TG-SVASTH (P512286) చివరి ముసాయిదా ESSA (కార్యనిర్వాహక సారాంశం)

TELANGANA STRATEGIC VISION FOR ATTAINING SUSTAINABLE TRANSFORMATION IN HEALTH CARE PROGRAM

P512286

పర్యావరణ మరియు సామాజిక వ్యవస్థల మదింపు (ESSA)

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కార్యనిర్వాహక సారాంశం (Executive Summary)

E.1 నేపథ్యం.

తెలంగాణ 4,695 ఉప కేంద్రాలు, 634 ప్రాథమిక ఆరోగ్య కేంద్రాలు (PHC), 248 పట్టణ ప్రాథమిక ఆరోగ్య ఉపకేంద్రాలు (UPHC) మరియు 474 బస్తీ దవాఖానాల ద్వారా ప్రాథమిక ఆరోగ్య సంరక్షణకు ప్రాధాన్యతనిచ్చి, అధిక OPD వినియోగాన్ని (1,373/1,000) సాధించింది. ఈ రాష్ట్రంలో 99.9% ప్రసవాలు ఆసుపత్రులలో జరగడంతో, మాతృ మరణాల రేటు (MMR) 48కి, శిశు మరణాల రేటు (IMR) 17కి తగ్గింది. 22 మాతా శిశు సంరక్షణ కేంద్రాలు (MCH కేంద్రాలు), 593 అంబులెన్సులు, రోగ నిర్ధారణ పరీక్షలు, అసంక్రమిత వ్యాధులు (NCD) స్క్రీనింగ్, మరియు అంగన్‌వాడీల అనుసంధానంలో వ్యాధుల నివారణ, చికిత్స మరియు నిరంతర సంరక్షణను బలోపేతం చేశాయి.

అయితే, జనాభా మరియు వ్యాధుల పరివర్తన కారణంతో ప్రస్తుత ఆరోగ్య వ్యవస్థ అసంక్రమిత వ్యాధుల (NCDలు) పెరుగుదలకు[1] మహిళలు మరియు వృద్ధుల సంరక్షణ, ప్రమాదం అంచున ఉన్న వర్గాలపై పడుతున్న ఆర్థిక భారం వంటి అంశాలపై దాటి దృష్టి సారించాల్సిన అవసరం ఉంది. ప్రభుత్వం నివారణ మరియు చికిత్స కార్యక్రమాలను, సమానమైన సమగ్ర చికిత్స సేవలు అందించడానికి మరియు మౌళిక సదుపాయాల కల్పన మరియు ప్రైవేట్ రంగంపై దృష్టి సారిస్తుంది. ప్రస్తుతం ఉన్న సవాళ్లను పరిష్కరించడానికి, విచ్ఛిన్నమైన, వ్యాధి–నిర్దిష్ట కార్యక్రమాల నుండి సమగ్ర, వ్యక్తి–కేంద్రీకృత సంరక్షణ వైపు ఒక పరివర్తనాత్మక మార్పు అవసరం. ఇందులో ప్రాథమిక ఆరోగ్య సంరక్షణ వ్యవస్థలను బలోపేతం చేయడం, నివారణ మరియు ముందస్తు చికిత్సకు ప్రాధాన్యత ఇవ్వడం, మరియు అన్ని కార్యక్రామాల సంరక్షణ సమన్వయాన్ని మెరుగు పరచడం వంటివి ఉన్నాయి. ప్రతిపాదిత కార్యక్రమం ఈ సమస్యలను పరిష్కరించడమే లక్ష్యంగా పెట్టుకుంది.

E.2 కార్యక్రమ అభివృద్ధి ముఖ్య ఉద్దేశ్యం (PDO) (RA)

1. ఈ కార్యక్రమ అభివృద్ధి లక్ష్యం (PDO) తెలంగాణలో ప్రాధాన్యత ఆరోగ్య సేవల నాణ్యతను మరియు వినియోగం మెరుగుపరచడం. ఈ కార్యక్రమం మూడు ప్రధాన ఫలితాల అంశాలను (Results Areas --- RAs) కలిగి ఉంది: ఇవి PDO ని చేరుకునేందుకు సహాయపడతాయి. PDO – అసంక్రమిత వ్యాధులు (NCD), కిషోరిలు, మహిళల తీర్చబడని అవసరాలు మరియు వృద్ధుల ఆరోగ్య సేవల నాణ్యతను మరియు వినియోగంపై దృష్టి సారిస్తుంది. RA1: ఎన్‌సిడి (NCD) అరికట్టి మహిళల ఆరోగ్యం మరియు వృద్ధుల సంరక్షణను మెరుగుపరచడానికి అందిరికీ సమగ్ర, సమానమైన మరియు జవాబుదారీతనంతో కూడిన నాణ్యమైన ఆరోగ్య కేంద్రాలుగా బలోపేతం చేయడం. RA2: ప్రజలు మరియు వైద్య సేవలందించే వారిలో ప్రవర్తనా మార్పులు తీసుకురావడం. ఇది ఆరోగ్య సేవల కోసం ఆసుపత్రులకు రాకపోవడం, నివారణ చర్యలు

తీసుకోకపోవడం వంటి అడ్డంకులను తొలగించడం. RA3: ప్రభుత్వ మరియు ప్రైవేట్ ఆరోగ్య, వ్యవస్థల పాలన, పర్యవేక్షణ మరియు జవాబుదారీతనాన్ని మెరుగుపరచడం.

E.3 ESSA గురించి పర్యావరణ మరియు సామాజిక వ్యవస్థల మదింపు

2. ప్రపంచ బ్యాంకు 'ప్రోగ్రామ్-ఫర్-రిజల్ట్స్' (PforR) (ఫలితాల కోసం కార్యక్రమం) విధానానికి నిర్దేశించిన నిబంధనలు, ఫైనాన్సింగ్ విధానం మరియు మార్గదర్శకాలకు అనుగుణంగా... పర్యావరణ మరియు సామాజిక వ్యవస్థల మదింపు (ESSA) నిర్వహించి, ఈ నివేదిక రూపొందించబడింది. ఈ ESSA ప్రధానంగా ఈ కింది అంశాలను పరిశీలించింది:

(a) ఈ కార్యక్రమం వల్ల కలిగే పర్యావరణ మరియు సామాజిక (E&S) ప్రభావాలు (సందర్భానుసారం ప్రత్యక్ష, పరోక్ష, ప్రేరిత మరియు సంచిత ప్రభావాలతో సహా). (b) ఆ ప్రభావాల నియంత్రణకు రుణగ్రహీత సామర్థ్యం (చట్టపరమైన చట్రం, నియంత్రణ అధికారం, సంస్థాగత సామర్థ్యం మరియు పనితీరు). (c) రుణగ్రహీత వ్యవస్థలను (చట్టాలు, నిబంధనలు, ప్రమాణాలు, విధివిధానాలు మరియు అమలు తీరు) ప్రధాన E&S సూత్రాలు మరియు ప్రణాళికా అంశాలతో పోల్చి కార్యక్రమ పనితీరుపై ప్రభావం చూపగలిగే ఏవైనా ముఖ్యమైన వ్యత్యాసాలను గుర్తించడం. (d) ప్రతిపాదిత కార్యక్రమం పర్యావరణ, సామాజిక లక్ష్యాలను సాధించే అవకాశాలు; మరియు. (e) కార్యక్రమ అపాయాలను ఎదుర్కొనడానికి 'ప్రోగ్రామ్ యాక్షన్ ప్లాన్' (PAP) ద్వారా విధానపరమైన అంశాలు మరియు నిర్దిష్ట నిర్వహణ అంశాలపై సామర్థ్యాన్ని, పనితీరును మెరుగుపరచడానికి తగిన చర్యలను సిఫార్సు చేయడం ఈ అంచనాలో ప్రాథమిక స్క్రీనింగ్, వివిధ భాగస్వామ్యాలతో సంప్రదింపులు, సామర్థ్య అంచనా మరియు ఫిర్యాదుల పరిష్కార యంత్రాంగం విశ్లేషణ వంటి వివిధ ప్రపంచ బ్యాంకు నిబంధనలను పరిగణనలోకి తీసుకున్నారు.

E.4 ESSA కోసం అనుసరించిన విధివిధానాలు

1. ESSA (పర్యావరణ మరియు సామాజిక వ్యవస్థల మదింపు) విధివిధానాల్లో ఈ కింది అంశాలు ఉన్నాయి:

(a) సంబంధిత విధానాలు, చట్టాలు, పథకాలు, ప్రక్రియలు మరియు సంస్థాగత వ్యవస్థలపై ద్వితీయ స్థాయి సమీక్ష (b) పరిశీలన (c) క్షేత్ర పర్యటనలు (d) రాష్ట్ర, జిల్లా మరియు గ్రామ స్థాయిల్లో వివిధ కీలక భాగస్వామ్యాలతో సంప్రదింపులు; మరియు (e) పర్యావరణ, సామాజిక (E&S) వ్యవస్థల సామర్థ్యం మరియు మెరుగుపరచాల్సిన అంశాల విశ్లేషణ. ఈ దశలను అనుసరించి ESSA నివేదికను రూపొందించబడింది. ఇందులో పరిశీలన ఫలితాలు, సిఫార్సులతో పాటు... 'ప్రోగ్రామ్ యాక్షన్ ప్లాన్' (PAP) మరియు 'ప్రోగ్రామ్ ఆపరేషన్ మాన్యువల్' (POM) కోసం సూచనలు పొందుపరచబడ్డాయి.

E.5 కీలక ప్రభావాలు: నష్టాలు మరియు అవకాశాలు

3. ఈ కార్యక్రమానికి సంబంధించి పర్యావరణ, సామాజిక నష్టాల (risk) తీవ్రత మధ్యస్థంగా ఉన్నట్లు ESSA నిర్దేశించబడింది. ప్రాజెక్టులో మరియు PAPలలో ప్రతిపాదించిన సిఫార్సులు ఈ అపాయాలను తగ్గించడానికి మరియు నిర్వర్తించడానికి తోడ్పడతాయి. ESSA ముసాయిదా ఫలితాలపై అభిప్రాయాలు సేకరించడానికి ఫిబ్రవరి 2026లో రాష్ట్ర స్థాయి బహుళ-పక్ష సంప్రదింపుల నిర్వహించాలని ప్రతిపాదించారు. ESSA నిర్వహణలో భాగంగా సంప్రదించిన పౌర సమాజ సభ్యులతో సహా విస్తృత శ్రేణి భాగస్వామ్య పక్షాలు ఇందులో పాల్గొంటారు. దీనికి ముందే ముసాయిదా (Draft) ESSA నివేదికను ప్రపంచ బ్యాంకు మరియు ఆరోగ్య, వైద్య మరియు కుటుంబ సంక్షేమ శాఖ (DoHMFW) పోర్టల్స్‌లో వెల్లడిస్తారు. తుది నివేదికను వచ్చిన అభిప్రాయాలను పరిగణనలోకి తీసుకున్న తర్వాత విడుదల చేస్తారు.

4. పర్యావరణం: మొత్తంగా చూస్తే, ఈ కార్యక్రమం పర్యావరణంపై సానుకూల ప్రభావాన్ని చూపుతుంది. అయితే ఈ కార్యక్రమంతో ముడిపడి ఉన్నాయి. ప్రధాన పర్యావరణ నష్టాలు అంటే బయో-మెడికల్ వ్యర్థాలు పెరుగుదల (BMW), నీరు మరియు పారిశుద్ధ్యం, వృత్తిపరమైన ఆరోగ్యం & భద్రత (OHS), సార్వత్రిక లభ్యత మరియు అగ్ని ప్రమాదాల నుంచి రక్షణ (life & fire safety) వంటి అంశాలకు రాష్ట్రంలో ఈ అంశాల నిర్దిష్ట విధానాలు, ప్రక్రియలు ఉన్నప్పటికీ, వాటి అమలు తీరు భౌగోళికంగా మారుతూ ఉంది. హైదరాబాద్ మరియు చుట్టుపక్కల జిల్లాల్లో అమలు తీరు మెరుగ్గా ఉండగా... వరంగల్, ఆదిలాబాద్, మహబూబ్‌నగర్ వంటి జిల్లాల్లో దృష్టి సారించాలనే అవసరం ఉన్నట్లు గమనించారు. ఈ కార్యక్రమంలో మౌళిక సదుపాయాల నిర్మాణం ప్రత్యక్షంగా లేదు. ఫలితాల అంశాలు (RAs) మరియు సంబంధిత DLIs పరిధిలో... పర్యావరణంపై లేదా ప్రజలపై గణనీయమైన దుష్ప్రభావం చూపేలా ఎలాంటి భారీ నిర్మాణ పనులు లేదా మూలధన వ్యయం లేదు. అన్ని పనులు ప్రస్తుతం ఉన్న ఆసుపత్రి ప్రాంగణాల పరిధిలోనే జరుగుతాయి. దీనివల్ల వచ్చే దుమ్ము, శబ్దం, OHS వంటి సమస్యలు తాత్కాలికమైనవి మరియు వాటిని ప్రస్తుత వ్యవస్థ ద్వారా సమగ్రంగా నిర్వహించవచ్చు. ఈ కార్యక్రమానికి పర్యావరణ నష్టం 'మధ్యస్థం' (Moderate)గా అంచనా వేయబడింది. ఇందుకు సంబంధించిన ప్రధాన కారణాలు కింది విధంగా ఉన్నాయి:

- సేవలు విస్తరించడం వల్ల అన్ని రకాల ఆసుపత్రి వ్యర్థాలు పెరుగుతాయి. ఇవి మున్సిపల్ చెత్తతో కలవకుండా లేదా బహిరంగంగా కాల్చకుండా నిరోధించడానికి... కచ్చితమైన విభజన, సురక్షితమైన నిర్వహణ, రీసైక్లింగ్ మరియు నిబంధనల ప్రకారం నిర్మూలించడం తొలగించాలి.
- పిపిపి (PPP) పద్ధతిలో నడిచే బయో-మెడికల్ వ్యర్థాల శుద్ధి కేంద్రాలు (BMWTFs) అన్ని ప్రాంతాల్లో సమానంగా లేకపోవడం వల్ల... వ్యర్థాల సేకరణ, రవాణా పద్ధతులు సరిగా లేవు. తగిన తనిఖీలు, నియంత్రణలు లేకపోతే... ఈ పరిస్థితి వైద్య సిబ్బందికి మరియు ప్రజలకు ఇన్ఫెక్షన్లు, బయో-మెడికల్ వ్యర్థాల ముప్పును పెంచుతుంది.

- పాదరస ఆధారిత పరికరాలను ప్రభుత్వం సేకరించడం నిలిపివేసింది. కాని ప్రస్తుతం వాడుకలో ఉన్న పరికరాలను కాలం చెల్లాక లేదా పగిలిపోయిన వాటిని తొలగించడానికి BMWM బయో మెడికల్ వేస్ట్ మేనేజ్ మెంట్ రాష్ట్ర ప్రమాణాలు మరియు దేశ ప్రమాణాలను అనుసరించాలి.
- మెరుగైన సేవలు మరియు విస్తరణ వల్ల నీటి వినియోగం, విడుదలయ్యే ద్రవ వ్యర్థాల పరిమాణం పెరుగుతుంది. నీటి వృథాను తగ్గించడానికి మరియు అన్ని స్థాయిల ఆసుపత్రుల్లో ద్రవ వ్యర్థాల శుద్ధి సమర్థవంతంగా జరగడానికి... వాతావరణ అనుకూల మౌళిక సదుపాయాలను ఏర్పరుచుకోవాలి.
- వృద్ధులు మరియు ప్రత్యేక అవసరాలు గల వ్యక్తులకు సులభంగా అందుబాటులో ఉండేలా ఆరోగ్య కేంద్రాలు సమ్మిళిత మౌలిక సదుపాయాలను ఏర్పాటు చేసుకోవాలి లేదా మెరుగుపరచుకోవాలి.
- గృహ వృద్ధుల సంరక్షణ విస్తరణ వల్ల ఆసుపత్రుల వెలుపల కూడా వ్యర్థాలు ఉత్పత్తి అవుతాయి. కాబట్టి ఈ వ్యర్థాల నిర్వహణకు అదనపు మార్గదర్శకాలు మరియు వ్యవస్థ అవసరం.
- ఇంటి వద్దే వృద్ధుల సంరక్షణ సేవలు అందించడం వల్ల వైద్య సిబ్బందికి మరియు రోగులకు భద్రతాపరమైన సమస్యలు రావచ్చు. దీనికి మెరుగైన OHS ప్రోటోకాల్స్, శిక్షణ మరియు రక్షణ చర్యలు అవసరం.

