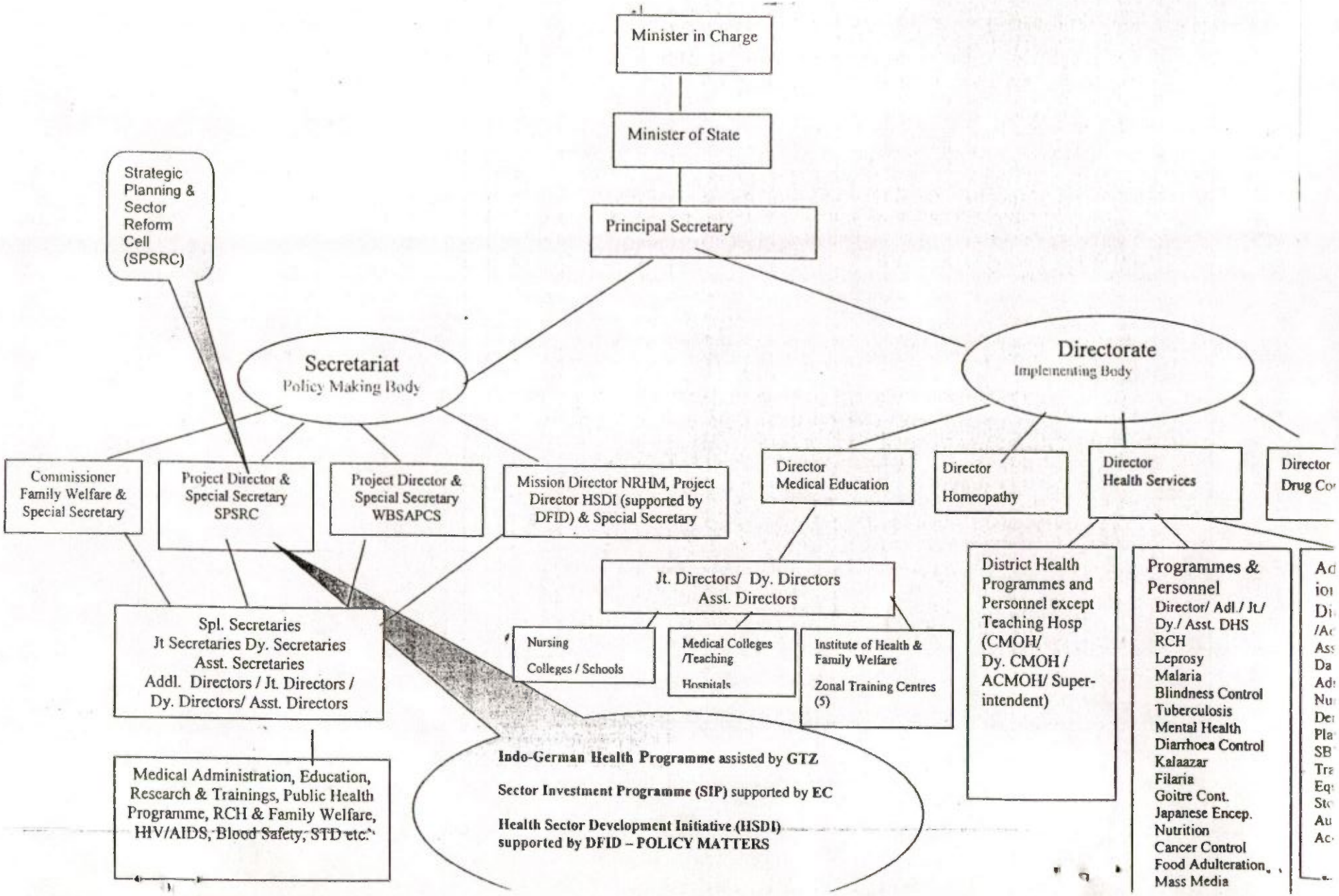


Implementation Arrangements for Monitoring and Evaluation

[TO BE COMPLETED BY MARKUS]

{END OF ANNEX 6 OF PAD}

Organisational Structure of Health & Family Welfare Dept. Govt. of West Bengal



Annex 8: Procurement Arrangements

INDIA: West Bengal Health Systems
(Recommended length 2-4 pages)

[*The following standard text should be used. Insert additional text as needed per the instructions in brackets*]

A. General

Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement Under IBRD Loans and IDA Credits" dated May 2004; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, and the provisions stipulated in the Legal Agreement. The various items under different expenditure categories are described in general below. For each contract to be financed by the Loan/Credit, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame are agreed between the Borrower and the Bank 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.

Procurement of Works: Works procured under this project would include: [*Describe the types of works*]. The procurement will be done using the Bank's Standard Bidding Documents (SBD) for all ICB and National SBD agreed with or satisfactory to the Bank. [*Indicate any special requirements specific to the project.*] [*If the project involves procurement carried out by communities, indicate where details can be found in the Project Implementation Manual or similar documents.*]

Procurement of Goods: Goods procured under this project would include :[*Describe the types of goods*]. The procurement will be done using the Bank's SBD for all ICB and National SBD agreed with or satisfactory to the Bank. [*Indicate any special requirements specific to the project.*]

Procurement of non-consulting services: [*Provide a general description of non-consulting services to be procured under the project and information on the bidding documents to be used for the procurement.*]

Selection of Consultants : [*Provide a general description of the consulting services from firms and individuals required for the project.*] Short lists of consultants for services estimated to cost less than $_____equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. [*If applicable, provide any information regarding engaging universities, government research institutions, public training institutions, NGOs, or any special organizations.*]

Operating Costs: [*Describe the operating costs which would be financed by the project and procured using the implementing agency's administrative procedures which were reviewed and found acceptable to the Bank.*]

Others: [*Describe if any special arrangements for scholarships, grants etc.*]

The procurement procedures and SBDs to be used for each procurement method, as well as model contracts for works and goods procured, are presented in the [*name the Project Implementation Manual or the equivalent document.*].

B. Assessment of the agency's capacity to implement procurement

Procurement activities will be carried out by [*name of the Implementing Agency*]. The agency is staffed by [*describe the key staff positions*], and the procurement function is staffed by [*describe the staff who will handle procurement*].

An assessment of the capacity of the Implementing Agency to implement procurement actions for the project has been carried out by [*name of the procurement staff*] on [*date*]. The assessment reviewed the organizational structure for implementing the project and the interaction between the project's staff responsible for procurement Officer and the Ministry's relevant central unit for administration and finance.

The key issues and risks concerning procurement for implementation of the project have been identified and include [*describe the risks/issues*]. The corrective measures which have been agreed are [*Describe the corrective measures*].

The overall project risk for procurement is [*give the risk rating*].

C. Procurement Plan

The Borrower, at appraisal, developed a procurement plan for project implementation which provides the basis for the procurement methods. This plan has been agreed between the Borrower and the Project Team on [*date*] and is available at [*provide the office name and location*]. It will also be available in the project's database and in the Bank's external website. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

D. Frequency of Procurement Supervision

In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended [*frequency*] supervision missions to visit the field to carry out post review of procurement actions.

E. Details of the Procurement Arrangements Involving International Competition

1. Goods, Works, and Non Consulting Services

(a) List of contract packages to be procured following ICB and direct contracting:

1	2	3	4	5	6	7	8	9
Ref. No.	Contract (Description)	Estimated Cost	Procurement Method	P-Q	Domestic Preference (yes/no)	Review by Bank (Prior / Post)	Expected Bid-Opening Date	Comments

(b) ICB contracts estimated to cost above [*fill in threshold amount*] per contract and all direct contracting will be subject to prior review by the Bank.

2. Consulting Services

(a) List of consulting assignments with short-list of international firms.

1	2	3	4	5	6	7
Ref. No.	Description of Assignment	Estimated Cost	Selection Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date	Comments

(b) Consultancy services estimated to cost above [*fill in threshold amount*] per contract and single source selection of consultants (firms) for assignments estimated to cost above [*fill in threshold amount*] will be subject to prior review by the Bank.

(c) Short lists composed entirely of national consultants: Short lists of consultants for services estimated to cost less than [*fill in threshold amount*] equivalent per contract, may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

Annex 9: Economic and Financial Analysis

INDIA: West Bengal Health Sector Development Project

West Bengal, as most Indian states, witnessed a constant deterioration of its fiscal balance during the decade of the 1990s. Between 1990-91 and 1999-2000, the revenue deficit in the state rose from 3.0 to 6.7 percent of Gross State Domestic Product (GSDP), and the fiscal deficit increased from 4.9 to 9.2 percent of GSDP. Since year 2000, **various government efforts have attempted to regain fiscal stability, with mixed results:** in fiscal year (FY) 2005-06 the GoWB's fiscal deficit is projected to still be approximately at the level it was in 2000-01. High and increasing interest payments on outstanding debt (in 2003-04, the ratio of interest to total revenue expenditure in West Bengal was 35 percent; by contrast, the Indian average was 22 percent) have made fiscal readjustment more difficult, in spite of some progress in the reduction of primary deficit, estimated at 2.2 percent of GSDP in FY 2005-06. In order to reduce its primary deficit, the state has increased its tax and non-tax revenues, has reduced the growth in non-plan revenue expenditure (mainly salaries and pensions), and has contained subsidies to Public Sector Undertakings (PSUs).

Over the last few years, GoWB has made expenditure cuts In the health sector chiefly through containing discretionary expenses (for example on drugs and maintenance), and by freezing new employment, thus allowing the number of staff vacancies to rise: officials estimate that that 10% of all posts are now vacant. These cuts have adversely affected quality of services. According to the recent Health PER Report, for example, the increase in vacancies has affected particularly rural and remote areas, reducing coverage of basic services: "These vacancies are concentrated in rural and deprived regions, which are least able to cope with them, given low purchasing power and inadequate alternative (private) provision."

Annex 10: Safeguard Policy Issues

INDIA: West Bengal Health Systems

Annex 11: Project Preparation and Supervision

INDIA: West Bengal Health Systems

	Planned	Acutal
PCN review		
Initial PID to PIC		
Initial ISDS to PIC		
Appraisal		
Negotiations		
Board/RVP approval		
Planned date of effectiveness		
Planned date of mid-term review		
Planned closing date		

Key institutions responsible for preparation of the project:

Bank staff and consultants who worked on the project included:

Name	Title	Unit

Bank funds expended to date on project preparation:

1. Bank resources:
2. Trust funds:
3. Total:

Estimated Approval and Supervision costs:

1. Remaining costs to approval:
2. Estimated annual supervision cost:

Annex 12: Documents in the Project File

INDIA: West Bengal Health Systems

Annex 13: Statement of Loans and Credits

INDIA: West Bengal Health Systems

Project ID	FY	Purpose	Original Amount in US$ Millions						Difference between expected and actual disbursements	
			IBRD	IDA	SF	GEF	Cancel.	Undisb.	Orig.	Frm. Rev'd
P079708	2006	TN Empwr & Pov Reduction	0.00	120.00	0.00	0.00	0.00	114.92	-0.14	0.00
P083780	2006	TN Urban III	300.00	0.00	0.00	0.00	0.00	299.25	-0.75	0.00
P077856	2005	Lucknow-Muzaffarpur National Highway	620.00	0.00	0.00	0.00	0.00	620.00	0.00	0.00
P077977	2005	Rural Roads Project	99.50	300.00	0.00	0.00	0.00	358.82	14.12	0.00
P075058	2005	TN HEALTH SYSTEMS	0.00	110.83	0.00	0.00	20.06	81.38	-2.60	0.92
P073370	2005	Madhya Pradesh Water Sector Restructurin	394.02	0.00	0.00	0.00	0.00	371.82	1.87	0.00
P073651	2005	DISEASE SURVEILLANCE	0.00	68.00	0.00	0.00	0.00	62.41	3.56	0.00
P084632	2005	Hydrology II	104.98	0.00	0.00	0.00	0.00	104.98	12.34	0.00
P084790	2005	MAHAR WSIP	325.00	0.00	0.00	0.00	0.00	293.38	-30.63	0.00
P084792	2005	Assam Agric Competitiveness	0.00	154.00	0.00	0.00	0.00	141.50	-2.47	0.00
P086518	2005	IN SME Financing & Development	120.00	0.00	0.00	0.00	0.00	79.40	34.40	0.00
P094513	2005	India Tsunami ERC	0.00	465.00	0.00	0.00	0.00	394.37	38.00	0.00
P073776	2004	ALLAHABAD BYPASS	240.00	0.00	0.00	0.00	0.00	193.58	61.58	0.00
P055459	2004	ELEMENTARY EDUCATION PROJECT (SSA)	0.00	500.00	0.00	0.00	0.00	353.65	141.41	0.00
P073369	2004	MAHAR RWSS	0.00	181.00	0.00	0.00	0.00	175.14	21.60	0.00
P050655	2004	RAJASTHAN HEALTH SYSTEMS DEVELOPMENT	0.00	89.00	0.00	0.00	0.00	84.89	26.30	0.00
P078550	2004	Uttar Wtrshed	0.00	69.62	0.00	0.00	0.00	66.07	-2.11	0.00
P079865	2004	GEF Biosafety Project	0.00	0.00	0.00	1.00	0.00	0.87	0.40	0.00
P082510	2004	Karnataka UWS Improvement Project	39.50	0.00	0.00	0.00	0.00	37.02	16.92	0.00
P073094	2003	AP Comm Forest Mgmt	0.00	108.00	0.00	0.00	0.00	78.44	3.49	0.00
P072123	2003	Tech/Engg Quality Improvement Project	0.00	250.00	0.00	0.00	40.11	206.83	64.26	-5.97
P071272	2003	AP RURAL POV REDUCTION	0.00	150.03	0.00	0.00	0.00	79.60	12.40	0.00
P067606	2003	UP ROADS	488.00	0.00	0.00	0.00	0.00	398.72	139.27	0.00
P050649	2003	TN ROADS	348.00	0.00	0.00	0.00	0.00	300.74	51.78	0.00
P076467	2003	Chatt DRPP	0.00	112.56	0.00	0.00	20.06	93.75	18.19	0.00
P075056	2003	Food & Drugs Capacity Building Project	0.00	54.03	0.00	0.00	0.00	52.99	22.35	0.00
P050653	2002	KARNATAKA RWSS II	0.00	151.60	0.00	0.00	15.04	107.63	53.24	0.00
P072539	2002	KERALA STATE TRANSPORT	255.00	0.00	0.00	0.00	0.00	165.52	15.19	0.00
P050668	2002	MUMBAI URBAN TRANSPORT PROJECT	463.00	79.00	0.00	0.00	0.00	444.51	156.18	0.00
P040610	2002	RAJ WSRP	0.00	140.00	0.00	0.00	15.04	105.75	53.00	0.00
P050647	2002	UP WSRP	0.00	149.20	0.00	0.00	40.11	108.52	93.87	0.00
P074018	2002	Gujarat Emergency Earthquake Reconstruct	0.00	442.80	0.00	0.00	80.23	178.00	187.80	5.92
P069889	2002	MIZORAM ROADS	0.00	60.00	0.00	0.00	0.00	40.03	5.98	0.00
P071033	2002	KARN Tank Mgmt	0.00	98.90	0.00	0.00	25.07	72.27	42.30	0.00
P071244	2001	Grand Trunk Road Improvement Project	589.00	0.00	0.00	0.00	0.00	290.30	247.97	0.00
P050658	2001	TECHN EDUC III	0.00	64.90	0.00	0.00	0.00	22.06	10.91	-0.51
P055454	2001	KERALA RWSS	0.00	65.50	0.00	0.00	10.00	31.93	21.37	4.65
P055455	2001	RAJ DPEP II	0.00	74.40	0.00	0.00	0.00	38.23	18.21	0.00

P035173	2001	POWERGRID II	450.00	0.00	0.00	0.00	0.00	95.72	76.65	31.74
P059242	2001	MP DPIP	0.00	110.10	0.00	0.00	20.06	40.00	36.56	18.09
P010566	2001	GUJARAT HWYS	381.00	0.00	0.00	0.00	61.00	123.10	164.43	129.31
P038334	2001	RAJ POWER I	180.00	0.00	0.00	0.00	2.02	56.24	58.26	2.24
P067216	2001	KAR WSHD DEVELOPMENT	0.00	100.40	0.00	0.00	20.06	69.67	73.72	0.00
P070421	2001	KARN HWYS	360.00	0.00	0.00	0.00	0.00	158.79	87.46	0.00
P010505	2000	RAJASTHAN DPIP	0.00	100.48	0.00	0.00	0.00	48.84	40.30	26.83
P045049	2000	AP DPIP	0.00	111.00	0.00	0.00	0.00	30.69	13.90	0.00
P009972	2000	NATIONAL HIGHWAYS III PROJECT	516.00	0.00	0.00	0.00	0.00	187.07	187.07	-22.93
P049770	2000	REN EGY II	80.00	50.00	0.00	0.00	18.00	49.62	60.20	52.86
P050657	2000	UP Health Systems Development Project	0.00	110.00	0.00	0.00	30.09	43.49	60.56	-3.25
P067330	2000	IMMUNIZATION STRENGTHENING PROJECT	0.00	142.60	0.00	0.00	0.00	0.23	-88.27	0.00
P059501	2000	IN-TA for Econ Reform Project	0.00	45.00	0.00	0.00	12.03	21.58	26.64	17.28
P055456	2000	IN-Telecommunications Sector Reform TA	62.00	0.00	0.00	0.00	20.00	11.47	31.47	8.36
P050667	2000	UP DPEP III	0.00	182.40	0.00	0.00	0.00	30.87	31.82	31.82
P045051	1999	2ND NATL HIV/AIDS CO	0.00	191.00	0.00	0.00	0.00	15.11	12.21	-1.93
P045050	1999	RAJASTHAN DPEP	0.00	85.70	0.00	0.00	0.00	18.89	15.94	15.94
P050646	1999	UP Sodic Lands II	0.00	194.10	0.00	0.00	0.00	28.08	22.92	-6.70
P050651	1999	MAHARASH HEALTH SYS	0.00	134.00	0.00	0.00	35.01	6.31	36.12	12.66
P049385	1998	AP ECON RESTRUCTURIN	301.30	241.90	0.00	0.00	0.00	60.55	58.61	41.24
P035827	1998	WOMEN & CHILD DEVLPM	0.00	300.00	0.00	0.00	25.07	50.71	64.51	0.58
P038021	1998	DPEP III (BIHAR and Jharkhand)	0.00	152.00	0.00	0.00	30.09	21.76	42.62	12.16
P010496	1998	ORISSA HEALTH SYS	0.00	76.40	0.00	0.00	0.00	15.64	9.90	-3.71
P010473	1997	TUBERCULOSIS CONTROL	0.00	142.40	0.00	0.00	13.04	14.16	32.02	2.08
		Total:	6,716.30	6,527.85	0.00	1.00	552.19	7,847.86	2,707.18	369.68

INDIA
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
2005	ADPCL	41.90	7.00	0.00	0.00	0.00	0.00	0.00	0.00
2006	AHEL	0.00	5.08	0.00	0.00	0.00	5.08	0.00	0.00
2005	AP Paper Mills	35.00	5.00	0.00	0.00	0.00	5.00	0.00	0.00
2005	APIDC Biotech	0.00	4.00	0.00	0.00	0.00	0.00	0.00	0.00
2002	ATL	17.65	0.00	0.00	12.18	17.65	0.00	0.00	12.18
2003	ATL	1.46	0.00	0.00	0.00	1.14	0.00	0.00	0.00
2005	ATL	9.96	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2003	BHF	10.93	0.00	10.93	0.00	10.93	0.00	10.93	0.00
2004	BILT	0.00	0.00	15.00	0.00	0.00	0.00	15.00	0.00
2001	BTVL	18.10	5.00	0.00	0.00	18.10	5.00	0.00	0.00
2003	Balrampur	14.34	0.00	0.00	0.00	14.34	0.00	0.00	0.00