5. సామాజికం (Social)

ఈ కార్యక్రమం ద్వారా నాణ్యమైన, తక్కువ ఖర్చుతో కూడిన, పటిష్టమైన ఆరోగ్య సేవలను అసంక్రమిత వ్యాధులు (NCD) అరికట్టడం మరియు కిశోరీలు, మహిళలు మరియు వృద్ధుల అవసరాలను పరిష్కరించడం; సమగ్ర మరియు వ్యక్తి-కేంద్రీకృత సంరక్షణ; ప్రాథమిక ఆరోగ్య సంరక్షణ ఆధారిత వ్యవస్థలను బలోపేతం చేయడం; ముందస్తు నివారణ వ్యూహాల పాలన మరియు జవాబుదారీతనాన్ని మెరుగుపరచడం వంటి గణనీయమైన సామాజిక ప్రయోజనాలు గుర్తించిన సామాజిక సవాళ్లు ఈ కింది విధంగా ఉన్నాయి:

- వ్యాధుల వ్యాప్తి తీరులో వచ్చిన మార్పులకు (epidemiological shift) అనుగుణంగా అనగా ఆర్ఎమ్ఎన్సిహెచ్ (RMNCH) సేవల నుండి ఎన్సిడి (NCD) నివారణ, నిర్వహణ, దీర్ఘకాలిక వృద్ధుల సంరక్షణ మరియు త్వరగా అనారోగ్యానికి గురయ్యే వర్గాలకు సేవలు అందించడం వైపు దృష్టి మళ్లిన నేపథ్యంలో ఆశా (ASHA)[2], ఏఎన్ఎం (ANM)[3] మరియు ఎంపీహెచ్డబ్ల్యూ (MPHW)[4] వంటి క్షేత్రస్థాయి సిబ్బంది ఆరోగ్య కార్యక్రమాలను అందించడంలో సవాళ్ళు.
- గ్రామీణ, మారుమూల ప్రాంతాల్లో, ముఖ్యంగా గిరిజన వర్గాల మరియు అనారోగ్యానికి గురైన వర్గాలకు వైద్య సేవలు అందించడంలో సవాళ్ళు.
- ఆరోగ్య సిబ్బంది మరియు విద్యార్థుల రక్షణ కోసం ఉద్దేశించిన 'పని ప్రదేశంలో లైంగిక వేధింపుల నివారణ చట్టం' (POSH Act) అమలులో పర్యవేక్షణ.
- బహుళ ఫిర్యాదుల పరిష్కార వ్యవస్థలు (GRM) ఉన్నాయి కాని వాటిని అనుసంధాన పరచి, బలోపేతం చేయాలి.

- జవాబుదారీతనాన్ని పెంపొందించడంలో కీలకమైన 'జన ఆరోగ్య సమితి' (JAS)[5] మరియు 'రోగి కళ్యాణ్ సమితి' (RKS)[6] సభ్యులకు వారి పాత్రలు, బాధ్యతలపై అవగాహన పెంచాలి.
- ప్రస్తుతం ఉన్న ఆరోగ్య మౌలిక సదుపాయాలలో... వృద్ధులు, ప్రత్యేక అవసరాలు గల వ్యక్తులకు అవసరమైన భౌతిక సౌకర్యాల (accessibility features) కొరత.

6. సామాజిక సమస్యల పరిష్కారం

ఈ సామాజిక సమస్యలను పరిష్కరించడానికి ఈ కార్యక్రమంలో పలు చర్యలు చేపట్టారు. ఫిర్యాదుల పరిష్కార యంత్రాంగాన్ని (GRM – SEA/SHతో సహా) బలోపేతం చేయడం, క్షేత్రస్థాయి ఆరోగ్య కార్యకర్తలకు రక్షణ చర్యలను మెరుగుపరచడం, స్థానిక కమిటీ సభ్యుల సామర్థ్యాన్ని పెంచడం, చిన్నపాటి మరమ్మత్తుల్లో కూడా అందరికీ అనుకూలమైన డిజైన్లను పాటించడం వంటివి ఇందులో ఉన్నాయి. ఇక 'ప్రోగ్రామ్ యాక్షన్ ప్లాన్' (PAP)లో భాగంగా... క్షేత్రస్థాయి సిబ్బంది ప్రస్తుత పని అధ్యయనం చేసి, వారి లక్ష్యాలు మరియు పని పరిధిలో సవరణలు సూచించడం; మారుమూల గ్రామాలు మరియు అనారోగ్యానికి గురయ్యే వర్గాలకు మెరుగైన సేవల కోసం వ్యూహాన్ని రూపొందించడం వంటి చర్యలు ఉన్నాయి. మిగిలిన అంతరాలను సేవలను మెరుగుపరచడానికి ఉద్దేశించిన వ్యవస్థాగత విధానం ద్వారా పరిష్కరించవచ్చు. ప్రాజెక్టులో రూపొందించిన వివిధ ప్రొటోకాల్స్, మార్గదర్శకాలపై ఆరోగ్య సిబ్బందికి ఇచ్చే శిక్షణలో వారి ప్రవర్తన మరియు భద్రతపై కూడా దృష్టి పెడతారు. ఇది 'POSH' ఆందోళనలను మరియు రోగులతో సరైన ప్రవర్తన అంశాన్ని పరిష్కరిస్తుంది. వృద్ధుల సంరక్షణకు సంబంధించిన ఆపరేషనల్ మార్గదర్శకాలను పాటించడం వల్ల ఆరోగ్య కేంద్రాలు వారికి మరింత అందుబాటులోకి వస్తాయి (DLI 4 మరియు 7).

7. పౌరుల భాగస్వామ్యం

రోగుల నుంచి అభిప్రాయాలను (feedback) సేకరించడానికి రాష్ట్ర ఆరోగ్య కార్యక్రమంలో అనేక విధానాలు ఉన్నాయి. ఉదా. మేరా ఆస్పతాల్ ఆశా (ASHA), ఏఎన్ఎం (ANM) వంటి క్షేత్రస్థాయి సిబ్బందితో మాట్లాడటం, ఫిర్యాదుల పెట్టెలు (complaint boxes), NQAS చెక్‌లిస్ట్ వంటివి. ఫలితాల అంశం–1 (RA 1)లో భాగంగా ఆరోగ్య సేవలలో నమోదు సకాలంలో చికిత్స పొందడం, మందుల వాడకంపై అవగాహన పెంచడానికి ప్రచార కార్యక్రమాలు (DLI 1) ఉన్నాయి. అలాగే గర్భాశయ ముఖద్వార క్యాన్సర్ స్క్రీనింగ్‌లో మహిళల భాగస్వామ్యాన్ని పెంచడం (DLI 2), గర్భిణులకు మెరుగైన సేవల కోసం మిడ్‌వైఫరీ నేతృత్వంలోని బృంద విధానాన్ని (team–based approach) అమలు చేయడం వంటివి ఇందులో ఉన్నాయి. ఫలితాల అంశం–2 (RA 2) ద్వారా చికిత్స తీసుకొని వారు లేదా మందులు వేసుకొని ఆసుపత్రులకు రాకపోవడం, నివారణ వారియొక్క ప్రవర్తనలో మార్పులు తేవడానికి క్యాంపెయిన్‌లు నిర్వహిస్తారు. DLI 5 కింద నిర్వహించే 'వార్షిక ఆరోగ్య పరీక్షల' ద్వారా ప్రవర్తనలో మార్పును కొనసాగిస్తూ, ఆరోగ్య సమస్యలను ముందస్తుగా గుర్తించి నివారించడానికి కృషి చేస్తారు. దానితో

పాటు, ప్రజల విశ్వాసాన్ని పెంచడానికి మరియు స్పందనను మెరుగుపరచడానికి ప్రస్తుతం ఉన్న ఫిర్యాదుల పరిష్కార వ్యవస్థను మరింత బలోపేతం చేసి నివేదికల విశ్లేషణను (reporting and analysis) మెరుగుపరచాలని ఈ కార్యక్రమం ప్రతిపాదిస్తోంది.

8. ఫిర్యాదుల పరిష్కార యంత్రాంగం (GRM)

ఫిర్యాదుల పరిష్కార వ్యవస్థను ఏకీకృతం చేయడం మరియు ఆధునీకరించడం అవసరం. ప్రస్తుతం 'ప్రజావాణి' (ముఖ్యమంత్రి పోర్టల్) వంటి రాష్ట్రస్థాయి వేదికలతో పాటు జిల్లా కలెక్టర్, పంచాయతీలు, ఆసుపత్రి నిర్వహణ కమిటీల పరిధిలోనూ ఫిర్యాదుల పరిష్కారానికి వెసులుబాటు ఉంది. ఆసుపత్రుల్లో మాన్యువల్ ఫిర్యాదుల కోసం బాక్సులు ఉన్నాయి, వీటిని నిర్ణీత వ్యవధిలో తెరుస్తున్నప్పటికీ, వాటి డాక్యుమెంటేషన్ సరిగా లేదు. వీటికి అదనంగా, జాతీయ ఆరోగ్య మిషన్ (NHM) కింద పనిచేస్తున్న 104 కాల్ సెంటర్ (24/7 మెడికల్ హెల్త్ సపోర్ట్ సర్వీసెస్) ప్రజలకు వైద్య సమాచారం, సలహాలు ఇస్తోంది. ఇది కొన్ని ఫిర్యాదులను కూడా స్వీకరించి పరిష్కారం కోసం సంబంధిత విభాగాలకు పంపుతోంది. అయితే, పనితీరును ట్రాక్ చేయడానికి శాఖా పరంగా ఈ విభిన్న వ్యవస్థలను అనుసంధానించాల్సిన అవసరం ఉంది. రాష్ట్రంలో ప్రభుత్వం ఏర్పరిచిన వివిధ ఫిర్యాధులని పరిష్కార కమిటీలు స్వీకరించి ఒక ప్లాట్ ఫాం పై క్రోడికరించడం, తద్వారా వాటి సామర్థ్యాన్ని ట్రాక్ చేయాలి. ప్రస్తుతం అందుబాటులో ఉన్న ఫిర్యాధు వ్యవస్థను ప్రచారం చేయాలి. ఫిర్యాధు పత్రాలు మరియు రికార్డింగ్ ప్రోటకాల్స్ సరళీకరించడం ద్వారా రిపోర్టింగ్ మరియు పర్యవేక్షణ మెరుగుపరచాలి. పై తెలిపిన విధంగా రిసల్ట్ ఫ్రేమ్ వర్క్ ఫిర్యాధుల వ్యవస్థలో మెరుగుదల, ఫిర్యాధుల స్వీకరణ మరియు పరిష్కారాలు, JCC CEA – SH లను ట్రాక్ చేస్తుంది.

E.6 చట్టవిధానం సంస్థాగత వ్యవస్థలు మరియు సామర్థ్యాల అంచనా

9. ఈ విధానాలు పర్యావరణ, సామాజిక (E&S) పరంగా తగినంత చట్టపరమైన విధాలు అమలులో ఉన్నాయని గుర్తించారు. జాతీయ మరియు రాష్ట్రాలకు వర్తించే సమగ్ర చట్టాలు, నిబంధనలు, ప్రణాళికలు మరియు విధానాలు ఆధారంగా ఉన్నాయి. నిబంధనలు తగినంతగా ఉన్నప్పటికీ, ఈ చట్టాలు మరియు విధానాలను సకాలంలో, సమర్థవంతంగా అమలు చేయడానికి సంస్థాగత వ్యవస్థలు మరియు సామర్థ్యాలు (capacities) మరింత మెరుగు పరచాలి.

10. ఈ ESSA కింది అంశాలను అంచనా వేసింది: వైద్య ఆరోగ్య కుటుంబ సంక్షేమ శాఖ పరిధిలోని శాఖలు డైరెక్టరేట్ ఆఫ్ పబ్లిక్ హెల్త్, తెలంగాణ వైద్య విధాన పరిషత్, వైద్య విద్యా సంచాలకులు);(ii) గ్రామీణ, పట్టణ ప్రాంతాల్లోని ఆరోగ్య కేంద్రాలు (సబ్ సెంటర్/పల్లె దవాఖాన, బస్తీ దవాఖాన, PHC/UPHC, CHC, ఏరియా ఆసుపత్రులు, జిల్లా ఆసుపత్రులు); (iii) వ్యర్థాల నిర్వహణ, వృత్తిపరమైన ఆరోగ్యం మరియు భద్రత, ప్రజలతో అనుసంధానం వంటి అంశాలతో సంబంధం ఉన్న ఇతర శాఖలు మరియు వాటాదారులు. జాతీయ నియంత్రణ (OCS) చట్రం మరియు రాష్ట్ర విధానాలు పటిష్టంగా ఉన్నప్పటికీ పర్యావరణ, సామాజిక నష్టాలను నిర్వహించడానికి ప్రస్తుత వ్యవస్థ, సంస్థాగత ఏర్పాట్లు మరియు సామర్థ్యాల పెంపు చర్యలను

బలోపేతం చేయాల్సిన అవసరం ఉంది. ముఖ్యంగా రాష్ట్రంలోని వివిధ ప్రాంతాల మధ్య ఉన్న వ్యత్యాసాలను తగ్గించడానికి ఇది అవసరం.

11. ఆరోగ్య మౌలిక వసతులు అంశం ప్రత్యక్షంగా ఈ అంచనాలతో భాగం కాదు, ఎందుకంటే, ఫలితాల అంశాలు (RAs) మరియు సంబంధిత DLIs పరిధిలో పర్యావరణంపై లేదా ప్రజలపై గణనీయమైన దుష్ప్రభావం చూపేలా ఎలాంటి భారీ నిర్మాణ పనులు లేదా మౌళిక వ్యయం లేదు. అన్ని పనులు ప్రస్తుతం ఉన్న ఆసుపత్రి ప్రాంగణాల పరిధిలోనే జరుగుతాయి. కాబట్టి భూసేకరణ లేదా ప్రజలను బలవంతంగా తరలించే (involuntary resettlement) ప్రసక్తి లేదు. నిషిద్ధ కార్యకలాపాల జాబితాను (exclusion list)[7] రూపొందించారు, దీని ఆధారంగా అన్ని పనులను పరిశీలిస్తారు.

12. **పర్యావరణం:** దేశవ్యాప్తంగా మరియు తెలంగాణ రాష్ట్రానికి వర్తించే సమగ్ర చట్టాలు, నిబంధనలు, సాంకేతిక మార్గదర్శకాలు మరియు ప్రమాణాలను సమీక్షించిన మీదట... పర్యావరణ వ్యవస్థలకు సంబంధించిన చట్టపరమైన నియంత్రణాత్మక విధానాలు తగినంతగా ఉన్నాయని తేలింది. అయితే, చట్టపరమైన నిబంధనలను పాటించడానికి అనుకూలమైన వాతావరణం అవసరం. బయో-మెడికల్ వ్యర్థాల నిర్వహణ నిబంధనలు-2016 (మార్చి 2022 సవరణల వరకు) అమలులో ఉన్నప్పటికీ, ఆసుపత్రుల (HCFs) వారి సామర్థ్యాన్ని బట్టి అమలు తీరులో వ్యత్యాసాలు ఉన్నాయి. ప్రమాదకర, ఘన, ప్లాస్టిక్ మరియు ఈ-వేస్ట్ (e-waste) నిబంధనల అమలులో అదనపు సామర్థ్యం అవసరం నిర్మాణ పనుల్లో పర్యావరణ, ఆరోగ్య, భద్రతా (EHS) అంశాల నిర్వహణలో బలోపేతం చేసుకోవడం ద్వారా ఆరోగ్య, వైద్య మరియు కుటుంబ సంక్షేమ శాఖ (DoHMFW) లబ్ధి పొందే వీలుంది.