2001	Basix Ltd	0.00	0.98	0.00	0.00	0.00	0.98	0.00	0.00
2005	Bharat Biotech	0.00	0.00	4.50	0.00	0.00	0.00	0.00	0.00
1984	Bihar Sponge	6.63	0.00	0.00	0.00	6.63	0.00	0.00	0.00
2001	CCIL	6.75	0.00	0.00	6.71	6.75	0.00	0.00	6.71
2003	CCIL	1.51	0.00	0.00	0.00	0.59	0.00	0.00	0.00
1990	CESC	8.11	0.00	0.00	0.00	8.11	0.00	0.00	0.00
1992	CESC	11.45	0.00	0.00	25.53	11.45	0.00	0.00	25.53
2004	CGL	15.00	0.00	0.00	0.00	8.00	0.00	0.00	0.00
2004	CMScomputers	10.00	10.00	2.50	0.00	10.00	0.00	0.00	0.00
2002	COSMO	5.00	0.00	0.00	0.00	5.00	0.00	0.00	0.00
2005	COSMO	0.00	4.20	0.00	0.00	0.00	4.20	0.00	0.00
2004	Cairn Energy	40.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1995	Centurion Bank	0.00	0.69	0.00	0.00	0.00	0.69	0.00	0.00
2005	Centurion Bank	0.00	0.07	0.00	0.00	0.00	0.07	0.00	0.00
2005	DCM Shriram	30.00	0.00	0.00	0.00	15.00	0.00	0.00	0.00
2003	DQEL	0.00	1.50	1.50	0.00	0.00	1.50	1.50	0.00
2005	Dabur	0.00	15.10	0.00	0.00	0.00	15.10	0.00	0.00
2003	Dewan	11.05	0.00	0.00	0.00	11.05	0.00	0.00	0.00
	EXB-STG	0.31	0.00	0.00	0.00	0.31	0.00	0.00	0.00
2001	GTF Fact	0.00	1.20	0.00	0.00	0.00	1.20	0.00	0.00
1994	GVK	0.00	5.24	0.00	0.00	0.00	5.24	0.00	0.00
1998	Global Trust	0.00	0.00	2.00	0.00	0.00	0.00	2.00	0.00
2003	HDFC	100.00	0.00	0.00	100.00	100.00	0.00	0.00	100.00
1998	IAAF	0.00	0.47	0.00	0.00	0.00	0.30	0.00	0.00
	ICICI-SPIC Fine	0.00	0.33	0.00	0.00	0.00	0.33	0.00	0.00
1995	ICICI-SPIC Fine	0.00	0.28	0.00	0.00	0.00	0.28	0.00	0.00
2000	ICICI-SPIC Fine	0.00	0.91	0.00	0.00	0.00	0.91	0.00	0.00
1998	IDFC	0.00	10.82	0.00	0.00	0.00	10.82	0.00	0.00
2005	IDFC	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2001	IIFL	0.00	3.19	0.00	0.00	0.00	2.06	0.00	0.00
1990	IL & FS	0.00	0.49	0.00	0.00	0.00	0.49	0.00	0.00
1993	IL & FS	0.00	0.84	0.00	0.00	0.00	0.84	0.00	0.00
1998	IL & FS	0.00	0.84	0.00	0.00	0.00	0.84	0.00	0.00
1992	IL&FS VC	0.00	0.14	0.00	0.00	0.00	0.14	0.00	0.00
1995	IL&FS VC	0.00	0.18	0.00	0.00	0.00	0.18	0.00	0.00
1996	India Direct Fnd	0.00	1.10	0.00	0.00	0.00	0.64	0.00	0.00
2001	Indian Seamless	6.00	0.00	0.00	0.00	6.00	0.00	0.00	0.00
1996	Indus II	0.00	0.42	0.00	0.00	0.00	0.42	0.00	0.00
1992	Indus VC Mgt Co	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.00
1992	Info Tech Fund	0.00	0.39	0.00	0.00	0.00	0.39	0.00	0.00
2005	K Mahindra INDIA	22.00	0.00	0.00	0.00	22.00	0.00	0.00	0.00
2005	KPIT	11.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2003	L&T	50.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00
1990	M&M	0.00	0.07	0.00	0.00	0.00	0.07	0.00	0.00
1993	M&M	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.00
2002	MMFSL	9.48	0.00	7.97	0.00	9.48	0.00	7.97	0.00
2003	MSSL	0.00	2.29	0.00	0.00	0.00	2.20	0.00	0.00
2001	MahInfra	0.00	10.00	0.00	0.00	0.00	0.79	0.00	0.00
1996	Moser Baer	0.00	0.39	0.00	0.00	0.00	0.39	0.00	0.00

1999	Moser Baer	2.06	6.24	0.00	0.00	2.06	6.24	0.00	0.00
2000	Moser Baer	18.45	9.68	0.00	0.00	18.45	9.68	0.00	0.00
1997	NICCO-UCO	1.88	0.00	0.00	0.00	1.88	0.00	0.00	0.00
2001	NIIT-SLP	8.60	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2003	NewPath	0.00	9.31	0.00	0.00	0.00	7.06	0.00	0.00
2004	NewPath	0.00	2.79	0.00	0.00	0.00	2.12	0.00	0.00
2003	Niko Resources	37.78	0.00	0.00	0.00	37.78	0.00	0.00	0.00
2001	Orchid	0.00	3.03	0.00	0.00	0.00	3.03	0.00	0.00
1997	Owens Corning	7.71	0.00	0.00	0.00	7.71	0.00	0.00	0.00
2004	Powerlinks	77.42	0.00	0.00	0.00	46.16	0.00	0.00	0.00
1995	Prism Cement	9.97	0.00	0.00	3.95	9.97	0.00	0.00	3.95
2004	RAK India	20.00	0.00	0.00	0.00	20.00	0.00	0.00	0.00
1995	Ram Calcining	0.00	2.73	0.00	0.00	0.00	2.73	0.00	0.00
2004	Ram Calcining	10.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00
2005	Ramky	3.96	10.90	0.00	0.00	0.00	0.00	0.00	0.00
2001	SBI	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1997	SREI	4.29	0.00	0.00	0.00	4.29	0.00	0.00	0.00
2000	SREI	7.50	0.00	0.00	0.00	7.50	0.00	0.00	0.00
2005	SRF Ltd	20.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1995	Sara Fund	0.00	3.71	0.00	0.00	0.00	3.71	0.00	0.00
2004	Seal.ion	5.12	0.00	0.00	0.00	5.12	0.00	0.00	0.00
2001	Spryance	0.00	1.90	0.00	0.00	0.00	1.90	0.00	0.00
2003	Spryance	0.00	0.95	0.00	0.00	0.00	0.95	0.00	0.00
2004	Sundaram Finance	45.54	0.00	0.00	0.00	45.54	0.00	0.00	0.00
2000	Sundaram Home	0.00	2.18	0.00	0.00	0.00	2.18	0.00	0.00
2002	Sundaram Home	9.01	0.00	0.00	0.00	9.01	0.00	0.00	0.00
1998	TCW/ICICI	0.00	0.80	0.00	0.00	0.00	0.80	0.00	0.00
2005	TISCO	100.00	0.00	0.00	200.00	0.00	0.00	0.00	0.00
2002	TML	50.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00
2004	UPL	17.50	0.00	0.00	0.00	17.50	0.00	0.00	0.00
1996	United Riceland	6.88	0.00	0.00	0.00	6.88	0.00	0.00	0.00
2005	United Riceland	8.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2002	Usha Martin	19.43	1.44	0.00	0.00	19.43	1.44	0.00	0.00
2001	Vysya Bank	0.00	3.66	0.00	0.00	0.00	3.66	0.00	0.00
2005	Vysya Bank	0.00	3.51	0.00	0.00	0.00	3.51	0.00	0.00
1997	WIV	0.00	0.57	0.00	0.00	0.00	0.57	0.00	0.00
1997	Walden-Mgt India	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.00
	Total portfolio	1,085.23	161.64	44.40	348.37	651.81	115.76	37.40	148.37

		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic.
2000	APCL	0.01	0.00	0.00	0.00
2005	Allain Duhangan	0.00	0.00	0.00	0.00
2004	CGL	0.01	0.00	0.00	0.00
2004	CIFCO	0.00	0.00	0.02	0.00
2001	GI Wind Farms	0.01	0.00	0.00	0.00
2005	KPIT	0.00	0.00	0.00	0.00

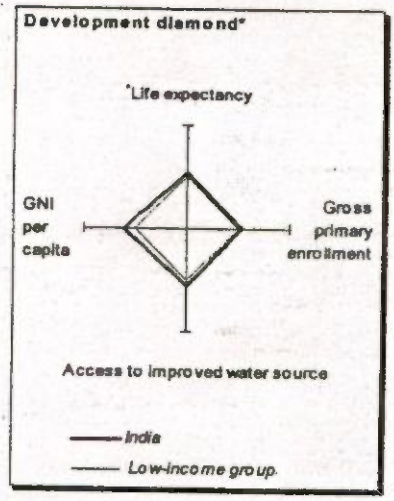
2D084	[illegible]	0.00	0.00	0.00	0.00
2D086	[illegible]	0.00	0.00	0.00	0.10
2D001	[illegible]	0.00	0.00	0.00	0.00
	[illegible]	0.03	0.00	0.02	0.10

Annex 14: Country at a Glance

INDIA: West Bengal Health Systems

POVERTY and SOCIAL

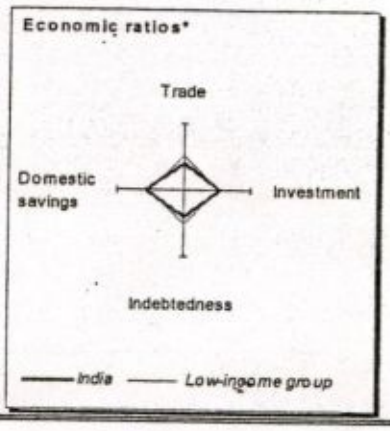
2004	India	South Asia	Low-income
Population, mid-year *(millions)*	1,079.7	1,448	2,338
GNI per capita *(Atlas method, US$)*	620	590	510
GNI *(Atlas method, US$ billions)*	672.8	860	1,194
Average annual growth, 1998-04			
Population *(%)*	1.6	1.7	1.8
Labor force *(%)*	2.1	2.1	2.1
Most recent estimate (latest year available, 1998-04)			
Poverty *(% of population below national poverty line)*	29	..	..
Urban population *(% of total population)*	29	28	30
Life expectancy at birth *(years)*	63	63	58
Infant mortality *(per 1,000 live births)*	65	66	79
Child malnutrition *(% of children under 5)*	47	48	44
Access to an improved water source *(% of population)*	84	84	75
Illiteracy *(% of population age 15+)*	39	41	39
Gross primary enrollment *(% of school-age population)*	99	97	94
Male	107	105	101
Female	90	92	86



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

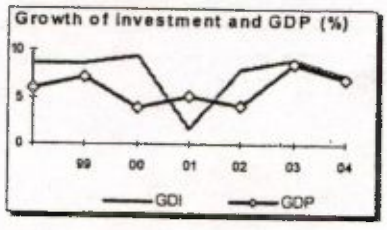
	1984	1994	2003	2004
GDP *(US$ billions)*	206.5	322.6	600.7	688.7
Gross domestic investment/GDP	21.6	23.4	23.0	24.6
Exports of goods and services/GDP	6.5	10.0	15.1	18.2
Gross domestic savings/GDP	18.8	24.8	28.1	22.8
Gross national savings/GDP	19.4	26.0	30.8	24.9
Current account balance/GDP	-1.4	-1.2	1.4	0.3
Interest payments/GDP	0.5	1.3	1.4	1.9
Total debt/GDP	16.5	31.8	19.2	17.6
Total debt service/exports	18.3	26.8	12.9	8.7
Present value of debt/GDP	..	..	18.7	..
Present value of debt/exports	..	..	89.3	..