13. **సామాజికం:** ఆరోగ్య సేవలు నిరంతరం అందించటానికి తగినంత మానవ వనరులు అవసరం. అయితే ప్రభుత్వం వివిధ కార్యక్రమాల ద్వారా మానవ వనరులు కొరత తగ్గించింది, కానీ ఇటీవల సిహెచ్‌సి (CHCs)లను ఏరియా ఆసుపత్రులుగా, వాటిని టీచింగ్ ఆసుపత్రులుగా అప్‌గ్రేడ్ చేయడం వల్ల సిబ్బంది ఆవశ్యకత మరింత పెరిగింది. తాత్కాలిక నియామకాల ద్వారా ఈ ఖాళీలను భర్తీ చేయడానికి శాఖ ప్రయత్నించినప్పటికీ, వేతనాల్లో వ్యత్యాసాలు అదనపు సవాళ్లను తెచ్చిపెట్టాయి. గ్రామీణ స్థాయిలో ఎన్‌సిడి (NCD) సేవలతో సహా ఇతర ఆరోగ్య సేవల 'ఆశా' (ASHA) పాత్ర కీలకమైనది. వ్యాధుల తీవ్రతకు అనుగుణంగా ఆశా, ఏఎన్ఎం మరియు ఎంపీహెచ్‌డబ్ల్యూల (MPHWs) పాత్రలను హేతుబద్ధంగా పునర్విభజించాల్సిన అవసరం ఉంది. మరోవైపు, ప్రతిపాదిత కార్యక్రమంలో ఎన్‌సిడి మరియు వృద్ధుల సంరక్షణకు చర్యలు ఉన్నప్పటికీ ఆసుపత్రులలో సౌకర్యాల (accessibility features) మెరుగుదల అవసరం ఉంది. అలాగే ఇంటి వద్దే సంరక్షణ (home-based caregiver) నమూనాలో ప్రైవేట్ రంగ భాగస్వామ్యానికి క్రమబద్ధీకరించడానికి విధానాలను రూపొందించే అవసరం ఉంది.

14. ప్రజా భాగస్వామ్యం మరియు పాలనా యంత్రాంగాలు కూడా సవాళ్లను ఉన్నాయి. జేఏఎస్ (JAS) మరియు ఆర్‌కెఎస్ (RKS) సభ్యుల సామర్థ్యాలు పెంచి తమ పాత్రలపై స్పష్టత, జవాబుదారీతనం, పారదర్శకత పెంచాలి. ఫిర్యాదుల పరిష్కార వ్యవస్థల క్రమబద్ధమైన రిపోర్టింగ్, ట్రాకింగ్ మరియు పర్యవేక్షణ సమన్వయం అవసరం ఉంది. గిరిజనులలో ఇప్పటికీ ఆరోగ్య

సేవలు తీసుకోవడంలో సంకోచం ఉంది. కాబట్టి అవుట్ రీచ్ కార్యక్రమాల ద్వారా వారికి ఆరోగ్య సేవలు అందించాలి. అంతేకాకుండా, లింగ ఆధారిత హింస మరియు లైంగిక వేధింపుల పరిష్కారానికి ఉద్దేశించిన 'అంతర్గత ఫిర్యాదుల కమిటీలు' (ICC) వీటిని బలోపేతం చేయాలి. అందరికీ అసమానతలు లేని, సమర్థవంతమైన ఆరోగ్య సేవలు అందాలంటే ఈ వ్యవస్థాగత లోపాలను సమగ్రంగా పరిష్కరించడం అవసరం.

E.7 మినహాయింపు ప్రమాణాలు (Exclusion Criteria)

ప్రపంచ బ్యాంకు PforR ఫైనాన్సింగ్ విధానం మరియు మార్గదర్శకాల ప్రకారం పర్యావరణం లేదా ప్రజలపై తీవ్రమైన దుష్ప్రభావం చూపే కార్యకలాపాలను ఈ ఆపరేషన్ నుంచి మినహాయించారు. వీటిలో ఈ కింది అంశాలు ఉన్నాయి:

(a) భూసేకరణ అవసరమయ్యే లేదా ప్రజలను బలవంతంగా తరలించే అవకాశం ఉన్న పనులు

(b) భూ వినియోగంలో మార్పులు లేదా భూమి/సహజ వనరుల ప్రవేశానికి ఆటంకం కలిగించే పనులు

(c) బాల కార్మికులు, బానిస కార్మికులు, బలవంతపు పని లేదా ప్రమాదకర కార్యకలాపాల్లో కార్మికుల వినియోగం

(d) ఏవైనా భౌతిక మరియు సాంస్కృతిక వనరుల ధ్వంసం లేదా నష్టం

(e) సామాజిక వర్గాలను దూరం చేయడం లేదా సామాజిక వర్గాల మధ్య గొడవలకు దారితీసే కార్యకలాపాలు;

(f) ఆస్బెస్టాస్ కలిగిన వస్తువులు (AC రేకులు, AC పైపులు వంటివి) వినియోగం, నిర్మాణం, కూల్చివేత పనులు; మరియు

(g) సంప్రదాయ యాజమాన్యం లేదా వాడుకలో ఉన్న భూములు, సహజ వనరులు, ఉమ్మడి ఆస్తులపై దుష్ప్రభావం చూపే పనులు; లేదా ఆదివాసీలు/గిరిజన సముయాలను తరలించడానికి కారణమయ్యేవి లేదా వారిపై తీవ్ర ప్రభావం చూపే పనులు.

E.8 కీలక సిఫార్సులు మరియు ప్రోగ్రామ్ యాక్షన్ ప్లాన్ (PAP) ప్రతిపాదనలు

15. ESSA సిఫార్సుల ప్రధాన ఉద్దేశం విధివిధానాలు, నష్ట నివారణ ప్రొటోకాల్స్ మరియు పర్యవేక్షణ వ్యవస్థలను మెరుగుపరచడం ద్వారా కార్యక్రమ నిర్వహణ వ్యవస్థను బలోపేతం చేయడం. దీనితో పాటు శిక్షణా కార్యక్రమాల ద్వారా సామర్థ్యాన్ని పెంచడం. కొన్ని అంశాలు ఇప్పటికే ఫలితాల ప్రణాళిక (results framework) మరియు DLRలలో అంతర్లీనంగా ఉన్నప్పటికీ, మిగిలిన చర్యలను 'ప్రోగ్రామ్ ఆపరేషన్స్ మాన్యువల్' (POM)లోని మార్గదర్శకాలతో కూడిన 'ప్రోగ్రామ్ యాక్షన్ ప్లాన్' (PAP) ద్వారా అమలు చేస్తారు.

పర్యావరణ సిఫార్సులు:

I. CBMWTF (కామన్ బయో-మెడికల్ వేస్ట్ ట్రీట్‌మెంట్ ఫెసిలిటీ)ల కాంట్రాక్టులు/ఒప్పందాలను ఈ కింది అంశాల కోసం ప్రామాణీకరించాలి మరియు క్రమబద్ధీకరించాలి:

a. పనితీరు ఆధారిత ప్రమాణాలు.

b. ప్రతి ఆపరేటర్ తమకు కేటాయించిన సేవా ప్రాంతం మొత్తాన్ని కవర్ చేయడం.

c. బ్యాగ్ లపై బార్‌కోడ్ వినియోగం తప్పనిసరి చేయడం.

d. ఆర్థిక లావాదేవీలను పరిగణనలోకి తీసుకుని ధరల (Tariff) నిర్ణయం.

e. బయో–మెడికల్ వ్యర్థాల నిర్వహణ (BMWM)పై ఆసుపత్రులకు (HCFs) క్రమం తప్పకుండా శిక్షణ.

II. బార్‌కోడింగ్ వ్యవస్థ బలోపేతం: వ్యర్థాల సేకరణ, రవాణా మరియు శుద్ధి/నిర్మూలన ప్రక్రియలను రియల్ టైమ్‌లో ట్రాక్ చేయడానికి వీలుగా బార్‌కోడింగ్ వ్యవస్థను విస్తరించాలి.

III. చిన్న ఆసుపత్రుల మదింపు: 100 పడకల కంటే తక్కువ ఉన్న ఆసుపత్రులలో బయో–మెడికల్ వ్యర్థాల నిల్వ గదుల (storage units) స్థితిగతులను మదింపు చేసి, వాటి మరమ్మతులు/నవీకరణకు ప్రాధాన్యత ఇవ్వాలి.

IV. సామర్థ్యం పెంపు: అంటువ్యాధుల నియంత్రణ మరియు వ్యర్థాల నిర్వహణపై నిరంతర శిక్షణల ద్వారా సామర్థ్యాన్ని పెంచాలి. పగిలిన పాదరసం పరికరాలు పసుపు రంగు BMWM బ్యాగ్ లో వేయకూడదు. సబ్–సెంటర్ల నుంచి పీహెచ్‌సీలకు వ్యర్థాలను సురక్షితంగా రవాణా చేయాలి.

V. కాల పరిమితి చెందిన పాదరస ఆధారిత పరికరాలను (Ex: BP మిషన్, థర్మామీటర్ వంటివి) BMWM ప్రమాణాల ప్రకారంగా తొలగించాలి. వైద్యశాఖ ఈ పరికరాలు సంఖ్యను సమీక్షించాలి. CBMWTF ఆపరేటర్లు నిర్వహించే శిక్షణల అంశాలు మరియు కాలవ్యవధిని పర్యవేక్షించాలి.

VI. ఇంటి వద్ద సంరక్షణ: ఈ ప్రోగ్రామ్ కింద అభివృద్ధి చేసే వృద్ధుల సంరక్షణ మార్గదర్శకాలు మరియు శిక్షణా మాడ్యూళ్ళలో వ్యర్థాల నిర్వహణ, అలాగే వైద్య సిబ్బంది మరియు రోగుల ఆరోగ్య భద్రతకు సంబంధించిన నిబంధనలు ఉండాలి.

VII. టీకాల ట్రాకింగ్: ఆరోగ్య సిబ్బంది అందరికీ టీకాలు వేయడం, ఏవైనా ప్రమాద ఘటనలు జరిగితే వాటిని కేంద్రీకృత ప్లాట్‌ఫామ్ ద్వారా ట్రాక్ చేయడానికి ఒక విధానాన్ని రూపొందించడాన్ని శాఖ పరిశీలించాలి.

VIII. నీటి సరఫరా మరియు వ్యర్థ జలాల నిర్వహణ: ఈ కింది చర్యల ద్వారా 'క్లైమేట్ స్మార్ట్' ఆసుపత్రులను ప్రోత్సహించాలి:

a. ఆసుపత్రులలో (100 పడకల కంటే ఎక్కువ ఉన్న వాటిలో) సెంట్రల్ వాటర్ ట్రీట్‌మెంట్ యూనిట్‌ను ఏర్పాటు చేయడం మరియు నీటి నాణ్యత పర్యవేక్షణ ప్రొటోకాల్‌ను కలిగి ఉండటం.

b. ప్రాథమిక మరియు ద్వితీయ స్థాయి ఆసుపత్రులలో కూడా BMWM నిబంధనల ప్రకారం ద్రవ వ్యర్థాల శుద్ధి కవరేజీని దశలవారీగా విస్తరించడం.

సామాజిక సిఫార్సులు

IX. క్షేత్రస్థాయి సిబ్బంది (Last mile workers): ఈ కార్యక్రమంలో ఎన్‌సిడి (NCD) సేవలతో సహా ఆరోగ్య సేవల పంపిణీలో ఆశా (ASHA) కార్యకర్తల పాత్ర అత్యంత కీలకం. కాబట్టి, మారుతున్న వ్యాధుల తీరుకు అనుగుణంగా ఆశా, ఏఎన్ఎం (ANM) మరియు ఎంపీహెచ్‌డబ్ల్యూ (MPHW) సిబ్బంది పనిపై అధ్యయనం (రివైజ్ట్ ఫోకస్) నిర్వహించాలి.

X. స్థానిక సంస్థలు: ప్రాథమిక ఆరోగ్య కేంద్రాలలో జవాబుదారీతనం మరియు పారదర్శకతను బలోపేతం చేయడానికి 'జన ఆరోగ్య సమితి' (JAS), 'రోగి కళ్యాణ్ సమితి' (RKS) సభ్యులకు వారి పాత్రలు, బాధ్యతలపై అవగాహన కల్పించాలి. వీరికి నిరంతరం నిర్ణీత వ్యవధిలో శిక్షణ ఇచ్చేలా ఒక యంత్రాంగాన్ని రూపొందించాలి. అదనంగా, ఎస్‌బిసిసి (SBCC) వ్యూహం ద్వారా ఈ సభ్యులు ప్రజలతో సన్నిహితంగా మెలిగి, వారి సమస్యలను అర్థం చేసుకునేలా చేస్తుంది. తద్వారా ఆ సమస్యలను సంబంధిత ఆరోగ్య అధికారుల దృష్టికి తీసుకెళ్లవచ్చు (IRI 7).

XI. అందుబాటు: ఆరోగ్య కేంద్రాల మరమ్మతులు మరియు ఆధునీకరణ పనులు చేపట్టేటప్పుడు వృద్ధులు, దివ్యాంగుల కోసం రెయిలింగ్‌లు, మరుగుదొడ్లలో పట్టుకునేందుకు పిడిలు, కూర్చునేందుకు అనువైన ప్రదేశాలు వంటి కనీస సౌకర్యాలను తప్పనిసరిగా ఏర్పాటు చేయాలి. ఈ ప్రోగ్రామ్‌లోని DLI 4 మరియు 7 కింద వృద్ధుల సంరక్షణ కోసం రూపొందించే నిర్వహణ మార్గదర్శకాలు మరియు ప్రొటోకాల్స్‌లో వృద్ధుల డే కేర్ సెంటర్ డిజైన్ కూడా ఉంటుంది. ఇది దుర్బల వర్గాలైన వృద్ధులకు ఆసుపత్రుల అందుబాటుకు సంబందించిన కష్టాలను పరిష్కరిస్తుంది.

XII. ఇంటి వద్దే సంరక్షణ (Home based care): ఇంటి వద్దే సంరక్షణ అందించే నమూనా ఆశాజనకంగా ఉన్నప్పటికీ రాష్ట్ర ఆరోగ్య శాఖ ప్రమాణాలకు అనుగుణంగా ప్రైవేట్ రంగ భాగస్వామ్యాన్ని అనుమతించడానికి తగిన నియంత్రణ చట్టాన్ని ఏర్పాటు చేయాల్సి ఉంది. ఇది సేవలు అందించే వారు (కేర్‌గివర్) మోడల్ మొత్తం వ్యూహంలో భాగంగా ఉండాలి. DLI 7 కింద రూపొందించే నిర్వహణ మార్గదర్శకాలు 'కేర్ ఎకానమీ' మరియు కేర్ గివర్ల ధృవీకరణపై ప్రత్యేక దృష్టి సారిస్తాయి. ఇది వృత్తిపరమైన నైపుణ్యాన్ని పెంచడమే కాకుండా, రాష్ట్రంలో ఉన్న కేర్ గివర్ల రంగాన్ని క్రమబద్ధీకరిస్తుంది.

XIII. ఫిర్యాదుల పరిష్కారం: ప్రస్తుతం ఉన్న ఫిర్యాదుల పరిష్కార యంత్రాంగాన్ని (GRM)... ప్రజలకు చేరువ చేయడం, స్పందన, ట్రాకింగ్ మరియు రిపోర్టింగ్ విషయాల్లో బలోపేతం చేయాలి. లైంగిక వేధింపుల (SEA/SH) నివారణతో కూడిన సమగ్ర GRM వ్యవస్థను అభివృద్ధి చేయాలి. ప్రక్రియలను డిజిటలైజ్ చేయడం, ఉన్న వ్యవస్థలపై అవగాహన కల్పించడం, బాధ్యతల పట్టికను క్రమబద్ధీకరించడం, ఐటీ రిపోర్టింగ్ ఫార్మాట్లను ప్రామాణీకరించడం, ప్రాజెక్టులో భాగంగా పర్యవేక్షించడం, పనితీరును సమీక్షించడం వంటివి చేయాలి. అవసరమైతే ప్రోగ్రామ్ లబ్ధిదారులు తమ సమస్యలను చెప్పుకోవడానికి ప్రత్యేక కాల్ సెంటర్‌ను ఏర్పాటు చేయాలి. GRM వ్యవస్థ మెరుగుదల, అందిన మరియు పరిష్కరించిన ఫిర్యాదుల (ICC, SEA–SHతో సహా) వివరాలను ఫలితాల ప్రణాళిక (Result Frame Work) ద్వారా ట్రాక్ చేస్తారు.

XIV. సామాజిక సమ్మిళితం (గిరిజన ప్రాంతాలు/వర్గాలు): తెలంగాణ జనాభాలో షెడ్యూల్డ్ తెగలు (ST) 9 శాతం (సుమారు 31.78 లక్షల మంది) ఉన్నారు. మొబైల్ మెడికల్ యూనిట్లు (MMU), కొత్త సబ్ సెంటర్లు ఉన్నప్పటికీ గిరిజన ప్రాంతాలు ఇంకా బహు ప్రమాణాల పేదరికం మరియు అభివృద్ధి లోపాలతో మరియు ఆరోగ్య మౌలిక సదుపాయాల కొరతతో సతమతమవుతున్నాయి. ఈ ప్రాజెక్టు గిరిజన ప్రాంతాల్లో ఆరోగ్య సేవలు మరియు ఫలితాల్లో ఉన్న అంతరాలను గుర్తించి, మెరుగైన ఫలితాల కోసం సిఫార్సులను ప్రతిపాదిస్తుంది. ఆరోగ్య సేవలను పొందడంలో వివిధ తెగల మధ్య ఉన్న వైవిధ్యాలను మరియు వారి స్థితిగతులను కూడా ఇందులో పరిగణనలోకి తీసుకుంటారు.

19. ముఖ్యమైన PAP చర్యలను కింద ఉన్న పట్టిక E.1లో పొందుపరచ బడింది.

పట్టిక E.1. E&S చర్యల కోసం ప్రతిపాదించబడిన PAP

చర్య వివరణ	బాధ్యత	సమయం	సమయం	పూర్తి అయినట్లు కొలమానం
అనారోగ్యానికి గురయ్యే వర్గాల సేవలు మరియు ట్రాకింగ్ మెరుగుపరచడానికి కావలసిన వ్యూహాన్ని తయారు చేయాలి.	(DoHMFW)	పునరావృతం	అమలులోకి వచ్చిన నాటి నుంచి 12 నెలల్లోగా	మొదటి సంవత్సరం : GAP మూల్యాంకనం (వివిధ వర్గాల మధ్య వ్యత్యాసం తో కలిపి) చేసి లక్ష్య సాధన ప్రణాళిక చేయడం. 2వ సంవత్సరం: ప్రణాళిక అమలు పరచడం. 3వ సంవత్సరం : అనారోగ్యానికి గురయ్యే వర్గాల సేవల అందుబాటు మెరుగుపరచిన మరియు ఫలితాల పై రిపోర్ట్ ఇవ్వాలి.
వ్యాధుల వ్యాప్తి తీరు ఆధారంగా ప్రస్తుత వ్యవస్థను మెరుగుపరచి చివరి పౌరునికి క్షేత్ర స్థాయి సిబ్బంది ద్వారా సేవలు అందించడం	(DoHMFW)	నిరంతరం	అమలులోకి వచ్చిన నాటి నుంచి 24 నెలల్లోగా	మొదటి సంవత్సరం : ప్రస్తుత వ్యవస్థ, గమ్యాలు, ఫలితాలు, అంతరాలు (Gaps), ఫలితాలు ఇచ్చిన కార్యక్రమాలపై స్టడీ చేయాలి. 2వ సంవత్సరం : గుర్తించిన అంతరాలు (Gaps) మరియు సత్ఫలితాలు ఇచ్చిన కార్యక్రమాలపై

				శిక్షణ ఇచ్చి సేవలు బలోపేతం చేయడం.
బయో-మెడికల్ వ్యర్థాల నిర్వహణ మెరుగుదల: అన్ని స్థాయిల ఆరోగ్య కేంద్రాలలో ప్రమాణాలకు అనుగుణంగా సేవా సంస్థలతో ఒప్పందాలు మరియు పద్ధతులను మెరుగుపరచడం.	(DoHMFW)	ఇతర	అమలులోకి వచ్చిన నాటి నుంచి 36 నెలల్లోగా	ఆరోగ్య కేంద్రం స్థాయిని బట్టి సేవా ప్రమాణాలు, ధరల వివరాలతో కూడిన ప్రామాణిక ఒప్పంద పత్రాల జారీ; బార్‌కోడ్ ద్వారా వ్యర్థాల ట్రాకింగ్; సేవలో పరిశ్రమ ప్రమాణాలు మరియు నిరంతర నాణ్యతా శిక్షణ.

1. తెలంగాణలో దాదాపు మూడింట ఒక వంతు (≈33%) వయోజనులు అధిక రక్తపోటుతో బాధపడుతున్నారు.

2. గుర్తింపు పొందిన సామాజిక ఆరోగ్య కార్యకర్త (ఆశా – ASHA): వీరు ప్రజలకు ఆరోగ్య సేవలను అందుబాటులోకి తేవడంలోనూ, ప్రజారోగ్యాన్ని పెంపొందించడంలోనూ సామాజిక ఆరోగ్య కార్యకర్తగా పనిచేస్తారు. వీరు సమాజానికి మరియు ప్రజారోగ్య వ్యవస్థకు మధ్య కీలక అనుసంధానకర్తగా వ్యవహరిస్తారు.

3. ఆక్సిలరీ నర్స్ మిడ్‌వైఫ్ (ఏఎన్ఎం – ANM) లేదా ఎంపీహెచ్‌డబ్ల్యూ (మహిళ): ఎంపీహెచ్‌డబ్ల్యూ (MPHW) డిప్లొమా పూర్తి చేసిన శిక్షణ పొందిన మహిళా ఆరోగ్య కార్యకర్తను ఏఎన్ఎం లేదా ఎంపీహెచ్‌డబ్ల్యూ-మహిళ అంటారు. వీరు తరచుగా ఉప ఆరోగ్య కేంద్రం (SHC) లేదా ప్రాథమిక ఆరోగ్య కేంద్రం (PHC)లో ఉంటూ, సమాజానికి మరియు అధికారిక ఆరోగ్య సేవలకు మధ్య ప్రాథమిక వారధిగా పనిచేస్తారు.

4. బహుళార్థ సాధక ఆరోగ్య కార్యకర్త (ఎంపీహెచ్‌డబ్ల్యూ – పురుషుడు): వీరు క్షేత్రస్థాయిలో, తరచుగా ఉప ఆరోగ్య కేంద్రం/ఆమ్ (AAM) కేంద్రంలో ప్రాథమిక ఆరోగ్య సేవలను అందించే కీలక ఆరోగ్య సిబ్బంది. వీరు ఏఎన్ఎం/ఎంపీహెచ్‌డబ్ల్యూ-మహిళతో సమాన హోదా కలిగి ఉంటారు.

5. జన ఆరోగ్య సమితి (JAS): స్థానిక ఆరోగ్య కేంద్రాల నిర్వహణలో పౌర భాగస్వామ్యాన్ని బలోపేతం చేయడానికి ఉప ఆరోగ్య కేంద్రాలు/ఆమ్ కేంద్రాలు/బస్తీ దవాఖానలు మరియు పీహెచ్‌సీలు/యూపీహెచ్‌సీల వద్ద ఏర్పాటు చేసిన సామాజిక ఆధారిత కమిటీయే 'జన ఆరోగ్య సమితి'. ఇది సమాజానికి మరియు ఆరోగ్య వ్యవస్థకు మధ్య వారధిగా పనిచేస్తుంది. జవాబుదారీతనం, రోగుల సంక్షేమం మరియు ప్రజారోగ్య సమస్యలపై ఉమ్మడి కార్యాచరణను ప్రోత్సహిస్తూ ప్రాథమిక ఆరోగ్య కేంద్రాల్లో ప్రజా భాగస్వామ్యం, జవాబుదారీతనాన్ని పెంచడంలో కీలక పాత్ర పోషిస్తుంది.

6. రోగి కళ్యాణ్ సమితి (RKS) / హాస్పిటల్ మేనేజ్‌మెంట్ సొసైటీ: ఇది ఒక రిజిస్టర్డ్ కమిటీ. ఇది ప్రభుత్వ ఆరోగ్య కేంద్రాలకు (సామాజిక ఆరోగ్య కేంద్రాలు, సబ్-డిస్ట్రిక్ట్ ఆసుపత్రులు (HDS) మరియు జిల్లా ఆసుపత్రులు వంటివి) ధర్మకర్తల మండలిగా వ్యవహరిస్తుంది. ఆసుపత్రి వ్యవహారాలను నిర్వహించడం, ప్రజా భాగస్వామ్యంతో నాణ్యమైన సేవలను అందించడం, ఆరోగ్య సేవల పంపిణీలో జవాబుదారీతనం, పారదర్శకత మరియు స్పందనను కొనసాగించడం దీని బాధ్యత. అలాగే రోగుల సమస్యలను పరిష్కరించడానికి ఫిర్యాదుల పరిష్కార యంత్రాంగాలను ఇది అమలు చేస్తుంది.

7. పర్యావరణ మరియు సామాజిక నష్టాల (risks) ఆధారంగా ప్రతిపాదిత PforR కార్యక్రమ వ్యయం నుంచి ఈ కింది అధిక-ప్రమాదకర కార్యకలాపాలకు సహాయాన్ని మినహాయించారు: కామన్ బయో-మెడికల్ వేస్ట్ ట్రీట్‌మెంట్ ఫెసిలిటీ (CBMWTF) ఏర్పాటు మరియు నిర్వహణ; కొత్త భవనాల నిర్మాణం లేదా ప్రస్తుతం ఉన్న భవనాల విస్తీర్ణానికి మించి చేపట్టే ఏవైనా నిర్మాణ పనులు; ఆస్బెస్టాస్ కలిగిన పదార్థాల (ఏసీ రూఫింగ్

షీట్లు, ఏసీ పైపులు మొదలైనవి) వినియోగం, నిర్మాణం, కూల్చివేత లేదా వేరుచేయడం వంటి పనులు; భూసేకరణ అవసరమయ్యే లేదా ప్రజలను బలవంతంగా తరలించే అవకాశం ఉన్న ఏవైనా కార్యకలాపాలను ఈ కార్యక్రమ పరిధి నుంచి మినహాయించారు; బాల కార్మికులు, వెట్టి చాకిరీ, బలవంతపు పని చేయించడం లేదా ప్రమాదకరమైన పనుల్లో కార్మికులను వినియోగించడం; ఏవైనా భౌతిక మరియు సాంస్కృతిక వనరులను ధ్వంసం చేయడం లేదా నష్టం కలిగించడం.

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FOR

TELANGANA STRATEGIC VISION FOR ATTAINING SUSTAINABLE TRANSFORMATION IN HEALTH CARE PROGRAM
P512286

ENVIRONMENT AND SOCIAL SYSTEMS ASSESSMENT
FINAL DRAFT

JUNE 2026

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LIST OF ACRONYMS

AAM	Ayushman Arogya Mandir
AH	Area Hospital
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
ATR	Action Taken Report
BDK	Basti Dawakhana Kendra
BMOH	Block Medical Officer of Health
BMWM	Bio-Medical Waste Management
BPL	Below Poverty Line
CBWTF	Common Bio-medical Waste Treatment Facility
CGA	Comprehensive Geriatric Assessment
CHC	Community Health Centre
CHO	Community Health Officer
CPCB	Central Pollution Control Board
DH	District Hospital
DLI	Disbursement Linked Indicator
DLR	Disbursement Linked Result
DME	Directorate of Medical Education
DMOH	District Medical Officer of Health
DoHMFW	Department of Health, Medical & Family Welfare
E&S	Environmental and Social
ESSA	Environmental and Social Systems Assessment
GBD	Global Burden of Disease
GBV	Gender Based Violence
GDP	Gross Domestic Product
GGH	Government General Hospital
GoT	Government of Telangana
GRM	Grievance Redressal Mechanism
HCF	Health Care Facility
HWC	Health and Wellness Center
ICC	Internal Complaint Committee
IEC	Information, Education, and Communication
ITDA	Integrated Tribal Development Agencies
IVA	Independent Verification Agency
JAS	Jan Arogya Samiti
M&E	Monitoring and Evaluation

MHSS	Medical Health Support Services
MMU	Mobile Medical Unit
MoEFCC	Ministry of Environment and Climate Change
MPHW	Multi-Purpose Health Worker
MPI	Multidimensional Poverty Index
NCD	Non-communicable disease
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHM	National Health Mission
NHM	National Health Mission
NQAS	National Quality Assurance Standards
OHS	Occupational Health and Safety
PAP	Program Action Plan
PCB	Pollution Control Board
PDO	Program Development Objective(s)
PforR	Program-for-Results Financing
PHC	Primary Health Centre
PISP	Program Implementation Support Plan
PMJUGA	PM Janjatiya Unnati Gram Abhiyan
POM	Program Operations Manual
PRI	Panchayati Raj Institutions
PVTG	Particularly Vulnerable Tribal Groups
RA	Result Area
RBSK	Rashtriya Bal Swasthya Karyakram
RKS	Rogi Kalyan Samiti
RMNCHA+	Reproductive, Maternal, Newborn, Child Health and Adolescent
SBCC	Social and Behavior Change Communication
SC	Scheduled Castes
SDG	Sustainable Development Goal
SEA/SH	Sexual exploitation and abuse and sexual harassment
SHC	Sub-health Centre
SHG	Self-Help Group
SOP	Standard Operating Procedure
SPMU	State Program Management Unit
ST	Scheduled Tribe
TGMSIC	Telangana State Medical Services and Infrastructure Corporation
TH	Teaching Hospital
TVVP	Telangana Vaidya Vidhana Parishad
UHC	Universal Health Coverage
UPHC	Urban Primary Health Centre

UPHC	Urban Primary Health Centre
WCD	Women and Child Development

EXECUTIVE SUMMARY

E.1 Background

1. Telangana has prioritized primary healthcare through 4,695 Sub-Centres, 634 PHCs, 248 UPHCs and 474 Basti Dawakhanas, achieving higher OPD utilization (1,373/1,000). The state reduced MMR to 43 and IMR to 18, with 99.9% institutional deliveries. Investments in 22 MCH centres, 593 ambulances, diagnostics, NCD screening, and Anganwadi convergence have strengthened prevention, access, and continuity of care. However, with demographic and epidemiological transition that demands for transformational health system that goes beyond the visible rise in non-communicable diseases (NCDs)*1*, care for women and the elderly and the financial strain on vulnerable populations requires attention. The state emphasizing to match the coverage on prevention with treatment, integrated care delivery plug in gaps related to public health infrastructure, and private sector. To address the exiting challenges, a transformative shift is essential—moving from fragmented, disease-specific interventions to integrated, person-centered care. This includes strengthening primary healthcare systems, prioritizing prevention and early intervention, and ensuring seamless coordination across all levels of care. The proposed Program aims to address these issues.

E.2 PDO and Results Area

1. The Program Development Objective (PDO) is to improve utilization and quality of priority health services in Telangana. The proposed Program comprises three Results Areas (RAs) that collectively contribute to achieving the overall PDO. The PDO's emphasis on the utilization and quality of health services broadly encompasses priority areas such as NCDs, and unmet needs of adolescents, women, and the elderly. RA1: Strengthened platforms to deliver high-quality care, focuses on creating integrated, equitable, and accountable platforms for health service delivery to improve NCD outcomes, women's health, and elderly care. The RA2: Behavioral interventions for both people and providers, addresses behavioral barriers limiting health-seeking, preventive care, and treatment adherence. And RA3: Improved governance and accountability, focuses on improving governance, oversight, and accountability across both public and private health and social care systems.