(average annual growth)	1984-94	1994-04	2003	2004	2004-08
GDP	5.4	5.8	8.6	6.9	6.1
GDP per capita	3.3	4.1	7.0	5.4	4.8

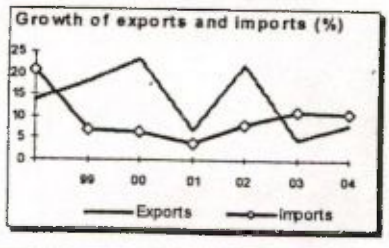


STRUCTURE of the ECONOMY

(% of GDP)	1984	1994	2003	2004
Agriculture	35.2	30.4	22.8	21.2
Industry	26.2	27.1	28.4	27.0
Manufacturing	18.4	18.9	15.6	16.1
Services	38.7	42.5	50.7	51.8
Private consumption	69.0	66.2	66.7	64.5
General government consumption	10.8	10.7	11.3	12.7
Imports of goods and services	7.9	10.3	16.1	18.0

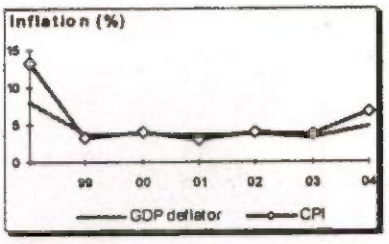


(average annual growth)	1984-94	1994-04	2003	2004
Agriculture	3.4	2.0	9.6	1.1
Industry	6.3	5.8	7.0	7.7
Manufacturing	6.2	5.6	6.9	7.7
Services	6.7	8.2	8.9	8.9
Private consumption	5.7	4.7	11.3	8.0
General government consumption	4.8	5.9	3.7	3.9
Gross domestic investment	5.0	6.9	9.0	7.3
Imports of goods and services	8.4	9.6	11.2	11.0



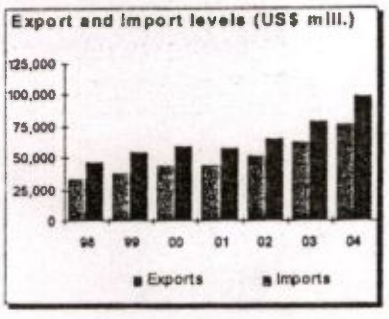
PRICES and GOVERNMENT FINANCE

	1984	1994	2003	2004
Domestic prices				
(% change)				
Consumer prices	4.3	7.6	3.7	6.6
Implicit GDP deflator	7.4	9.7	3.2	4.9
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	18.0	18.7	19.9
Current budget balance	..	-3.7	-4.9	-5.8
Overall surplus/deficit	..	-7.5	-9.3	-10.6



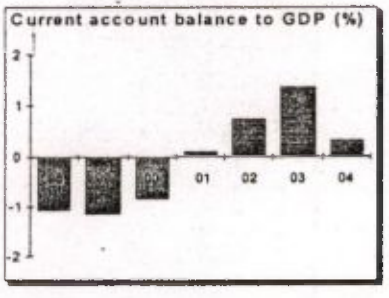
TRADE

	1984	1994	2003	2004
(US$ millions)				
Total exports (fob)	10,061	26,855	62,952	76,345
Tea	321	1,126	1,321	..
Iron	453	988	2,341	..
Manufactures	5,614	20,404	47,616	57,898
Total imports (cif)	15,715	35,904	79,658	99,836
Food	1,384	1,144	3,059	..
Fuel and energy	4,596	5,928	20,570	..
Capital goods	2,546	7,638	17,132	20,915
Export price index *(1995=100)*	99	109	93	104
Import price index *(1995=100)*	119	104	100	113
Terms of trade *(1995=100)*	83	105	94	92



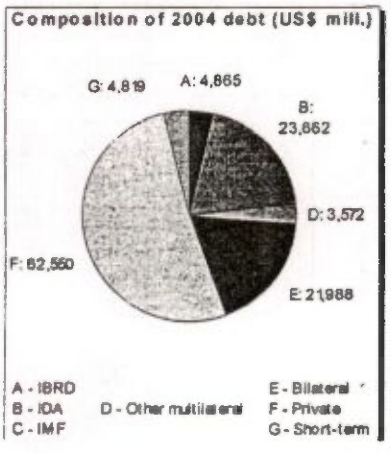
BALANCE of PAYMENTS

	1984	1994	2003	2004
(US$ millions)				
Exports of goods and services	13,508	32,990	90,568	108,948
Imports of goods and services	18,065	41,437	98,590	121,250
Resource balance	-4,557	-8,447	-8,022	-12,302
Net income	-838	-3,431	-4,703	-4,800
Net current transfers	2,496	8,093	18,885	19,243
Current account balance	-2,899	-3,785	8,160	2,141
Financing items (net)	2,516	9,526	8,820	19,655
Changes in net reserves	383	-5,741	-16,980	-21,795
Memo:				
Reserves including gold *(US$ millions)*	5,952	25,186	111,848	133,441
Conversion rate *(DEC, local/US$)*	11.9	31.4	46.0	44.9



EXTERNAL DEBT and RESOURCE FLOWS

	1984	1994	2003	2004
(US$ millions)				
Total debt outstanding and disbursed	34,036	102,483	115,277	121,456
IBRD	1,688	11,244	4,126	4,865
IDA	8,545	17,758	22,351	23,662
Total debt service	2,973	10,951	14,469	11,337
IBRD	257	1,641	2,079	288
IDA	109	325	771	755
Composition of net resource flows				
Official grants	483	418	559	646
Official creditors	1,363	970	2,231	..
Private creditors	1,895	1,438	8,565	..
Foreign direct investment	0	983	3,137	4,020
Portfolio equity	0	3,824	11,355	8,998
World Bank program				
Commitments	2,651	2,064	1,600	2,705
Disbursements	1,114	1,783	1,717	1,835
Principal repayments	129	1,062	2,468	784



THE URBAN HEALTH STRATEGY

AUGUST 2008

GOVERNMENT OF WEST BENGAL

THE URBAN HEALTH STRATEGY

GOVERNMENT OF WEST BENGAL

Background:

The mission of the Government of West Bengal is **"To improve the health status of all the people of West Bengal, especially the poorest and those in greatest need"** as stated in the West Bengal Health Sector Strategy (2004-13).

According to the Census of India 2001, the urban population of the state stands at 22.4 million, which is 28% of its total population of 80.2 million. Historically, the percentage of urban population in the state has always been higher than the national average. The state ranks first in respect of the average population density in urban areas (approximately 6745 per Sq Km) and fourth in terms of absolute size of urban population amongst all Indian states.

West Bengal has experience of implementing successful urban health programmes in several parts of the state. However the state does not have a well structured and clearly articulated statewide urban health strategy. A multitude of health care providers exist with different jurisdictional areas and varying statutory responsibilities. This poses management and implementation problems and fragments efforts. Further, there is a lack of organized and coordinated primary health care services in urban areas. Hence a consistent and focused approach to urban health is imperative

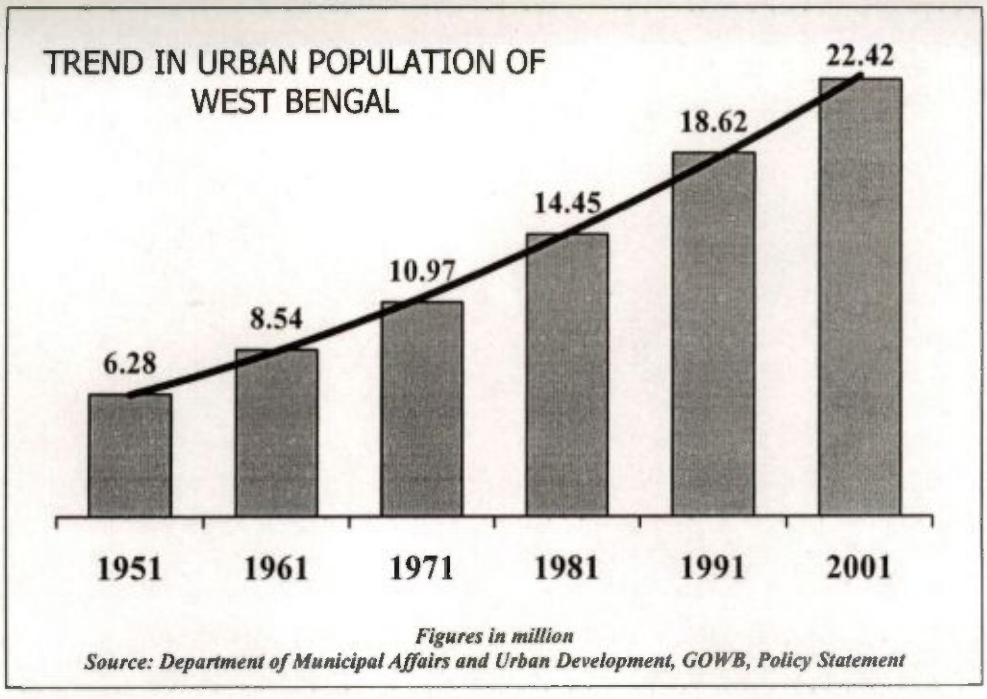
The Government is now committed to ensuring accessible, equitable and quality health care services to the urban population of the State. Towards this end the Department of Health & Family Welfare (DHFW) and Department of Municipal Affairs & Urban Development (DMA & UD) propose to contextualise the strategic framework within which the State shall seek to address the health concerns of the urban poor.

Current Urban Health Scenario in West Bengal

Urbanization in West Bengal

The urban population of West Bengal has had an upward spiral though the rate of increase has slowed down in recent years. This is partially due to the state policy on agricultural prosperity that has significantly checked the process of rural to urban migration.