E.3 About the ESSA

2. In line with the World Bank's requirements for using the PforR instrument, as stipulated in the Program-for-Results Financing (Policy) and Directive, an Environmental and Social Systems Assessment (ESSA) was conducted, and this report was prepared. This ESSA examined (a) the potential environmental and social (E&S) effects of the Program (including direct, indirect, induced, and cumulative effects as relevant); (b) the borrower's capacity (legal framework, regulatory authority, organizational capacity, and performance) to manage those effects; (c) the comparison of the borrower's systems—laws, regulations, standards, procedures, and implementation performance—against the core E&S principles and key planning elements to identify any significant differences between them that could affect Program performance; (d) the likelihood that the proposed Program achieves its E&S objectives; and (e) recommendation of measures to address capacity for and performance on policy issues and specific operational aspects, relevant to managing the Program risks through a Program Action Plan (PAP). The assessment considered various World Bank requirements that include preliminary screening, stakeholder engagement, capacity assessment, and analysis of the grievance mechanism.

1Approximately one-third of adults (≈33%) in Telangana are hypertensive

E.4 Methodology Used for the ESSA

The methodology for the ESSA included (a) secondary literature review of applicable policies, legislations, schemes, procedures, and institutional system; (b) screening; (c) site visits; (d) consultations with key stakeholders at state, district, and village level; and (e) analysis and synthesis of strengths of the E&S systems and areas for improvement. These steps were followed for preparing the ESSA report highlighting the findings, recommendations, and suggesting inputs to the PAP and the Program operation manual (POM).

E.5 Key Impacts: Risks and Opportunities

3. The ESSA finds that the E&S risk rating for the Program is Moderate. The proposed recommendations in the project and PAPs will address minimizing and management of risks. A state-level multi-stakeholder consultation is proposed in June, 2026 to seek feedback on the draft ESSA findings from a wide range of stakeholders, including civil society members who were consulted while conducting ESSA. The draft ESSA report will be disclosed prior to that on the external portal of WB and DoHM&FW and final disclosure will be done after incorporating the feedback received.

4. **Environment.** Overall, the Program shall have a positive environmental impact. The key environmental risks associated with the Program are related to increased healthcare/biomedical waste (BMW), water and sanitation, occupational health & safety (OHS), universal access, and life & fire safety. While the State has defined systems and procedures in these areas, implementation quality varies geographically—generally strong in and around Hyderabad district and requiring more attention on moving away from Hyderabad as observed in districts of Warangal, Adilabad, and Mahbubnagar. Health infrastructure is not directly included in the scope of this operation- the RAs and corresponding DLIs do not cover any capital expenditure or major construction and/or actions that are anticipated to have significant adverse impacts on the environment and/or on the community. All interventions will be carried out within the existing footprint of the facilities, and the associated risks (dust, noise, OHS) shall be temporary and managed through Program systems. Environmental risk for the Program has been assessed as 'Moderate'. Key concerns are as follows:

- Expanded service coverage will increase all healthcare waste streams, necessitating strict segregation, safe handling, and compliant management, recycling, and disposal to prevent mixing with municipal waste or open burning as well as accounting of healthcare waste generated and managed.
- Uneven coverage of PPP-operated Biomedical Waste Treatment Facilities (BMWTFs) is leading to poor collection and transport practices. Without adequate checks and balances, this practice shall elevate risks related to infection and BMW for healthcare workers and communities.
- Though DoHMFW has issued orders and not procuring any mercury-based equipment, disposal of in-use mercury-based equipment at end of life and mercury spills need to be managed strictly in accordance with the Biomedical Waste Management Rules and applicable national regulations.
- Improved services and coverage will lead to increase in water demand and effluent volumes, requiring HCFs to adopt climate-smart infrastructure to reduce water wastage and ensure effective effluent treatment across all tiers of facilities.
- HCFs need to establish or upgrade inclusive infrastructure to ensure accessibility for elderly people and people with disabilities.
- Expansion of geriatric care will generate waste outside of the institutional settings, necessitating additional guidelines and systems for home-based waste management.

- Home-based elderly care introduces safety risks for healthcare workers and patients, requiring enhanced OHS protocols, training, and protective measures.

5. **Social.** The Program has considerable social benefits like quality, affordable, and resilient health services through response to NCDs; addressal of needs of adolescents, women, and the elderly; integrated, person-centered care; strengthening primary health care oriented integrated care systems; proactive, preventive strategies; and improving governance and accountability mechanism. The social risks identified include:

- Challenges in outreach service delivery through frontline workers such as ASHA*2*, ANM*3*, and MPHW*4*, particularly in accordance with the epidemiological shift from RMNCH towards increased focus on NCD prevention, management, long-term elderly care, and adapting services for vulnerable groups.
- Challenges in healthcare delivery in rural and remote areas particularly among the tribal communities and other vulnerable groups.
- Monitoring implementation of the POSH Act to safeguard health workers and students.
- Multiple GRS (Grievance Redressal Systems) but tracking and reporting needs integration and improvement.
- Awareness and capacities of Jan Arogya Samiti (JAS)*5*/ Rogi Kalyan Samiti (RKS)*6* members regarding their roles and responsibilities (critical for reinforcing accountability measures).
- Gaps in physical accessibility features in some of the existing health infrastructure for the elderly and people with disability.

6. To address these social concernsthe exiting government programs, the Program includes strengthening the GRM system (including SEA/SH), improving safeguards for last mile health workers, providing capacity development for local committee members, adopting inclusive designs in any minor refurbishments. The PAP actions include an assessment study of frontline workers to suggest revision in coverage and targets and development of strategy for improved outreach to vulnerablevulnerable population and remote areas. The remaining gaps will be addressed through Program intervention that emphasize on systemic approach for improving service delivery. The regular training of health staff on various protocols and guidelines developed under the project will also emphasis on behavior of providers and safety that will address the concern of POSH and appropriate behavior with patients. Following the operational guidelines for elderly will make the health facilities more accessible (DLI 4 and 7).

7. **Citizen Engagement**. The state health program has several mechanisms in place for capturing patient feedback, including interactions with front-line workers such as ASHA and ANMs, mechanisms

*2*Accredited Social Health Activist (ASHA) serves as a community health workers who facilitate access to healthcare services, promote public health, and functions as a vital intermediary between communities and the public health system.

*3*Auxiliary Nurse Midwife (ANM) or MPHW (Multi-purpose health worker)-Female is a trained female health worker completed the MPHW diploma and serves as a primary contact between the community and official health services, often based at a sub-health center (SHC) or primary health centre (PHC)

*4*Multi-Purpose Health Worker (MPHW)-Male is a key community health functionary who delivers primary healthcare services at the grass-roots level, often at a Sub-Health Centre/ AAM Center, and is equivalent to ANM/MPHW-Female.

5Jan Arogya Samiti (JAS) is a community-based committee established at SHC/AAM Centers/ Basti Dawakhanas, and PHCs/UPHCs to strengthen citizen participation in managing local health facilities. They serve as a bridge between communities and the health system, promoting accountability, patient welfare, and collective action on public health issues, and play a pivotal role in strengthening community participation and accountability in primary healthcare facilities.

6Rogi Kalyan Samiti (RKS) / Hospital Management Society is a registered committee that acts as a group of trustees for public health facilities (like Community Health Centres, Sub-District Hospitals, and District Hospitals) to manage the hospital's affairs, ensure quality services with community participation, and maintain accountability and transparency,and responsiveness in healthcare delivery, and operationalizing grievance redressal mGechanisms to address patient complaints.

such as mera-*haspatal*, complaint and feedback box, and NQAS checklist verifying the feedback mechanisms. As part of RA 1, the Program planned community awareness campaigns to encourage enrollment, timely care-seeking, and adherence to prescribed treatment (DLI 1), community engagement to raise awareness and encourage women's participation in cervical screening Program interventions (DLI 2) and enable team-based approach led by midwifery for better health services for women. The RA 2 further addresses behavioral barriers limiting health-seeking, preventive care, and adherence to treatment through SBCC and IEC campaigns and the intervention of annual health check-up under DLI 5 will sustain the behavior change and proactively identify the health issues at early stage for effective prevention and management. In addition, the Program proposes to further strengthen and track the existing grievance redress mechanisms, improve reporting and analysis to enhance responsiveness and citizen trust.

8. The GRM system requires consolidation and modernization. There are state-wide portals like the Chief Minister portals (Prajavani) as well as provisions for grievance redressal within the purview of the District Collector, Panchayats, and Hospital Management Committees. Health facilities have complaint boxes for manual complaints and are open periodically for redressal but lack documentation. In addition, there is a call center (104) that functions as a 24/7 Medical Health Support Services (MHSS) under the National Health Mission (NHM) and provides medical information and non-emergency advice to citizens. 104 also receives some complaints, which are recorded and passed on to the respective Directorate for resolution. However, multiple systems need integration at the Department level for tracking performance, uptake and efficiency. The information on complaints managed by various Grievance Redressal Committees constituted in the state needs to be aggregated on a common platform to track efficiency. Existing GRM needs wider publicity for greater uptake, formats and protocols for receiving and recording grievances require streamlining to enhance reporting and monitoring. As mentioned above, the results framework will track GRM systems improvement, complaints received and resolved including ICC, SEA-SH.

E.6 Assessment of Legal Framework and Institutional Systems and Capacities

9. The policy and legal framework for E&S systems of the relevant sectors was found to be adequate and backed up by a set of comprehensive laws, regulations, plans, and policies that are applicable nationally and statewide. While the provisions are adequate, institutional systems and capacities cancan be further strengthened.

10. The ESSA covers an assessment of (i) the agencies within Department of Health and Family Welfare (Directorate of Public health, Telangana Vidya Vidhana Parishad, Directorate of Medical Education); (ii) the health service centres in rural and urban areas (like SHC/AAM centre, Basti Dawakhana, PHC/ UPHC, CHC, AH, DH/GGH, TH) (iii) associated sector departments and stakeholders that are impacted by and are relevant to the healthcare waste management; occupational health and safety; community interface and overall environment and social management for health service delivery in the state. While the country's regulatory framework and state policies are robust, the current system, institutional arrangements and capacity development activities for managing the environmental and social risks, require strengthening particularly to bridge gaps across the geographical locations in the state.

11. Health infrastructure is not directly included in the scope of this operation- the RAs and corresponding DLIs do not cover any capital expenditure or major construction and/or actions that are anticipated to have significant adverse impacts on the environment and/or on the community. All interventions will be carried out within the existing footprint of the facilities, and hence, no land

acquisition and/or any involuntary resettlement is anticipated. An exclusion list*7* has been prepared against which all activities will be screened.

12. **Environmental**: Based on the review of comprehensive laws, regulations, technical guidelines, and standards, that apply nationwide and to the state of Telangana, the legal and regulatory framework for environmental systems is found to be adequate. However, an enabling environment is required to comply with the legal and regulatory requirements. While the provisions of the Biomedical Waste (Management and Handling) Rules, 2016, as amended up to March 2022, are being implemented, but in varying capacities by HCFs. DoHMFW can benefit by strengthening their procurement on condemnation of mercury-based equipment and management of EHS aspects of civil works.

13. **Social**: Adequate human resources are critical for rendering uninterrupted health services. While the state has taken several steps*8* to address gaps, recent upgrades of health centers—from CHCs to Area Hospitals, and then to Teaching Hospitals—have further increased the demand for personnel. Similarly, ASHAs, pivotal to health care service delivery at the community level, including NCD service delivery, will also have expanded responsibilities across programs. There are opportunities for redistribution of roles among ASHAs, ANMs, and MPHWs, aligned with epidemiological demands. Meanwhile, the proposed Program includes measures to strengthen NCD and elderly care, facilities require improvement in accessibility features, and the home-based caregiver model requires regulatory frameworks to streamline private sector participation.

14. Community engagement and governance mechanisms require further strengthening. JAS and RKS members need capacity development support to enhance their roles on accountability and transparency. The grievance redressal systems requirerequire integration for systematic reporting, tracking and monitoring. There is still reluctance in tribal communities towards institutionalized health care and there is scope to improve the outreach to address the low indicators. Additionally, mechanisms for addressing gender-based violence and sexual harassment—such as Internal Complaint Committees require strengthening. Addressing these systemic gaps holistically is essential for equitable and effective health service delivery.

E.7 Exclusion Criteria

The operation excludes activities assessed to have a significant adverse impact on the environment and/or people as defined in the World Bank Policy and Directive on PforR Financing. These includes: (a) Any activity that may involve land acquisition or have potential involuntary resettlement; (b) Any activity that may involve changes in land use or access to land and/or natural resources; (c) Use of child or bonded or forced labor or labor involved in any hazardous activities; (d) Destruction or damage to any physical and cultural resources; (e) Any activity which could lead to marginalization of, or conflict within or among, social groups; (f) Activities involving asbestos-containing materials (AC roofing sheets, AC pipes, and so on), such as construction, demolition, and dismantling; and (g) Any activity that would have adverse impacts on land and natural resources subject to traditional

7 The following high-risk activities will be excluded from support under the proposed PforR Program expenditure based on environmental and social risks: Establishment and operation of CBMWTF; Construction of new buildings or any construction beyond the existing footprint of buildings; Activities involving asbestos containing materials (AC roofing sheets, AC pipes, and so on) such as construction, demolition, dismantling; Any activity that may involve land acquisition or have potential involuntary resettlement will be excluded (screened out) from the Program boundary; Use of child or bonded or forced labor or labor involved in any hazardous activities; Destruction or damage to any physical and cultural resource

8 Telangana is one of the few states which has established Medical Recruitment Board. Telangana has initiated one of the largest health workforce expansions: 11,728 healthcare staff recruited since December 2023; 4,343 additional posts under recruitment (by June 2026); 2,929 future recruitments planned as well as key additions: 9,132 nurses; 1,170 doctors; 1,260 lab technicians

ownership or under customary use or occupation or common property resources; or cause relocation of Indigenous People/ tribal communities or have a significant impact on them.

E.8 Key Recommendations and Inputs to the Program Action Plan (PAP)

15. The ESSA recommendations aim to reinforce the Program's management system by improving procedures, risk mitigation protocols, and monitoring systems, alongside capacity-building through core training programs. While some elements are already embedded within the results framework and DLRs, the remaining actions are to be formalized through the Program Action Plan (PAP) with guidelines in the Program Operations Manual (POM).

Environmental Recommendations

I. Contracts/MoUs of CBMWTFs to be standardized and streamlined for:
   a. Performance based standards
   b. Full coverage of defined service area by each Operator
   c. Mandatory use of bar code
   d. Tariff structure factoring economics of the BMWM across government and private hospitals
   e. Regular trainings to HCFs on BMWM

II. Strengthen bar coding system for BMW collection to expand its applicability to real time tracking of collection, transportation and treatment/disposal.

III. Condition assessment of BMW storage units of less than 100 bedded hospitals and prioritize refurbishment/upgrade of units

IV. Improve capacity on IPC and health care waste management through regular trainings. Mercury spills should not be disposed as yellow category waste. Transportation of waste especially from sub-centers to PHCs should be done in a safe manner. Monitor content and periodicity of trainings on BMWM by CBMWTF Operators.

V. Mercury waste arising due to mercury spills and end-of-life mercury-based equipment should be discarded in accordance with BMWM Rules. For the same, DoHMFW should take stock of mercury-based equipment in use.

VI. Guidelines and training modules for standard home-based care for vulnerable elderly to be developed under the Program should include provisions for healthcare waste management and health & safety of healthcare workers as well as patients.

VII. DoHMFW should consider having a centralized data platform to track immunization of all health care workers as well as any IPC related incidents.

VIII. Include management of water supply and effluent discharge thereby promote climate smart hospitals through:
   a. Installing a centralizing water treatment unit in HCFs (starting with >100 bedded HCFs) and having a water quality monitoring protocol
   b. For effective management of effluent wastewater from HCFs as per BMWM Rules, expanding coverage of effluent treatment plants to primary and secondary care hospitals in a phased manner.

Social Recommendations

IX. Last mile workers: Given that ASHAs are central to health care service delivery, including NCD-related services envisaged under the Program, a study proposed to be conducted covering ASHA, ANM, & MPHW in line with epidemiological shift (revised focus).

X. Local institutions: To strengthen accountability and transparency measures at the primary health care facilities, JAS and RKS members need to be made aware of their roles and

responsibilities, and a mechanism needs to be developed for periodic training of JAS and RKS members. Additionally, the SBCC strategy will help these members communicate closely with the community and understand their issues that will be represented with required health officials (IRI 7).

XI. Accessibility: The health facilities need to incorporate basic accessibility features like handrails, toilets with features like grab handles, and seating spaces, etc. for the elderly and disabled population into their repair and upgradation measures. Under the program, the DLI 4 and 7 will develop the operations guidelines and protocol for elderly care that also includes the design of day care centre for elderly that will address the access issues.

XII. Home based care: The home-based caregiver model is encouraging but requires establishing appropriate regulatory frameworks for private sector participation in accordance with standards set by the state's health department and shall be part of the overall strategy for the caregiver model. The operational guidelines under DLI 7 have special emphasis on care economy and certification of care giver, this will not only develop the professional and address the regulation around the unorganized sector of care givers in the State

XIII. Grievance redressal: The existing GRM system requires strengthening for uptake, access, responsiveness, tracking and periodic reporting and monitoring. An integrated GRM system, including SEA/SH will be developed through improved resource allocation at state and districts, digitization and awareness building, streamlining responsibility matrix, improving IT reporting formats, monitoring as a part of the project, followed by review of performance. If needed, establish a separate call centre for Program activities that will allow the Program beneficiaries to raise their concerns. The results framework will track GRM systems improvement, complaints received and resolved including ICC, SEA-SH.

XIV. Social Inclusion (Tribal districts/communities): Scheduled Tribes constitute 9 percent of Telangana's population, approximately 31.78 lakh people. Tribal regions continue to grapple with multidimensional poverty and development deficits9. Despite MMUs and new Sub Health Centers, uptake of institutional healthcare is low. The project will identify gaps in health services and outputs in tribal areas and propose recommendations to be adopted for improved outcomes during the tenure. This also requires factoring in the intra-tribe diversities and trajectories of accessing and availing health services.

16. The key PAP actions are presented in Table E.1. below.

Table E.1. Recommended E&S Actions for PAP

Action	Responsibility	Timing		Completion Measurement
Development of approach and strategy for improving and tracking services for the vulnerable	DoHFW	Continuous	Within 12 months of effectiveness	Year 1: Gap assessment including intra-group disparities and development of Targeted Inclusion Action Plan Year 2: implementation of Targeted Inclusion Action Plan Year 3 onwards: Report on improved access and outcomes amongst the vulnerable
System strengthening to improve last mile	DoHFW	Recurrent	Within 24 months of	Year 1: Study for mapping current systems, targets, outputs, gaps and goo

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Telengana Socio Economic Outlook, 2024, Government of Telengana

Action	Responsibility		Timing	Completion Measurement
service delivery (by frontline health workers) in line with the epidemiological shift			effectiveness	practices Year 2 onwards: Organize training, create last mile support systems to fill the identified gaps and upscale good practices
Improved bio-medical waste management contracts and practices with service providers as per standards in all levels of health facility	DoHMFW	Other	Within 36 months from effectiveness	Standard contract documents with details of service standards and pricing as per level of health facility issued; waste tracking through barcode; industry standards for service and regular quality training

I. INTRODUCTION

A. CONTEXT

1. Telangana is one of India's more economically prosperous and urbanized states, and it significantly contributes to the GDP. From 2012-13 to 2022-23, the state experienced a remarkable annual GDP growth rate of 10.8 percent, surpassing the national average[10]. Per capita income in Telangana is US$3,700 (INR. 317,000), notably higher than the national average of US$1,704 (INR. 146,000). The state also ranks first in equitable income distribution with a Gini coefficient of 0.10[11], and has achieved rapid poverty reduction, from 14 percent in 2007 to 3.76 percent in 2022-23. Despite this rapid growth, poverty reduction remains slower among socially excluded groups.

2. Over the past decade, Telangana has made commendable gains in improving population health outcomes. With a population of 38.5 million, the state's life expectancy stands at 70 years. Key maternal and child health indicators outperform national figures: under-five mortality (23), infant mortality (17), and neonatal mortality (15) per 1000 live births are better than the national average.[12] Further, Telangana has attained the SDG 2030 target of 25 for under-five mortality and is on track to reach the SDG 2030 target of 12 for neonatal mortality.[13] The maternal mortality ratio is 43 per 100,000 live births, less than half of the national average (93)[14]. Institutional deliveries are nearly universal, including in rural areas. Ninety-nine percent of pregnant women receive at least one antenatal care visit (India 97), and 87 percent of children are fully immunized (India 76). In addition to national programs, several innovations at the state level - including Basti Davakhanas to improve primary health care for the urban poor and a hub-and-spoke model to improve access to free diagnostic services across public facilities have helped expand access to care. Telangana is a frontrunner to introduce a midwifery initiative, aiming to enhance the quality of care for pregnant women and newborns while improving health system efficiency.

3. Telangana's health landscape is increasingly dominated by non-communicable diseases (NCDs), which now account for two-thirds of the disease burden, particularly affecting the working-age population. Conditions like heart disease, diabetes, stroke, and chronic obstructive pulmonary disease (COPD) are leading causes of morbidity and mortality, yet only a small fraction of affected individuals have their conditions under control. Risk factors such as high alcohol and tobacco use among rural men, low cancer screening rates, and delayed diagnoses contribute to preventable hospitalizations and premature deaths. Meanwhile, there is a need for preventive and integrated healthcare systems that are better suited to the chronic nature of these diseases. Rapid urbanization has also led to a surge in road traffic injuries, with 7,000 fatalities reported in 2024 alone.

4. Rapid demographic shifts are compounding these challenges, as the elderly population is projected to grow significantly by 2035. Older adults face a high prevalence of chronic conditions, functional limitations, and increased care needs, yet nearly half remain undiagnosed or untreated. The lack of integrated geriatric care and weak coordination between health and social welfare systems has led to fragmented services, high costs, and a heavy burden on informal caregivers, especially women. Mental health issues, social isolation, and economic dependency further exacerbate the vulnerability of the urban elderly.

5. Women's health in Telangana highlights the need for a holistic approach to ensure quality

10 Directorate of Economic and Statistics, 2024.
11 Telangana Socio Economic Outlook 2023 repot
12 Sample Registration System 2020
13 IHME
14 Special Bulletin on Maternal Mortality 2019-2022, SRS Office of Registrar General of India

care and equity. The state has alarmingly high rates of C-sections and hysterectomies, especially among rural, uneducated women, raising concerns about overmedicalization and poor regulation in private healthcare. Health services remain narrowly focused on maternal care, neglecting broader reproductive, mental, and chronic health needs. Low literacy, early marriage, and entrenched gender norms hinder access to quality care, while widespread anemia and metabolic risks highlight the urgent need for a comprehensive, life-course approach to women's health.

6. Climate change is emerging as a major threat to public health in Telangana, compounding existing challenges. The state's semi-arid climate, frequent droughts, and dependence on agriculture make it particularly vulnerable to rising temperatures, which have increased by 1.1 to 1.7°C since 1994[15]. This has led to more frequent heatwaves and heightened risks of heat stress, waterborne and vector-borne diseases, and food insecurity. Urban areas are especially affected, facing growing threats from air pollution and heat-related illnesses. In response, Telangana has launched the State Action Plan on Climate Change and Human Health (SAPCCHH), aiming to mitigate current and future climate-related health risks. The plan emphasizes heat action strategies, improved air quality monitoring, and stronger coordination across sectors to build climate resilience. These efforts are particularly focused on protecting vulnerable populations who are most at risk from the health impacts of climate change.

7. The Government of Telangana has made significant strides in strengthening preventive and promotive healthcare through an extensive primary care network comprising 4,695 Sub-Health Centres, 634 Primary Health Centres, 248 Urban PHCs, 474 Basti Dawakhanas, and 421 AYUSH dispensaries. While the state has adequate Sub-Centres and only a marginal PHC shortfall, gaps persist in secondary care, with one secondary facility for every 36 primary institutions (compared to India's 1:26), reflecting a strong primary care focus. This is evident in higher OPD utilization (1,373 per 1,000 population vs. 1,337 nationally), though IPD rates remain lower (59.8 vs. 62.6).

8. Telangana has achieved notable health outcomes: Maternal Mortality Ratio reduced from 81 to 43, Institutional Deliveries at 99.9%, and Infant Mortality Rate at 17 (vs. 25 nationally). Key investments include 22 MCH centres, LaQshya-certified labour rooms, 347 trained midwives, and 234 TIFFA machines (1.67 lakh scans). Urban and rural access has expanded through 474 Basti Dawakhanas (3.92 crore consultations), 593 ambulances (13–14 minute response), 102 Amma Vodi services (82.19 lakh beneficiaries), and Telangana Diagnostics (1.70 crore patients; 30.89 crore tests). Complementary efforts include NCD screening using CBAC, VHSND-led awareness, and convergence with Anganwadis to address malnutrition and anemia, reducing access barriers and strengthening continuity of care.

9. Telangana has proactively addressed health workforce shortages through systemic reforms and large-scale recruitment. The state established a Medical Recruitment Board to manage attrition and ensure continuity of services. Since December 2023, 11,728 staff have been recruited, including 9,132 nurses, 1,170 doctors, and 1,260 lab technicians, with 4,343 additional posts under recruitment and 2,929 planned—demonstrating a sustained, structured approach to closing HR gaps.

10. To address the health infrastructure, Telangana is undertaking major investments to strengthen secondary and tertiary care, with ₹9,398 crore for super-specialty hospitals and 9,100 additional beds, including a 2,000-bed Osmania Hospital and new TIMS facilities. Expansion of NIMS, 31 critical care blocks, cancer day-care centres, and 99 dialysis units reflect a future-ready system. With health spending at ~4% of GSDP, the state aims to scale to 8%, linking health investment to long-

15 State Action Plan on Climate Change and Human Health

term economic growth and resilience[16].

11. Telangana has strengthened regulation of the private health sector through adoption of the Clinical Establishments Act and enhanced oversight in food and drug safety. Food safety testing increased from 4,310 to 9,651 samples, with 83,858 registered businesses, supported by mobile testing units and awareness initiatives. Drug regulation efforts include 54,755 inspections, 9,420 enforcement actions, and detection of substandard and spurious drugs, ensuring quality and patient safety.

12. However, with demographic and epidemiological transition that demands for transformational health system that goes beyond the visible rise in non-communicable diseases (NCDs)*17*, care for women and the elderly and the financial strain on vulnerable populations requires attention. The state emphasizing to match the coverage on prevention with treatment, integrated care delivery plug in gaps related to public health infrastructure, and private sector. To address these challenges, a transformative shift is essential—moving from fragmented, disease-specific interventions to integrated, person-centered care. This includes strengthening primary healthcare systems, prioritizing prevention and early intervention, and ensuring seamless coordination across all levels of care.

13. Telangana has implemented targeted, last-mile interventions to improve access to healthcare in rural and tribal areas. Initiatives such as "Sankalp" focus on reducing neonatal mortality through capacity building and facility strengthening. The state has expanded infrastructure with birth waiting homes, diagnostic hubs, bike ambulances, multi-purpose centers, and mobile health teams. Outreach through MMUs, specialist camps, and tribal-focused programmes (PM-JANMAN, DA-JGUA) ensures service delivery in remote areas, complemented by inclusive services like Mythri and geriatric clinics.

B. THE GOVERNMENT PROGRAM

14. The overall Government health budget, valued at US$12.69 billion over six years, is implemented by seven Directorates, each with defined functions and independent budgets. The Department of Health, Medical & Family Welfare (DoHMFW) provides overall coordination, leadership and capital investment for primary care. The Commissioner, Department of Public Health and Family Welfare (DPH&FW) oversee clinical and outreach services in primary care. Separate directorates manage drug control and alternative medicine while the Institute of Preventive Medicine supports diagnostic, analytical and blood supply services. Telangana Vaidya Vidhan Parishad oversees secondary care, while the Director of Medical Education is responsible for medical, nursing and paramedical education, as well as tertiary hospitals.

15. The proposed Program has identified four entities namely DoHMFW, Commissioner Health and Family Welfare, Director Public Health, and Director of Medical Education to which the result areas will be linked. The budget lines attributable to Program objectives were identified to define Government program "p", valued at US$5.03 billion for over six years. A subset of these expenditure categories related to delivering primary, secondary health services; reproductive, maternal newborn and adolescent health; NCDs and supply of medicines were identified to define proposed Program "P" valued at US$1.64 billion over six years, which is 14 percent of the overall health budget and 33 percent of Government program "p".

[16] *Telangana Raising 2047*

17Approximately one-third of adults (≈33%) in Telangana are hypertensive

C. BANK-FINANCED PROGRAM

16. As mentioned above, the Bank financed Program is the subset of the identified Government program and is defined in the Table below.

D. PROGRAM

PROGRAM DEVELOPMENT OBJECTIVE(S) AND RESULTS AREAS

17. The Program development objective is to improve utilization and quality of priority health services in Telangana. And measured by (1) Improved control of hypertension among those receiving regular treatment at PHC facilities (Percent), (2) Increased number of high-volume facilities offering midwife-led and team-based pregnancy and childbirth care (Number), (3) Increased utilization of standard home-based care by vulnerable elderly (Percent), and (4) Improved anemia control among moderately anemic adolescent girls in 14 priority districts (Percent). The key Result Areas includes:

18. **RA# 1: Strengthened platforms to deliver high-quality care**. RA1 focuses on creating integrated, equitable, and accountable platforms for health service delivery to improve NCD outcomes, women's health, and elderly care. By strengthening service continuity across levels of care, building provider capacity, and deploying digital systems for patient tracking, RA1 addresses fragmentation and ensures that care pathways are seamless from prevention to advanced treatment. Interventions also incorporate climate-health considerations, ensuring that health services, particularly for the elderly, are resilient to climate-related vulnerabilities.

19. Linked to RA#1 are DLI 1, which aims to strengthen early detection and management of hypertension and diabetes; DLI 2 to improve coverage of cervical cancer screening and access to treatment for cervical pre-cancers; DLI 3 to strengthen platforms for delivering high-quality pregnancy and childbirth services through the introduction of a midwife-led and team-based care model; and DLI 4 to expand utilization of standard home-based care for vulnerable elderly populations.

20. **RA# 2: Behavioral interventions for both people and providers.** RA 2 addresses behavioral barriers limiting health-seeking, preventive care, and adherence to treatment. It emphasizes scalable,

low-cost interventions targeting both the population and health care providers, promoting proactive care, lifestyle modification, adherence to chronic disease treatment, and prevention-oriented clinical behaviors. Integrated Social and Behavior Change Communication (SBCC) strategies will engage communities through local civil society organizations, schools, workplaces, and social media platforms. Provider behavior will be strengthened through training, supportive supervision, and aligned incentives to foster prevention-oriented, patient-centered, and coordinated care.

21. Linked to RA#2 are DLI 5 which aims at improving health-seeking behavior to prevent secondary complications of NCDs; and DLI 6 to improves adolescent health and nutrition behaviors, particularly in reducing anemia caused by poor compliance with supplementation and preventive practices.

22. **RA# 3: Improved governance and accountability**. RA3 focuses on improving governance, oversight, and accountability across both public and private health and social care systems. It introduces innovative service delivery models, such as elderly day-care centers, that require new institutional arrangements, clear operational guidelines, and monitoring mechanisms to ensure effectiveness and responsiveness. RA 3 also supports the professionalization and standardization of caregiving, strengthening skills, accreditation, and employability, thereby expanding the care economy while improving quality of services. In parallel, the RA promotes regulatory oversight and accountability in the private sector, ensuring adherence to treatment protocols, improved provider behavior, and transparent delivery of high-quality care for priority health services. Together, these interventions aim to institutionalize governance reforms, foster a skilled workforce, and enhance citizen trust in health and social care systems.

23. Linked to RA#3 are DLI 7 that focuses on improving governance and operationalizing new models of care for the elderly while professionalizing caregiving; and DLI 8 to strengthen governance and accountability in the private health sector, ensuring adherence to standardized treatment protocols and improving provider behavior for patients with hypertension and diabetes.