The trend in urban population is depicted in the following table :



Figures in million

Source: Department of Municipal Affairs and Urban Development, GOWB, Policy Statement

Urban Units in West Bengal

The number of various urban units in West Bengal in 2001 is as follows :

Municipal Corporation	Municipalities
6	120

Health Infrastructure in Urban West Bengal

The public health infrastructure of West Bengal is overstretched due to the huge population pressure on the state and because of the fact that a lot of curative services are also rendered through the public healthcare delivery system. 76% of all health institutes in the state are run by the government, compared to 40% in other parts of India (West Bengal Human Development Report 2004).

From the Mapping of Health Infrastructure in Urban Local Bodies in West Bengal (executed by West Bengal Municipal Association), it is found that the health infrastructure in the 126 municipalities is a collage with different combinations of facilities available, ranging from abundance to paucity. There are towns with plentiful health facilities – government, private and community-based interventions. On the other hand, there are towns, which do not have a minimum health infrastructure.

Health infrastructure in the municipalities is divided in four categories viz.

1. Hospitals, health centres and sub-centres supported by the State Health Department.

2. Facilities owned by the other government departments,

3. Municipality controlled facilities and

4. Private sector facilities.

A major problem is inequitable distribution of health facilities in the different categories of municipalities, especially the facilities owned by the municipalities. 25% of the facilities are taken away by the 4% of the municipalities and 50% of the facilities are enjoyed by only 12% of them. Cold chain is another factor that requires to be looked into to ensure efficacy of vaccines. It was found that only 40% of the municipalities have control over their cold chain, for others they depend on the State Health Department. (West Bengal Municipal Association, 2005).

It was found that 42% of all facilities supported by the State Health Department and situated within municipal boundaries are part of the rural health system. Facilities owned by government organizations and other government departments, like jail hospitals and ESI hospitals, serve special groups of people and are hence inaccessible to the general population.

Private facilities are abundant in some municipalities and bridge the gap between demand and supply. These include private nursing homes, a large group of private practitioners, a few NGO initiatives and quacks. These available facilities are concentrated in bigger towns and small municipalities are dependent on rural infrastructure located in municipal areas. There are super specialists physicians practicing side by side with unqualified Rural Medical Practitioners (RMPs). No information flows from the private agencies to the government system. As a result services provided by them remain unaccounted for. In the absence of a stringent quality assurance system, the quality of health care in private sector is always under question.

Urban Health and Disease Burden

Unfortunately, policymakers do not have enough information on the health conditions of the urban poor. Where there is data specific to the health of the urban populations, it often suffers from at least some weaknesses. First, health data is usually aggregated to provide an average of all urban residents - wealthy and poor - rather than disaggregated by income or a wealth. It thus masks the health conditions of the urban poor. Second, the urban poor are often overlooked altogether. The informal or often illegal status of low-income urban settlements contributes to the fact that public health authorities often do not have the means or the mandate to collect data on urban poor populations. Further, health

data are usually based on household surveys. This means that most surveys do not count the homeless.

Communicable diseases are a major problem in urban populations in general and slum populations in particular. "High levels of overcrowding also make poor urban residents vulnerable to contracting communicable diseases such as tuberculosis, acute respiratory infections, and meningitis. Vaccine-preventable diseases such as measles spread more rapidly in overcrowded urban areas among non immunised populations. Inadequate provision for drainage can increase risk of malaria as its mosquito vector breeds in flooded areas and ditches; inadequate provision for sanitation often raises the risk of urban dengue and yellow fever because the vector breeds in latrines, soakaway pits, and septic tanks... High rates of HIV/AIDS are becoming an increasingly distressing fact of urban life in developing countries. " (Lancet Millennium Project series, March 2005).

Recent years have seen a series of out break of vector borne diseases like Dengue, Malaria and water borne diseases like Hepatitis A and acute diarrheal diseases in various ULBs. There have been reported deaths besides acute ill health, burdening the already stretched health system. This reflects the inadequacy of the ULBs to prevent these situations and to respond effectively and rapidly to contain the outbreaks.

Recent SRS data available for the year 2006 shows an appreciable improvement in the birth rate in the urban areas down to 12.3 and an infant mortality rate of 29 per 1000 live births. However, it is assumed that these averages are a result of the improved status in the 41 Kolkata Municipal Area municipalities and 22 others (a total of 63 municipalities) which has had dedicated programme with external assistance since 1992. The 63 municipalities, which do not have any dedicated health programme, are also the ones, which have a distinct disadvantage in terms of geographical location (further away from Kolkata), very poor health service facilities (Mapping Of Health Infrastructure In Urban Local Bodies, November 2005, West Bengal Municipal Association).

Disaggregated data for urban poor women's fertility, contraception usage and attended delivery data is not available currently. However, the overall indicators for these outcomes is available for the state as a whole and several of the health indicators (notably MMR, NMR, IMR and TFR) for West Bengal are better than their national equivalents.

The following tables reveal the major health indicators for the state.

A comparison of the birth rate and death rate of West Bengal

Birth Rate			Death Rate		
Rural	Urban	Total	Rural	Urban	Total
20.7	12.3	18.4	6.2	6.3	6.2

Sample Registration System 2006

Selected Health and Demographic Indicators for India and West Bengal

Indicators	West Bengal			All India
	Rural	Urban	Combined	
Life expectancy at birth (years)(2000-04)(SRS)	63.0	69.4	64.4	63
Total Fertility Rate (SRS 2005)	2.4	1.4	2.1	2.9
Maternal Mortality Ratio (per 1,00,000 LB)(RGI Survey 2001-03)	-	-	194	301
Current use of contraception by any modern method (NFHS-3) 2005-06	49.9	49.9	49.9	48.5
Female literacy rate (2001 census)	53.2	75.7	59.6	53.7
Infant Mortality Rate (SRS 2006)	40.0	29.0	38.0	57
Neonatal mortality rate (per 1000 LB) SRS 2005	32	20	30	37
Child Mortality Rate (per 1000 LB) (1-5 years) NFHS-3	-	-	12.2	18.4
Child Vaccinations : complete 2002-04 (NFHS-3)	62.8	70.3	64.3	43.5
Perinatal Mortality Rate(SRS 2005)	34	21	31	37
Still Birth Rate (SRS 2005)	9	7	9	9

Strategic issues to be addressed in Urban Health

- Lack of uniform urban health infrastructure and non-availability of primary health care in some urban areas.
- Non existence of appropriate screening and referral system. Secondary and tertiary care often remain underutilized on one hand and on the other, several secondary and tertiary care facilities are often overcrowded in terms of outpatient attendance and inpatient bed occupancy leading to poor quality of services.
- The limited presence of private service providers due to locational disadvantages of some municipalities.

- The limited organizational experience in the delivery of health care in 63 non Kolkata Municipal Area (KMA) municipalities.

- The lack of population based health status data and its implication for planning and benchmarking.

- Poor disease surveillance, absence of appropriate diagnostic services etc. often putting the public health system under strong criticism when the early warning signals for impending outbreaks are not recognized and outbreaks spread.

Experiences and Lessons learnt in Urban Health Care in West Bengal

The State has the experience of various projects (CUDPIII, IPP-VIII, IPP-VIII (Extn.), CSIP RCH Sub Project and HHW's Scheme) covering 63 ULBs. In KMA areas, through the Kolkata Metropolitan Development Authority (KMDA), the Department of Health and Family Welfare (DHFW) has implemented four projects funded by external agencies. The projects are World Bank (WB) funded CUDP-III (1984 – 1992), DFID funded CSIP (1992-1998), WB funded IPP-VIII (1994-2002) and European Commission supported UHIP. Post IPP-VIII funding, DHFW also has the experience and learning from the maintenance phase, which continues till date.

An independent end line survey of IPP- VIII project showed a notable fertility decline among the slum population, marked improvement in maternal and child health as evidenced by a decrease in infant mortality and increased utilization of the RCH services. The projects provided lessons both in implementation and organizational front.

Institutional lessons:

a. Decentralization in administrative and financial matters can create both ownership and local political commitment at the Urban Local Body (ULB) level and lead to strengthened capacity and confidence in managing such programmes.

b. Various community structures (ward committees) along with adequate leadership of the local bodies can work on combating exclusion, mobilizing resources and energy, and achieving effective implementation. The ward committees can help in creating awareness about the project besides providing their inputs in the micro planning for their ward and help facilitate the work of the Honorary Health Workers.

c. Community participation can be encouraged through the ward/block committees in different stages of planning, implementation and monitoring of the programme in their respective wards/block.

d. The deployment of female honorary health workers (HHW) approximately @ 1 per 1000 poor population can be effective in bringing about a major change in the health seeking behaviour and help achieve desired heath outcomes.

e. Use of private practitioners to complement primary clinical care and immunization services through the sub centres work reasonably well, wherever they are available.

f. Flexibility in project design allows for accommodation of local needs and capacities.

g. It is important to clarify the roles and responsibilities of the multiple organizations providing urban health services.

h. It is needed to identify and recognize the marginalized populations like settlements along railway tracks, rag pickers, migrants in squatter colonies etc. to avoid being excluded from the benefits of such projects.

i. A system of repeated and continued refresher trainings for HHW and regular feedback mechanisms are required to make effective use of lessons learned from the field.

Technical Lessons:

a. A formal referral chain with linkages to facilities providing higher-level care should be ensured since stand-alone facilities like maternity homes are difficult to sustain.

b. There is need to include the larger urban population for preventive and public health intervention.

c. Service package should include a mix of public health and primary level curative care in addition to emphasis on preventive and promotive care.

d. There is need for population based health status data and it being factored in local planning.

The Urban Health Strategy outlines some broadly common objectives and operational strategies for all ULBs but it would be adequately adapted to the local needs, priorities and available resources depending on the commitment and capacities of the ULBs and other key stakeholders.

Goal

The goal of the Urban Health Strategy of the Government of West Bengal is:

Improved health for all urban populations with special focus on poor, underserved and vulnerable population

Objectives

- To decrease maternal, child and infant mortality by providing better and consistent quality services to families in urban areas with special focus on urban poor, underserved and vulnerable populations through enhanced demand and universal access to quality services.

- To reduce the prevalence of communicable diseases currently covered by the national health programmes and reduce the risk of epidemic outbreaks by reducing exposure to health risk factors.

- To improve the quality of basic health services by providing supervisory, managerial, technical and interpersonal skills to all levels of health functionaries.

- To generate awareness and enhance community mobilization through IEC/BCC to supplement and make the above interventions effective

Key strategies

- ❖ Universal coverage – the entire urban population including both APL and BPL to be covered, while keeping the focus on BPL.
- ❖ Strengthening service delivery through a uniform 3-tier service delivery model.
- ❖ Strengthening institutional arrangements and inter departmental convergence.
- ❖ Strengthening monitoring and evaluation.