DISBURSEMENT-LINKED INDICATORS

24. **Program resources will be disbursed based on the achievement of 8 DLIs.** The achievement of all DLIs will be reviewed and confirmed by an independent verification agency (IVA).

Table 1. DLIs and Allocated Financing

Purpose of DLI	DLI	Allocation (US$)
Strengthen primary prevention and continuum of care for key NCDs	DLI 1: Increased enrollment of patients with hypertension and diabetes, and control of hypertension in primary health care facilities (Percentage, gender disaggregated)	*80,000,010*
Scale up cancer screening and expand preventive treatment	DLI 2: Improved coverage of screening and availability of treatment for pre-cancer lesions for cervical cancer (Number)	*48,000,000*
Advance midwifery reforms and quality of care	DLI 3: Improved quality of pregnancy and childbirth services through midwife-led and team-based care model (Number)	*67,500,000*
Expand community-based services for the elderly	DLI 4: Increased utilization of standard home-based care by vulnerable elderly (Percentage)	*52,000,000*
Promote health-seeking behavior and secondary NCD prevention	DLI 5: Improved health seeking behavior for prevention and management of secondary complications of common NCDs (Percentage)	*61,600,000*
Drive multisectoral action for improved nutrition outcomes	DLI 6: Improved adolescent health and nutrition behaviors through school-based interventions	*65,000,000*

Integrate health and social care for elderly well-being	DLI 7: Strengthened governance for elderly care and expansion of the care economy (N)	*61,757,490*
Raise quality standards and regulation in the private sector	DLI 8: Improved accountability in the private sector to deliver high-quality care for hypertension and diabetes (Percentage)	*39,950,000*

PROGRAM IMPLEMENTATION ARRANGEMENTS

19. The proposed Program will follow the existing DoHMFW governance and management architecture for overall stewardship and implementation. There will be a three tired governance structure: (i) Project Steering Committee (PSC), chaired by the Chief Secretary and consisting of Principal Secretaries of Departments of Health & Family Welfare, Finance, Planning, Empowerment of Persons with Disabilities, Senior citizens and Transgender persons, Panchayat Raj and Municipal Administration and Urban Development. Transport, Forests & Environment and Sate Pollution Control Board provide overall stewardship including provision of administrative and financial approvals for the Program and promote cross sector collaboration; (ii) Executive Committee (EC) headed by the Principal Secretary Health, Medical and Family Welfare consisting of Commissioner Health and Family Welfare, Directors of Medical Education and Public Health and Family Welfare, Commissioner TVVP, Managing Director of Telangana State Medical Services and Infrastructure corporation (TGMSIC), Chief Executive Officer of Rajiv Arogyasri Health Care Trust and State Chief Information Officer, Ayushman Bharat Digital Health Mission governed by the Steering committee will provide overall strategic direction to the project including approvals for annual workplans and budgets, staffing and administrative sanctions required for implementation; and (iii) State Program Management Unit (SPMU) will be responsible for day to day implementation of the approved Program, ensure compliance with legal covenants, fiduciary and safe guard requirements including Program Action Plan, and timely reporting of results to the Independent Verification Agency (IVA). SPMU would be headed by the Commissioner health and family welfare, or equivalent in the department.

20. A Program advisory group led by an eminent public health professional will be constituted to share emerging knowledge and best practices to improve Program impact. This group will meet once a year and provide a technical brief to the EC. The group will consist of representatives from academia, professional bodies such as the Indian Medical Association, Federation of Obstetricians and Gynecologists, organizations supporting the elderly and the Telangana Private Nursing Homes Association, Head of the Regional Geriatric care Center at Nizam's Institute of Medical Sciences, Superintendent of MNJ Cancer Hospital, Director, Indian Institute of Health and Family Welfare.

21. In line with the existing implementation structure and programmatic responsibilities within the DoHMFW, there are three directorates that will primarily contribute to the achievement of project results: the Telangana Vaidya Vidhan Parishad (TGVVP), the Commissioner health and Family Welfare/ PMU, and the Directorate of Public Health and Family Welfare (DPH&FW). The TGVVP, which is responsible for managing secondary-level health facilities and ensuring quality of care across facilities, will lead implementation of activities contributing to improved quality of care. The Commissionerate / PMU, which is responsible for planning, monitoring, and analyzing data from the multiple data sources within the DoHMFW for informed decision making, will lead implementation of activities aimed at making health services more responsive to the population. In addition, it will coordinate overall project implementation and track results. Finally, the DPH&FW, which is responsible for all activities related to preventive, promotive, and curative services at the primary levels will lead implementation of activities contributing to improved access to an expanded scope of services. Under each of the three directorates, there are specific administrative staff, teams, health facility staff, and contractors at the state, district and mandal levels that will be involved in delivering the project results. Additionally, the National Health Mission (NHM), coordinated by the State Program Manager,

will provide support and financing to all three implementing directorates. The project implementation arrangements are shown in Figure below.

Figure 1: Institutional Design for TG-SVASTH

E. ESSA PURPOSE AND OBJECTIVES

22. An Environmental and Social Systems Assessment (ESSA) was carried out in line with Program. This was undertaken to (a) identify the possible environmental and social (E&S) benefits/opportunities, risks, and impacts applicable to the interventions of the Program; (b) review the policy and legal framework related to the management of E&S impacts of Program interventions; (c) assess the institutional capability regarding E&S management systems within the Program system; (d) assess the performance of the Program system with respect to the basic principles of the Program-for-Results (PforR) instrument and identify gaps; and (e) submit recommendations and Program Action Plans (PAPs) to address gaps and improve performance during the Program's implementation.

23. The findings, conclusions, and opinions expressed in this document are those of the World Bank and the recommended actions that flow from this analysis will be discussed and agreed with counterparts and will become legally binding agreements under the conditions of the new loan.

F. ESSA METHODOLOGY

24. PROCESS: The following tasks and processes were involved in shaping the report.

Figure 2. Process Adopted for the ESSA

25. Mapping Of Stakeholders: All project-related stakeholders were mapped under the following six categories:

A. Implementing Agencies under the Department of Health and Family Welfare
   I. Directorate of Public Health & Family Welfare (for Primary healthcare services)
   II. Telangana Vidya Vidhana Parishad - TVVP (for Secondary healthcare services)
   III. Directorate of Medical Education - DME (for Tertiary healthcare services and Teaching hospitals)

B. Health service centers
   I. Sub-health Centre (SHC) and or Ayushman Arogya Mandir (AAM)
   II. Urban AAM or Basti Dawakhana Kendra (BDK)
   III. Primary Health Centre (PHC)
   IV. Urban Primary Health Centre (UPHC)
   V. Community Health Centre (CHC)
   VI. Urban Community Health Centre (UCHC)
   VII. Area Hospital (AH)
   VIII. District Hospital (DH)/ Government General Hospital (GGH)
   IX. Teaching Hospital (TH)

C. Service providers and users under the project

Providers	**Beneficiaries**
1) Medical Officer/Nurse/Lab Technicians/ Pharmacist/Assistants	1) Women
2) Community Health Officer	2) Elderly
3) Accredited Social Health Activist	3) Tribal communities
4) Auxiliary Nurse Mid-wife	4) People with disabilities
	5) Migrant labour

5) Staff and consultants at all four verticals of DoHMFW **6)** Doctors, Faculty, Medical students (including nursing and technicians)	6) Poor (BPL) households 7) Slum dwellers

D. Other related relevant institutions/stakeholders under DoFHW
   i. Indian Institute of Health & Family Welfare (IIHFW)
   ii. Nizam Institute of Medical Sciences (NIMS)
   iii. Aids Control Society
   iv. Institute of Preventive Medicine (IPM) and Telangana Diagnostics
   v. Medical Colleges

E. Other Govt. Depts which implement schemes/activities with DoFHW
   i. Telangana Medical Services and Infrastructure Development Corporation (TGMSIDC)
   ii. State Pollution Control Board (PCB)
   iii. Department of Social Welfare
   iv. Women Development & Child Welfare
   v. Department for Empowerment of Persons with Disabilities, Senior Citizens and Transgender Persons
   vi. Department of School Education
   vii. Regional Directorate of Skill Development and Entrepreneurship (RDSDE)
   viii. Department of Road Transport
   ix. Department of Rural Development and Panchayati Raj
   x. Municipal Administration and Urban Development
   xi. Department of Tribal Welfare

F. Others
   i. Common Bio-Medical Waste Treatment Facility Operators
   ii. NGOs
   iii. Media

26. Assessment through secondary sources: Policies, Program/Scheme Guidelines, Circulars, Notifications, GOs, Institutional Arrangements, Evaluations/Internal Assessments, Departmental Annual Plans & 4 Year Strategic Plans, Monitoring and Management frameworks, independent studies on performance and implementation challenges. (See list of references as Annexure 1)

27. Assessment through primary sources: Interactions with both service providers and beneficiaries as well as key stakeholders in the Telangana health sector were organized including physical visits to key institutions and select health centers. The identification of locations was based on purposive sampling. The site visits and interactions were carried out using pre-designed checklists (Annexure 2.1 and 2.2).

28. Rationale for selection of districts for site visits: Apart from the one on one with all the verticals under DoHMFW and select line departments, out of 33 districts in Telangana, five were identified for site visits and field level interactions. The criteria for selecting the districts was based on multiple factors to ensure capturing diverse samples and context. This included socio-economic indicators, geographical location, rural-urban demography, state health ranking (on NCD, MH and Geriatric Services) remoteness and presence of scheduled areas/tribal population, private sector

penetration, migrant population, climate change vulnerability[18] and Department of Science and Technology[19] and MOEFCC[20]. The sample selection was further informed by the number of HCFs with lower than desirable frequency of waste collection- this was obtained through analysis of SPCB's bar coded data of waste collection. For details, see Annex 3.

29. The draft ESSA has been disclosed before the Program Appraisal so that the views of interested members of the broader public may be solicited and considered before Program approval. This includes the Executive Summary translated in Telugu. Further, the final ESSA report and recommended actions will be updated before negotiations, and the final version will be disclosed accordingly.

18 Adilabad has been classified as highly vulnerable to climate change by the Department of Science and Technology. However, the state itself comes under low vulnerability. Telangana is classified as lower middle 25% vulnerable states in India. The major driver of vulnerability in the state is due to a lack of forest area per 1,000 rural population and low per capita income. Districts with a vulnerability level of above 0.597 and above include Kumarambheem Asifabad (0.702), Adilabad (0.652), Jayashankar Bhupalpally (0.647), Peddapalli (0.629), Warangal Rural (0.614), Rajanna Sircilla (0.597). Mahabubnagar has ranked low on adaptative index (0.32) and high on districts with high exposure to drought (0.92).

19 Department of Science and Technology (DST), Government of India. 2021. Climate Vulnerability Assessment for Adaptation Planning in India Using a Common Framework. New Delhi: DST. Available at: https://dst.gov.in/sites/default/files/Full%20Report%20%281%29.pdf.

20 State Action Plan on Climate Change for Telangana State. Hyderabad: Environment Protection Training and Research Institute (EPTRI). Submitted to the Ministry of Environment, Forests and Climate Change, Government of India. https://moef.gov.in/uploads/2017/09/Telangana.pdf (accessed November 25, 2025).

A. ENVIRONMENTAL CONTEXT

1. Telangana is the twelfth largest State in terms of both area and the size of the population in the country. Telangana is located on the Deccan Plateau and lies in the Southern region of India. The State is in the central stretch of the eastern seaboard of Indian Peninsula. The State is bordered by the States of Maharashtra to the North and North-West and Chhattisgarh to the North, Karnataka to the West, and Andhra Pradesh to the South, East and North- East.

2. Telangana State is divided into four agroclimatic zones based on the geographical characteristics such as rainfall, nature of soils, climate etc., viz., (i) Northern Telangana Zone (ii) Central Telangana Zone, (iii) Southern Telangana Zone and (iv) High Altitude and Tribal Zone. The Climate of the State is predominantly hot and dry. The annual normal rainfall of the State is around 905.3 mm. Important soils include red sandy loams, red loams with clay base along with very small patches of alluvial soils. The maximum and minimum temperatures during south west monsoon ranges between 13°C - 27°C and 29°C - 34°C, respectively.

3. The State is drained by two big rivers, namely Krishna and Godavari Rivers. About 43 % of the area is covered in Krishna basin and about 56% of the area is covered in Godavari Basin. Telangana has the advantage of having flow from the western Ghats apart from local tributaries. However, most of the flow occurs only in 3 to 4 months of South-West monsoon, i.e., June to September.

4. Forest fires are an environmental concern in the state. The forest cover of the state is 24008.92 sq km, including scrubs, of which 25.01 % is very highly fire prone and another 17.99 % is highly fire prone. 13117 forest fires were detected in 2022-23 and increased to 13479 fires in 2023-24[21].

5. Climate change: Telangana faces rising climate risks that include intense heatwaves, droughts, variable monsoon rainfall and local flooding. These factors will strain health service delivery and increase health burdens such as heat-related illnesses, vector-borne diseases, food insecurity and disaster-related injuries. Health systems must adapt to maintain continuity and quality under climate stress. The state's dependence on agriculture heightens vulnerability to heat stress, water/vector borne diseases and food insecurity. Rising temperatures and more frequent heatwaves will have significant health implications for vulnerable populations and the elderly.

B. SOCIO-ECONOMIC PROFILE OF TELANGANA

6. Telangana, formed in June 2014, comprises 33 districts and 76 revenue divisions. The total population of the state is approximately 35 million (Census 2011), and is projected to be around 39 million now, accounting for around 3 percent of India's population. It has rapidly evolved into a high-growth, innovation-driven economy, with Hyderabad leading tech-enabled services. Despite this urban prosperity, rural and tribal regions continue to grapple with multidimensional poverty and development deficits.[22] The state's development trajectory reflects both impressive economic progress and persistent social inequities, particularly in access to services and opportunities.

7. Economically, Telangana outpaces national benchmarks with a 10.8% annual GDP growth rate from 2012–13 to 2022–23 and a per capita income of US$3,700—more than double the national

21 India : State of Forest Report 2023 Vol 2

22 Telengana Socio Economic Outlook, 2024, Government of Telengana

average.[23] It ranks first in equitable income distribution (Gini coefficient of 0.10) and has significantly reduced poverty from 14% in 2007 to 3.76% in 2022–23.[24] However, socially excluded groups, including Scheduled Castes (15.04%) and Scheduled Tribes (9.07%), experience slower poverty alleviation. Tribal populations are largely concentrated in districts bordering Maharashtra and Chhattisgarh, such as Mahabubabad, Bhadradri Kothagudem, and Adilabad, which remain underdeveloped.

8. Telangana can be broadly divided into four distinct regions, each with unique geographic, economic, and social characteristics. The Hyderabad region, encompassing the capital and its surrounding districts, is highly urbanized and economically vibrant and has high access to services. Northern Telangana, which includes districts like Adilabad, Nirmal, Komaram Bheem, and others, is predominantly tribal and underdeveloped. These areas face persistent challenges such as high poverty rates, limited access to basic services, and social exclusion. Southern Telangana, comprising Mahabubnagar, Nagarkurnool, Wanaparthy, and others, is historically backward and characterized by semi-arid conditions. The Eastern Telangana includes districts such as Khammam, Bhadradri Kothagudem, Warangal, Mahabubabad, and other present a mixed demographic of tribal and rural populations. While some pockets have seen industrial and agricultural development, others continue to struggle with poverty and limited access to services.

9. The Scheduled V area in Telangana is spread over 9 districts (Adilabad, Asifabad, Mancherial, Warangal, Mulugu, Mahbubabad, Khammam, Bhadradri-Kothagudem and Nagarkurnool) covering 85 Mandals (30 fully & 55 partly) and 1,174 villages. These are covered under five Integrated Tribal Development Agencies (ITDA) areas, namely ITDA Utnoor, ITDA Bhadrachalam, ITDA Eturunagarm, ITDA Mannanur, and ITDA Plan areas. The Particularly Vulnerable Tribal Groups (PVTGs) in Telangana include Chenchu, Thoti, and Konda Reddis. The government implements special schemes to address the specific needs of these communities, focusing on areas like housing, education, health, and livelihoods.