Key Strategy 1: Universal Coverage

The Urban Health Strategy proposes to target the entire urban population of West Bengal, while keeping the focus on the poor, the marginalized and the underserved.

Key Strategy 2: Strengthening service delivery through a uniform 3-tier service delivery model

A multi pronged approach will be taken to strengthen service delivery through a plethora of measures:

- Institutionalizing the existing 3-tier primary health care model (Appendix-1) by

- Strengthening community out reach through the Honorary Health Worker (HHW) and First Tier Supervisor (FTS) at the sub-center
- Strengthening infrastructure – physical and human resource related (Including introduction of a new cadre of personnel called First Tier Supervisor (FTS) – Public Health to be based at ULBs).

- Community empowerment and involvement through a number of measures like recruitment of HHW's from the community, discussions and awareness generation on health & nutrition issues and determinants of health through existing community groups (CDS / SHG's etc), participation of these groups in ward committees and through them providing organizational inputs in planning and managing the programs
- Supporting and strengthening existing facilities in ULBs, where needed.
- Strengthening the public health role of the municipalities through establishing standardised outbreak control protocols, etc.
- Preparation of ULB specific action plan to reflect the operational strategies, and address the ULB specific determinants of health.
- Introducing newer models of service delivery where necessary like :
  - Public Private Partnerships (PPPs) with NGOs/private sector for training, data management etc
  - Mobile health care services in hard to reach areas etc
- Adopting and implementing appropriate Behaviour Change Communication (BCC) strategies to improve health communication – this will combine interactive group and interpersonal methods on the ground, mass media initiatives and advocacy with various stakeholders.

Key Strategy 3: Strengthening institutional arrangements and inter departmental convergence

The institutional arrangements will take into account the multiplicity of agencies that will form part of the arrangement and will be planned to be conducive to:

- Strengthening stewardship role of DHFW through establishment of Urban health cell in DHFW
- Strengthening the capacity of Department of Municipal Affairs (DMA) through establishment of an Urban Health Cell with dedicated officials to oversee urban health and strengthening the implementation capacity of the State Urban Development Agency
- Formation of an inter-departmental coordination committee steered by the DHFW , with representation from other key stakeholders like Department of Municipal Affairs and Urban Development, Department of Public Health Engineering, Department of Women and Child Development (DWCD), School Education Department, Higher Education Department and Kolkata Municipal Corporation (refer Appendix-2 for chart on institutional arrangements for Urban Health)

- Formation of a health committee under the District Health and Family Welfare Samity, under the Chairmanship of the District Magistrate to liaise with the ULB level Health and Family Welfare Committees.
- Defining the roles and responsibilities of the departments, including patterns of fund flows. (Refer Appendix 3)
- ULB and ward level health committees to coordinate multi departmental response including, but not limited to:
    - Water quality management, solid waste management, sanitation and hygiene, tracking of seasonal disease outbreaks, compulsory reporting of all notifiable disease from all health facilities and undertaking vector control measures.
- To continue with the decentralisation of management and implementation of the program to the municipalities
- Improved capacity of human resources at all levels – community level, ULB level and at the level of State Urban Development Agency
- Referral linkages with the District and the Block facilities of the DHFW.

Key Strategy 4: Strengthening Monitoring and Evaluation

The UH strategy will enable establishment of the necessary institutional and financial requirements to have a well-functioning Monitoring and Evaluation (M&E) system ensuring measurement of performance and impact to become regular and hence able to continuously inform the planning process.

The M&E will work in the overall framework of the HMIS for the DHFW and MA & UD and will include, but not be limited to:

- Establishing routine monitoring systems and its implementation in consultation with both departments (Refer Appendix 4)
- Designing systems to record and capture early warning signals for impending outbreaks in order to improve epidemiological surveillance and disease prevention
- Periodic surveys to capture health status of the urban population

APPENDIX 1

SERVICE DELIVERY MODEL

Service Delivery Model:

The programme envisages implementation of a multi level service delivery model supporting a strong community outreach intervention. The service package will include apart from emphasis on preventive and promotive care a mix of public health and primary level curative care.

The First Tier

The objective of the community outreach is to move the health care from institutions to the doorstep with access of all beneficiary households to Honorary Health Workers (HHWs). The community level operational strategy will be to include both urban poor and the general population. For the Urban Poor an intensive approach including regular home visits and maintaining a Family Health Card will be initiated. A community outreach clinic providing basic preventive and promotive services will be provided close to their habitation. (refer to the 2nd tier – sub center)

The service delivery will be expanded to all municipal population through initiation of outreach services using female honorary health workers (HHWs) to be recruited from urban communities. This outreach will be organized with the Ward as the geographical unit. The Ward Councilor/ Ward Health sub committee would be providing support and oversight.

For the general population the approach would be to provide Public Health inputs through various educational and service strategies included under various National Health Programmes.

The number of HHWs per ULB will be determined by the number of urban poor in that ULB distributed one per 1000 such poor population or the number of wards whichever is more. The municipalities will allocate the HHWs according to the agglomeration of low socio economic population in a ward.

The Second Tier

This will be designated as Sub Centre and will cater to a population of 5000 urban poor from a cluster of wards, such that it provides a much better level of primary health care and introduce more flexibility in its timings. The sub centre will be closer to the community and the municipality, aided by the GIS maps for optimum location.

A First Tier Supervisor (FTS) will be selected from amongst the HHWs after at least six months experience and an additional training input. One set of these FTS will be

allocated responsibility at the sub centres and provide support to five HHWs in their outreach work and will manage the sub centre. First Time Supervisor (FTS) will be providing counseling plus basic primary care.

There will be another category called the FTS – Public Health who will be responsible for 20,000 general population in terms of the public health inputs. They will be part of the ULB team and work under the supervision of the Health Officer (HO) of the ULB.

The Sub Centre will be manned by a FTS and a Medical Officer (part time).

A structured Monitoring and supervision schedule will be in place and training of the FTS will include developing skills for appropriate supportive supervision work undertaken through monitoring and performance Indicators.

The Third Tier- Referral Facility

The referral Facility the third tier of support will be a BPHC/Rural Hospital/Sub Divisional Hospital/ District hospital. Where these are not accessible or the municipalities have successfully implemented maternity home then these can be used as referral facilities.

In 15 ULB where no such DHFW secondary facility exists an Urban Health Centre under the management of the DHFW will be set up. This facility will serve as a daily OPD besides providing preventive interventions not available at the sub center.

Package of Services

First Tier : Community level Honorary Health Workers (HHWs)

The HHW will provide the following services, at the minimum,

- Fortnightly visit to at least 200-300 households. Daily at least 15-20 houses are required to be visited. The family schedule to be updated in every visit noting births and deaths including entry of newborns, new comers and deletion of those died or left permanently and whether the birth was under a safe hand or in a institute
- Enquiring about pregnancies and registering them. Enquiring about abortion and MTP and noting the same
- Focused counselling on antenatal care and providing them referral slips to visit the sub-centre.
- Enquiring about immunization status of mother and infants and children.

RCH

- Identifying malnourished children, motivation and referral slips to sub-centre

- To distribute contraceptives
- Referral for institutional delivery/ emergency referral
- Motivating and taking the mother / pregnant women / children to the sub centre for immunization.
- Encouraging the pregnant mothers to visit the sub centre for ANC check up by the PTMO
- Information, education and communication: breast feeding, contraceptives, diet, ORS, personal hygiene, immunization, environment including general cleanliness, promoting institutional delivery and utilization of existing institutions, etc
- Encouraging mothers to go in for institutional delivery.
- To hold mothers meeting

RCH- Linked activities

- Follow up of referrals
- To assist in outreach immunization activities
- To assist in immunisation campaign whenever undertaken: Pulse polio etc

Public Health – Direct

- While Enquiring about any death in the family; ascertain whether the death is from any listed communicable diseases.
- Enquiring for occurrence of important identified communicable diseases in the house during the period from last visit till present and looking for any current illness in the family ; noting the same and advising accordingly.
- Preparation of HMIS report including recognition of early warning signals and information to higher level.
- Recognizing danger sign with relation to ARI, Diarrhoea etc. and advising on initiation of treatment and referral whenever needed
- Distribution of ORS and demonstrating preparation of ORS
- To motivate adolescent boys and girls/men and women through referral to appropriate treatment centres
- Liaison with community leaders
- Participating in the ward committee meeting

Public health – Linked service

- Support to National Health programs
- Support to outbreak investigation etc
- HHW will be accountable to ward committee/ councillor

Second Tier: Sub Centre

This will be designated as Sub Centre and will cater to a population of 5000 urban poor such that it provides a much better level of primary health care and introduce more flexibility in its timings. The Sub Centre will be manned by a FTS and ULB Health Officer/ a medical officer and will offer the following minimum services:

- Child health care services including immunization, distribution of IFA, Vitamin A, ORS packets etc.
- ANC services and counseling for institutional delivery.
- Promotion of Family Planning - oral pills, condom use, counseling for adoption of terminal methods.
- Primary treatment of common ailments

The specific services will be delivered through predetermined clinic days as follows:

1. ANC/PNC and Family Planning counseling clinic – two days in a month.
2. Immunization Clinic – Once a week.
3. General treatment clinic by Doctor – Once a week.
4. Growth Monitoring of U-5 children Clinic – Once a month.
5. Health Awareness Programme – Once in a fortnight.

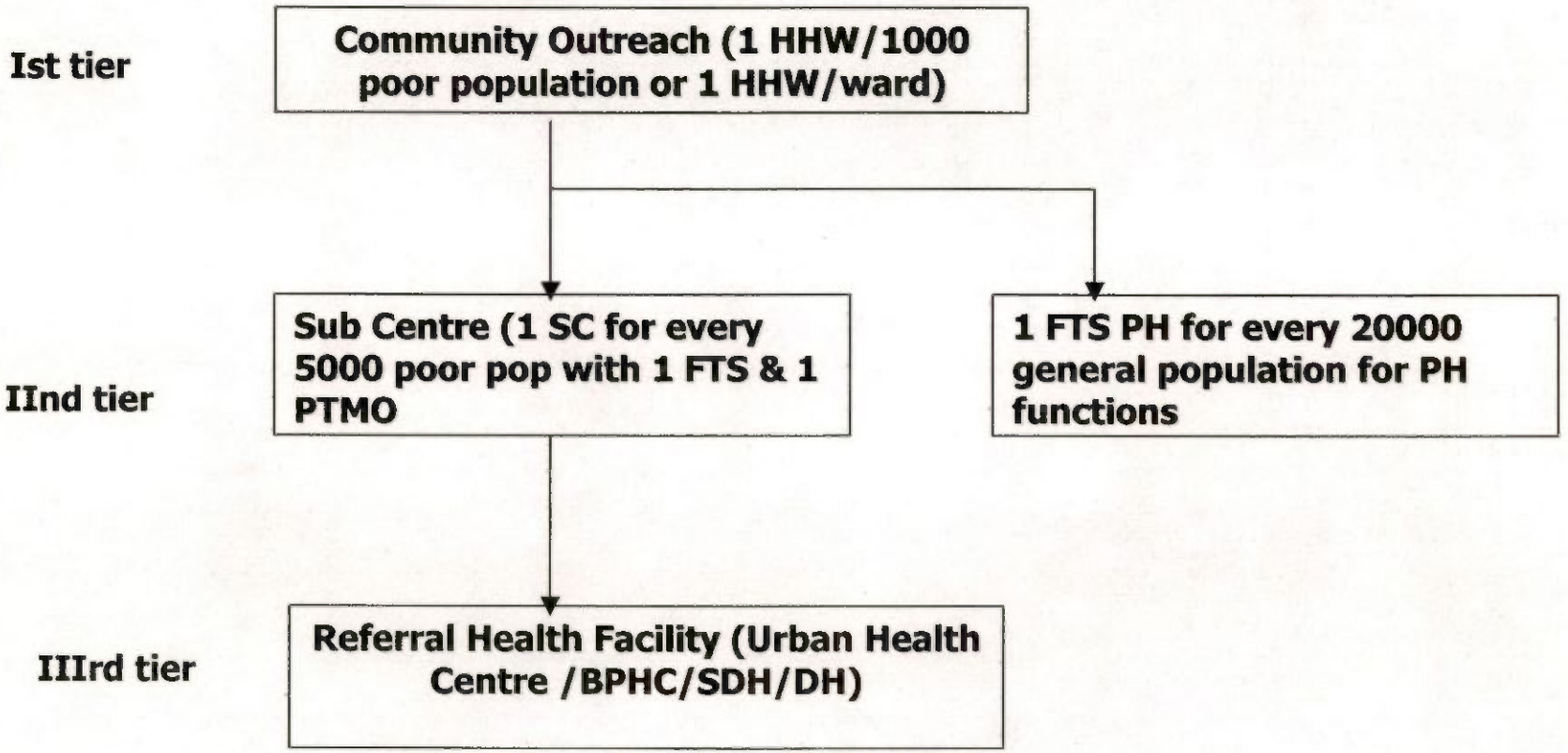
The Third Tier- Referral Facility:

The referral Facility the third tier of support will be a BPHC/Rural Hospital/Sub Divisional Hospital/ District hospital.

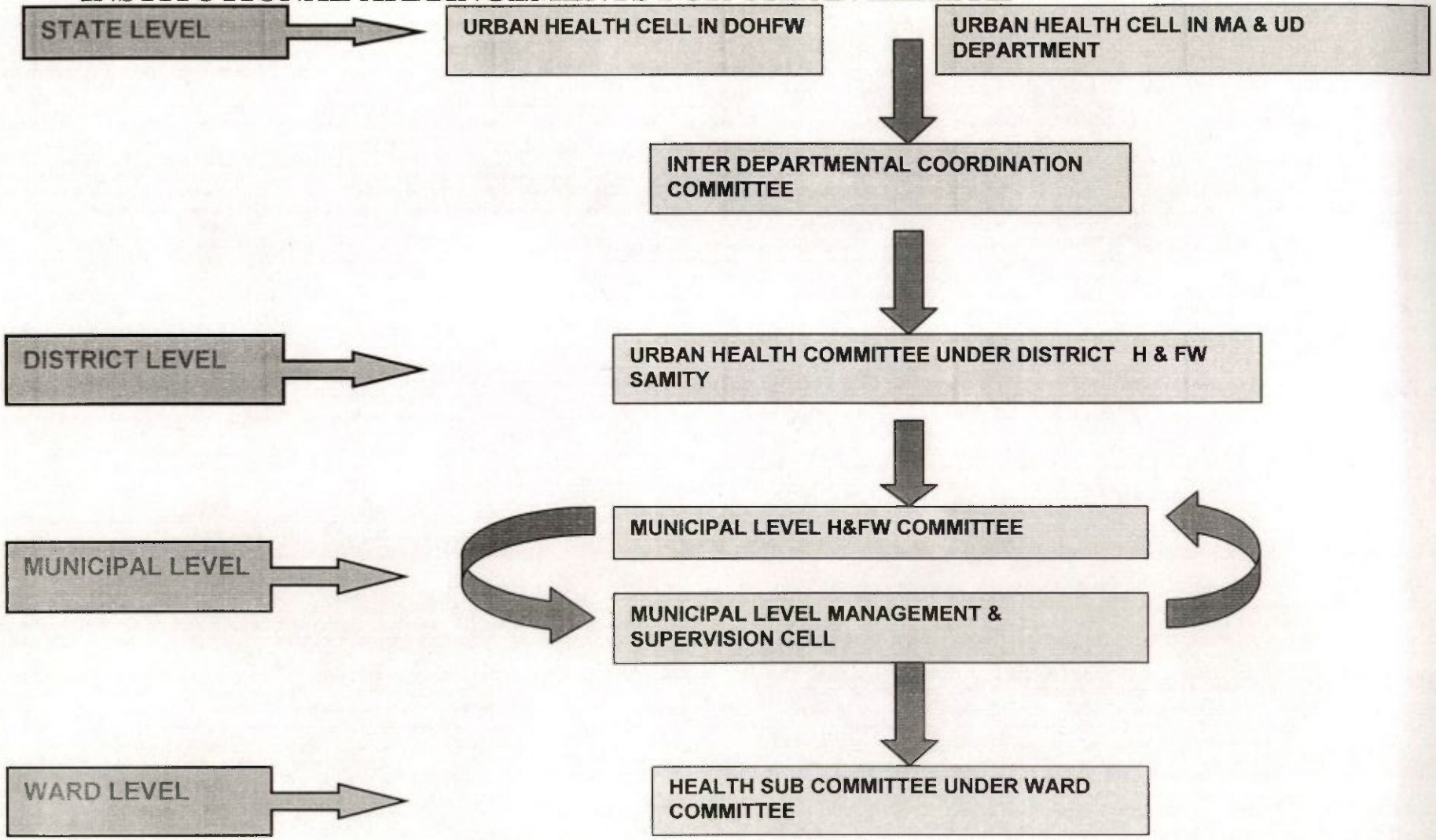
The facilities available will include a minimum of the following services:

- Full range of Family Planning services including laparoscopic services.
- Institutional Delivery services
- Essential and Emergency Obstetric Care
- MTP services
- Child health referral services including essential and emergency newborn care.
- Basic medical and surgical services.
- Services under national disease control programmes

SERVICE DELIVERY MODEL



APPENDIX 2
INSTITUTIONAL ARRANGEMENTS FOR URBAN HEALTH



Appendix 3

Roles and responsibilities of key agenceis

Department of Health and Family Welfare

The DOHFW will play a lead role in steering policy, formulation of standards and norms, operational guidelines and, coordinating with department of municipal affairs.

An Urban health cell will be formed in the DHFW to manage activities related to the urban health. At the district level, aUrban Health committee under the District Health Samity will be formed and a nodal person at the district level responsible for urban health affairs will be identified.

Role of Municipal Affairs Department

The Municipal Affairs Department will be responsible for implementation of the Program through the 126 municipalities. It will be responsible for the overall execution of the Program and will provide management support. It has identified the State Urban Development Agency (SUDA) to provide technical backstopping, capacity building and monitoring/supervision support to the implementation efforts.

The department of municipal affairs is entrusted with the responsibility of providing legal and administrative support to the urban local bodies of the state and to implement some of the urban development Programs through the ULBs. The key functions of the department are to facilitate as well as monitor municipal functions of Corporations and ULBs, to formulate acts and rules governing the ULBs, and to facilitate capacity building of ULBs.

SUDA : State Urban Development Agency

SUDA was set up in 1991 with a view to ensuring proper implementation and monitoring of the centrally assisted Programs for generating employment opportunities and alleviation of poverty throughout the state. SUDA is a society registered under the West Bengal Societies Registration Act, 1961.

The main function of SUDA is to manage the programs through coordination with different agencies like MA & UD, ULBs, DHFW, provide technical assistance to ULBs, monitor and report on progress, mobilise resources, and act as a nodal agency for various Programs.

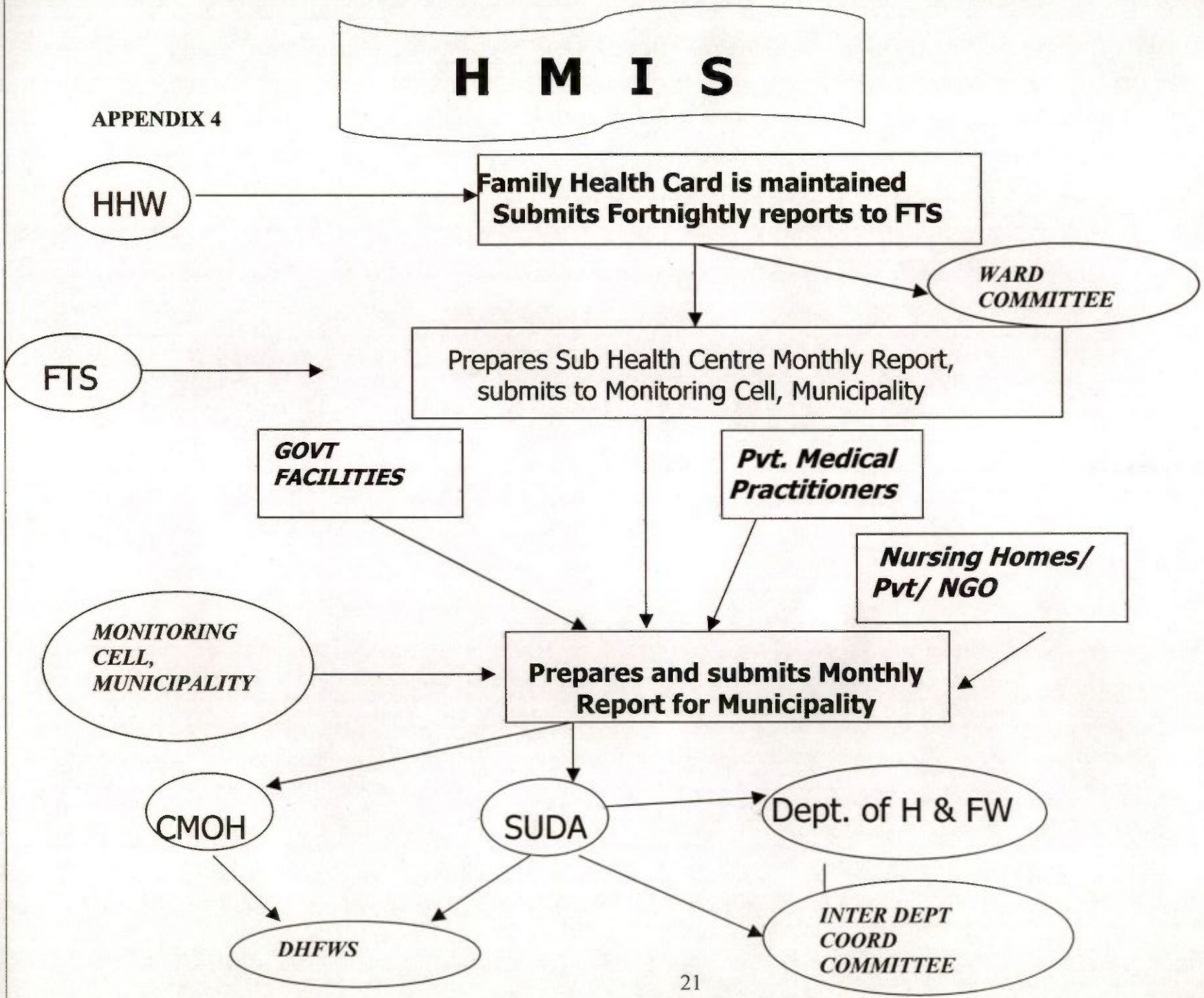
The technical agency (SUDA) of the Municipal affairs department will be the key agency to provide technical backstopping, capacity building and monitoring/supervision support to the implementation efforts. More specifically it will provide support in the area of: (i) managing the partnerships with ULBs. (ii) Capacity building of ULBs. (iii) IEC /BCC activities. (iv) Administrative and HR functions. (v) Accounting, commercial and supply chain functions.

ULBs

At the ULB level, technical support would be provided by the implementing agency, and staffing at ULB and outreach level would be optimized in order to achieve the program objectives efficiently and effectively.

The Urban Local Bodies would be the implementing organisations. They would be responsible for implementing the health programs including staff recruitment, placement, training, managing logistics, ensuring linkages with other arms of the ULB like conservancy, sanitation etc, procurement (where necessary), monitoring the placement and functioning of sub centres, submission of regular reports and expenditure statements to appropriate authorities and liaisoning with SUDA and DHFW where necessary.

APPENDIX 4


H M I S
HHW
Family Health Card is maintained
Submits Fortnightly reports to FTS
WARD COMMITTEE
FTS
Prepares Sub Health Centre Monthly Report, submits to Monitoring Cell, Municipality
GOVT FACILITIES
Pvt. Medical Practitioners
Nursing Homes/ Pvt/ NGO
MONITORING CELL, MUNICIPALITY
Prepares and submits Monthly Report for Municipality
CMOH
SUDA
Dept. of H & FW
DHFWS
INTER DEPT COORD COMMITTEE

KUSP
FOOTFALLS OF FUTURE

02-06-2008

CHANGE MANAGEMENT UNIT

NOTE

Sub: Urban Health Strategy

Programme Director, BHP & e.o. Special Secretary, Health & Family Welfare Department has forwarded the proposed Urban Health Strategy of Government of West Bengal to our Department.

The Health Strategy is placed in the file. Some comments from Dr S Goswami of SUDA on the Health Strategy is also placed in the file for kind perusal.

We may ask the Health Department to include the following in the Health Strategy:

1) A section may be included where the role of Urban Local Bodies vis-à-vis the State Government may be specified for clarity.

2) The strategy with respect to facilities already run by ULBs, which do no find place in this strategy, may be clarified. For example, Health Administrative Unit, Regional Diagnostic Centre, extended OPD and some General Hospitals.

The strategy may also address the issue of low pay and low motivation of the Community Health System workers and need for uniformity with Health Department. The availability of part time medical officer or clinic based medical officer may also be addressed in the strategy.

Another discussion may be held with the Department of Health and Family Welfare before the strategy is finalized.

(Arhab Roy)
Spl. Secretary, M.A. Dept.

Encl: As stated above.

Principal Secretary,
Municipal Affairs Deptt.

U.O. No.CMU- 94/2003(Pt-vi)/97
Date: 02-06-2008

In addition to the above the strategy need to highlight the involvement of the community as part of the key strategy, linkage with other social sector activities like mid day meal, ICDS and other nutrition programme. Provisions on basic amenities and sanitation also need mention as they are key inputs in health care activities. An ULB level structure need to be in place to oversee the programme.

on the issue of services
the sub centre perhaps need
strengthening. The general treatment clinic by
Doctor should be atleast 3 days a week

we may send our views to
Health Dept accordingly.

[signature]
3/6/08

[signature]
9/6/08.

MIC

Pr. Secy (Health)

May Pl. see and discuss.

[signature]
21/6/08

CS (CL & Secy)

DD (GIS)

[signature] Advisor
23.6.08

Discussed. The issue was
recently discussed with Pr. Secy
Urban Dev. Deptt. A further meeting will be made
with them for finalisation.
[signature]
31/6/08.

Notes at nsp 1-2 may kindly be referred to. The response of Health & Family Welfare Department to the observations of Municipal Affairs Department on the draft Urban Health Strategy may be seen at Flag-B. Accordingly, the draft Urban Health Strategy has been revised and placed at Flag-A.

In this connection, the discussion on the draft Strategy held in the meeting of MIC, Health & Family Welfare Department and MIC, Municipal Affairs Department on August 21, 2008 at Swasthya Bhavan may kindly be recalled. A presentation on the revised draft was also made in the meeting where Principal Secretaries of both the Departments were also present. A copy of the power point presentation is placed at Flag-C. After detailed discussion during the meeting, the draft Strategy was considered acceptable to both the Departments to address Urban Health issues.

However, a formal approval to the draft Urban Health Strategy may be recorded in the file before the same is officially adopted.

Also as decided in the meeting, the Urban Health Strategy, duly approved, would be placed for its dissemination in a meeting with Chairmen/Chairpersons of Municipalities to be convened by Municipal Affairs Department.

23/8/08

Deputy Director
Strategic Planning & Sector Reform Cell

Programme Director, Basic Health Project
& e.o. Special Secretary

23.8.08

Principal Secretary

May be approved.

26/8/08

Approved.

27/8/08

M/S

Principal Secretary
Municipal Affairs Dept.

2/9/08

S.C (IC ISan)

28/8/08

J.D (BHP)

28/8/08

The file was handed over to me by Spl. Secy Health since I was present during the meeting to discuss the Urban Health strategy. The Urban Health strategy as has been finalised may now be viewed. This should be done in the joint name of Deptt Health and Municipal Affairs so that it will have greater acceptability amongst both ULBs as well as functionaries of Health deptt.

Secy Municipal Affairs may also like to see.

4/9/08

Secretary M.A.

MIC M.A & UD

5/9/08

San Development Deptt.
Diary No. 809
Date 5.9.08

5/9/08.

Sec'y/M.A.

further action may be taken by Higher Deptt.

8/9/08

SS (H&FW)

Urban Re. File

Courier.

Government of West Bengal
Health & Family Welfare Department
Strategic Planning & Sector Reform Cell
Swasthya Bhavan, GN-29, Sector-V,
Bidhannagar,Kolkata-700091.
Telefax: 2357- 0955/ 1896

Office of Health Soc. DATE 11/6/08

State Urban Development Agency Received 9 JUN 2008

No.HF/SPSRC/WBHSDP/115/2006/ 97 Dated June 3, 2008

From : S.K. Sen
Program Director, BHP
& e.o. Special Secretary

To :

1. Ms. Chhanda Sarkar, Director, SUDA
2. Dr. Shibani Goswami, Health Expert, SUDA
3. Dr. N.G. Gangopadhyay, Advisor, Health , SUDA
4. Ms. Bulbul Bakshi, Program Manager, GTZ Health Sector Support
5. Ms. Rajarshi Narayan, TAST

Sub: Meeting with The World Bank Team visiting the State on 9-12 June, 2008 in connection with the proposed West Bengal Health Systems Development Project to be funded by The World Bank.

Sir /Madam,

A meeting will be held with The World Bank Team on June 9, 2008 at 11 am in the Conference Hall of WBSAP & CS in connection with the proposed West Bengal Health Systems Development Project to be funded by the World Bank.

You are requested to kindly make it convenient to attend the abovementioned meeting.

Yours faithfully,

S.K.Sen
Program Director, BHP &
e.o. Special Secretary

No.HF/SPSRC/WBHSDP/115/2006/ 97 Dated June 3, 2008

Copy forwarded to:
Sri Arnab Roy, IAS, Project Director, CMU & e.o. Special Secretary, Department of Municipal Affairs.

S.K.Sen
Program Director, BHP &
e.o. Special Secretary

Courier.

Government of West Bengal
Health & Family Welfare Department
Strategic Planning & Sector Reform Cell
Swasthya Bhavan, GN-29, Sector-V,
Bidhannagar,Kolkata-700091.
Telefax: 2357- 0955/ 1896

PO(FF)

State Urban Development Agency Received 1933 6 MAY 2008

No.HF/SPSRC/WBHSDP/115/2006/ 97 Dated June 3, 2008

From : S.K. Sen
Program Director, BHP
& e.o. Special Secretary

Office of DATE

To :

1. Ms. Chhanda Sarkar, Director, SUDA
2. Dr. Shibani Goswami, Health Expert, SUDA
3. Dr. N.G. Gangopadhyay, Advisor, Health , SUDA
4. Ms. Bulbul Bakshi, Program Manager, GTZ Health Sector Support
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Sri Arnab Roy, IAS, Project Director, CMU & e.o. Special Secretary, Department of Municipal Affairs.

S.K.Sen
Program Director, BHP &
e.o. Special Secretary