10. Telangana is the home of diversified tribal groups. As per the Andhra Pradesh (A.P) Recognition Act, 2014, there are 32 Scheduled Tribe communities in the state; their population consists of around 9 per cent of the total state population. The major tribal groups in the state are Lambadi, Koya, Gonds, Pardhan, Andhetc. (Annual Report 2018- 2019). Studies[25] show that in select districts like Bhadradri Kothagudem diseases such as diabetes and hypertension are more prevalent among tribal women, and most of them prefer or seek traditional medicines. The practice of seeking traditional treatments and reluctance towards institutional medical care is common in remote tribal hamlets in the state. Further there are intra-tribal disparities that influence health and well-being like access to healthcare, food intake, birth weight, seasonal infections, and sanitation facilities. There are significant differences where the Gond, Kolam, and Chenchu communities continue to face challenges, have unique needs and vulnerabilities calling for a targeted approach rather than considering STs as a homogeneous group.[26]

11. Acute poverty in Telangana has shown a sharp decline over the past one decade, the National Multidimensional Poverty Index of Niti Aayog shows. The headcount of people living in acute poverty is calculated to have dropped to 3.76% by 2022-23. It was 13.18% at the time of formation of the new State.[27] Multidimensional poverty in tribal regions remains high. Muslims constitute

23 Directorate of Economic and Statistics, 2024
24 Telangana Socio Economic Outlook 2023 repot
25 Chandana et al. (2020), Lakshmi & Paul (2019), Ramdas (2013), Punnaiah (2018), and Reddy (2014)
26 Santhosh Gugulothu, Understanding The Health Disparities: A Study Of Tribal Communities In Telangana, South India Journal of Social Sciences, December 2024
27 India National Multi-Dimensional Poverty Index, Progress review 2023. NITI Ayog

the largest minorities in Telangana about 12.75%[28] They are educationally more backward and economically weaker than most of the population in the state who are Hindus.[29]

12. Literacy rate in the state is about 66% out of which female literacy rate is about 58% compared to the male literacy rate which is about 75%.[30] Gender gap in literacy more pronounced in the State. According to the National Statistical Office (NSO) data on literacy, 15.4 per cent more males are literate than females in Telangana - the highest gap in all the southern states.[31] As per the report, there is also a huge difference in the literacy rate of women in urban and rural areas. Only 4.2 per cent of women in the State are graduates in rural areas, compared to 21.2 percent in urban areas.[32]

13. Gender disparities in the state persist across social, economic, and geographic dimensions. The state has a sex ratio of 988 females per 1000 males, but the child sex ratio remains low at 933, indicating a continuing preference for male children. While the overall female literacy rate stands at approximately 65%, compared to 80% for males, significant gaps exist between urban and rural areas, as well as among marginalized groups such as Scheduled Castes (SC), Scheduled Tribes (ST), and Muslim communities. Girls in tribal districts like Adilabad, Mahabubabad, and Bhadradri Kothagudem are particularly vulnerable to school dropout, early marriage, and lack of access to life skills education.[33]

14. Violence against women and girls remains a major concern. High rates of domestic violence and child marriage are prevalent in backward districts like Mahabubnagar, Jogulamba Gadwal, and Adilabad.[34] Although government initiatives such as SHE Teams and One-Stop Centres are in place, access to justice, survivor support services, and community-based prevention strategies need to be expanded and strengthened. Government efforts have laid a foundation for progress, but structural barriers such as patriarchal norms, early marriage, limited mobility, and unequal caregiving responsibilities persist. The intersection of gender with caste, tribe, and economic vulnerability further exacerbates exclusion, limiting women's access to education, employment, legal rights, and leadership opportunities.

15. Women's participation in the formal labour force remains low, with an estimated female labour force participation rate of only 24%. A majority of women are engaged in informal, unpaid agricultural or domestic work, with limited access to productive assets, credit, or digital tools.[35] The Self-Help Group (SHG) network, facilitated by SERP Telangana, has expanded financial inclusion and collective bargaining power for women, but challenges remain in scaling up economic empowerment through skilling, market linkages, and entrepreneurship. The state has invested in flagship schemes such as the MCH Kit and Arogya Lakshmi to address maternal and child health, resulting in improved institutional deliveries and supplementary nutrition coverage.[36] However, high levels of anaemia among women and adolescent girls, especially in tribal and rural areas, continue to pose public health challenges.

16. Health indicators of the state is average compared to rest of India. Crude birth rate in the state is 16.4 per 1000 population (India 19.5); Infant Mortality Rate is 17 per 1000 live births (India 28).

28 Telengana State at a Glance, Directorate of Economics and Statistics, Government of Telengana.
29 Sujit Kumar Mishra, A Study of Muslims in the Newly Formed State of Telangana, Social Change, SAGE Publication 2018.
30 Telengana Statistical Year Book 2016
31 Indian Express, E Paper, 15 July 2025
32 Ibid
33 Human Development Report, Telangana, 2017, Centre for Economic and Social Studies, Government of Telangana
34 https://wdcw.tg.nic.in/scheme_sabala.html
35 Women Labour Force Participation in Telengana, IWWAGE
36 https://chfw.telangana.gov.in/programmes.html

The Total Fertility Rate in the state is lower than rest of India. In Telengana it is 1.5 whereas in India it is about 2. The Maternal Mortality Rate is much lower compared to rest of the country. In Telangana it is about 43 whereas in India it is about 97.

17. The State has been able to provide Reproductive Maternal Newborn Child Adolescent Health Plus Nutrition services with major focus on primary and secondary care services under the NHM. Indicators for Antenatal care (ANC), institutional deliveries, C sections, distribution of IFA tablets, follow up of high-risk pregnancies, provision of postnatal and newborn care - have shown substantial improvement since 2005 (NFHS 4). The maternal mortality ratio has significantly declined from 134 (2007-09) to 43 (2022-24). In Telangana, 84.4% of women received 4 ANC check-ups. As per NFHS 5 report- Jagitial, Kamareddy, Khammam, Nizamabad and Peddapalli districts reported high ANC coverage ranging between 54.8% - 64.7%; and Mahabubnagar, Mancherial, Siddipet, Vikarabad and Wanaparthy districts reported low ANC coverage ranging between 76.3% - 81.9%. As reported in HMIS 2019-20, around 99.9% of the deliveries took place in institutions, out of which 47.6% took place in public health facilities. Total percentage of C-sections (48.9%) is higher than the WHO's standard (10-15%); and out of the total reported C-sections, about 53.7% is conducted at private facilities in the State. Around 29.7% of women are tracked for the first postpartum checkup between 48 hours and 14 days. Prevalence of anaemia in women aged 15-49 years increased from 56.6% (NFHS-4) to 57.6% (NFHS-5). Anaemia in females of reproductive age group is thrice than that in men of similar age group.[37]

18. According the UNFPA Report, the anticipated proportion of the elderly population in Telangana is forecast to rise to 17.1% in 2036, a notable increase from the 11% recorded in 2021.*38* A significant portion of this demographic, particularly women in rural areas and both men and women in urban areas, relies on others for economic support. The Telangana government recognizes the need for specialized geriatric care, including addressing issues like cognitive impairment and mental health concerns among the elderly. The state has established the Elder Spring Response System (toll-free number 14567), a helpline for senior citizens, to aid and support. Studies reveal that a significant percentage of the elderly in Telangana experience conditions like hypertension, diabetes, and musculoskeletal pain. Many rely on private healthcare facilities, particularly for inpatient and outpatient services. A considerable portion of the elderly population faces disabilities, including those related to vision, hearing, and mobility. The state government recognizes the need for specialized geriatric care services and a shift towards integrating geriatric care into primary healthcare. One of the greatest challenges remains ensuring affordable and accessible healthcare services, including specialized geriatric care, remains a priority for this section of the population.

C. LEGAL AND POLICY ASSESSMENT

19. The Government of India (GoI) and the State government have enacted a range of laws, regulations, and procedures which are relevant to managing the environmental and social effects of the Program. The details of national laws, state acts, guidelines and health schemes along with their relevance to the project is provided in Annex 4.1, 4.2, 4.3 and 4.4

20. Based on the review of comprehensive laws, regulations, technical guidelines, and standards, that apply nationwide and to the state of Telangana, the legal and regulatory framework for environmental systems are found to be adequate. However, an enabling environment is required to

37 Health Dossier, 2021, Reflections on Key Health Indicators, Telangana, Department of Women and Child Development, Telangana

38 Caring for Our Elders, Institutional Responses, India 2023, UNFPA

comply with the legal and regulatory requirements. While the provisions of the Biomedical Waste (Management and Handling) Rules, 2016, as amended up to March 2019, are being implemented but in varying capacities by HCFs. Additionally, additional capacity is required in ensuring compliance for other healthcare wastes such as hazardous, solid, plastic, and e-waste rules.

21. The National Green Tribunal (NGT) has been taking serious observations to protect and prevent damage to the environment including BMWM. Strengthening of systems are required to improve management and monitoring of all healthcare waste streams.

22. Overall, the national- and state-level policies were found to be adequate to address the social risks related to the project investments, including Constitutional provisions under Articles 15,16 and 46; those for ensuring OHS for workers and fair working conditions; women's safety; no child labor; no bonded labor; social inclusion; grievance redressal; access to information and safeguarding against disasters. These include Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996; Minimum Wages Act, 1948; Payment of Wages Act, 1936; Payment of Gratuity Act, 1972; Workmen's Compensation Act, 1923; Maternity Benefit Act, 1961; Inter-State Migrant Workmen (Regulation of Employment and Conditions of Service) Act, 1979; Motor Transport Workers Act, 1961; Rights of Persons with Disabilities Act, 2016; Right to Information Act 2005 and rule; the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013; and the Criminal Law (Amendment) Act, 2013 - Sexual Offences.

D. CURRENT INSTITUTIONAL MECHANISMS FOR HEALTH CARE SERVISES

23. The State Department of Health, Medical and Family Welfare (DoHM&FW) receives policy stewardship from the Minister. The Principal Secretary, supported by Additional, Joint, and Deputy

Secretaries provides strategic and administrative steer. At the operational level, the Commissioner Health and Family Welfare, who also heads the National Health Mission (NHM) coordinates several Directorates/ Commissionaires, including the Directorate of Public Health, Telangana Vaidya Vidhan Parishad (Commissionerate for Secondary Hospitals); Institute for Preventive Medicine and Indian Institute of Health and Family Welfare (State In-service training center). There are separate Directorates/ Commissionerate for Medical Education, AYUSH, Telangana State AIDS Control Society,

24. Drugs Control, and Arogyasri e-Healthcare Trust, which report directly to the Principal Secretary.

25. The public healthcare delivery system in Telangana is a three-tier system. The network of Sub Centres (SCs), Primary Health Centres (PHCs), Urban Primary Health Centres (UPHCs) form the Primary Tier of the public healthcare delivery system for rural and urban areas, and provide preventive and protective healthcare services such as immunization, epidemic diagnosis, childbirth and maternal care, family welfare, etc. Community Health Centres (CHCs). The Area Hospitals (AHs) and District Hospitals (DHs) serve as the Secondary tier for the rural and urban population and provide treatment and management of diseases or medical conditions that require specialized care. Tertiary healthcare involves providing advanced and super specialty services through Government General Hospitals (GGHs) or Teaching Hospitals (part of Medical colleges and Nursing colleges) and is largely in urban areas with well-equipped diagnostic and investigative facilities.

26. Each District is headed by a District Medical Officer of Health (DM&HO). The responsibility of DM&HO is to oversee the implementation of national health programs, enforce health rules, conduct disease surveillance, and promote community health. This includes managing the primary healthcare sector and ensuring the effective implementation of various medical, health, and family welfare programs. The secondary-level hospitals (sub-divisional and district hospitals) are headed by superintendents who report to the DM&HO and are accountable to a hospital management committee. At the block level, the Block Medical Officer of Health (BMOH) is responsible for providing services and for monitoring and supervising the primary health centers and health program implementation.

27. The healthcare facilities in the state

S.No	Type of Health Centre	Criteria and Coverage	Current Numbers
1	Sub-health Centre (SHC)	One for every 5000 people. Not 24x7 (open from 9AM to 4PM)	4,695
2	Basti Dawakhana (BDK)/ Urban sub-health centre (USHC)	One for every 5000 people. Not 24x7 (open from 9AM to 4PM)	474
3	Primary Health Centre (PHC)	One on every 5 SHC. Not 24x7 (open from 9AM to 4PM)	634
4	Urban Primary Health centre (UPHC)	One on every 5 BDK. Not 24x7 (open from 9AM to 4PM) All the functional U-PHCs have also been notified as health & wellness centers and rendering the expanded package of services	248
5	Community Health Centre (CHC)	Set up at block level; On a population coverage of about 50,000 in urban areas, with some variation for slums, and a location within or near a slum.	106
6	Area Hospital (AH)/ Sub-Divisional Hospital (SDH)	A secondary healthcare facility that provides services with about 100 beds and several clinical specialties	72
7	District Hospital (DH)	Following IPHS norms, at least one bed per thousand population in each district. The bed count typically ranges from 100 to over 500. And one in every district. Given that many DHs have recently been upgraded to TH, there is a shortfall in DH numbers.	6
8	Teaching Hospital (TH)	In a recent GO, the government of Telangana has opened teaching hospitals in every district	49

28. While rapid diagnostic blood tests are done in all PHC onwards centers, the detailed tests are done through a hub and spoke model by collecting samples from all the smaller facilities (Basti davakhanas, PHCs, CHCs, sub divisional hospitals, and even district hospitals) every working day and transported to the district hub laboratories, and reports are shared online/ sent to individuals phones.

A. ENVIRONMENTAL RISKS AND IMPACTS

1. Overall, the Program shall have a positive impact. The key environmental risks associated with the Program pertain to increased healthcare/biomedical waste (BMW), water and sanitation, occupational health & safety (OHS), universal access, and life & fire safety. While the State has defined systems and procedures in these areas, implementation quality varies geographically—generally strong in and around Hyderabad district and, require focus in districts such as Warangal, Adilabad, and Mahbubnagar. Health infrastructure is not directly included in the scope of this operation- the RAs and corresponding DLIs do not cover any capital expenditure or major construction and/or actions that are anticipated to have significant adverse impacts on the environment and/or on the community. All interventions will be carried out within the existing footprint of the facilities, and the associated risks (dust, noise, OHS) shall be temporary and managed through program systems. Environmental risk for the Program has been assessed as 'Moderate'. Key concerns are as follows:

- Expanded service coverage will increase all healthcare waste streams, necessitating strict segregation, safe handling, and compliant management, recycling, and disposal to prevent mixing with municipal waste or open burning.
- Uneven coverage of PPP-operated Biomedical Waste Treatment Facilities (BMWTFs) results in poor collection and transport practices, elevating infection risks for healthcare workers and communities.
- Rising water demand and effluent volumes require HCFs to adopt climate-smart infrastructure to reduce water wastage and ensure effective effluent treatment across all tiers of facilities.
- HCFs need to establish or upgrade inclusive infrastructure to ensure accessibility for elderly persons and people with disabilities.
- Expansion of geriatric care will generate waste outside institutional settings, necessitating additional guidelines and systems for community and home-based waste management.
- Home-based elderly care introduces safety risks for healthcare workers and patients, requiring enhanced OHS protocols, training, and protective measures.
- Radioactive and mercury waste must be managed strictly in accordance with the Biomedical Waste Management Rules and applicable national regulations.

B. SOCIAL BENEFITS AND OPPORTUNITIES

2. Potential Benefits: Overall, the Program is expected to have positive social impacts. No land acquisition and/or involuntary resettlement are anticipated as the Program does not involve any major civil work or construction. The Program has considerable social benefits like quality, affordable, and resilient health services through:

- Improved access and delivery of health services particularly in remote and underserved tribal areas;
- Strengthening early detection and management of hypertension and diabetes with regular follow-up, treatment, and complication prevention;
- Improved breast and cervical cancer screening services with a referral mechanism for treatment and systematic patient tracking to reduce loss to follow-up;
- Addressing the needs of adolescents, women, and the elderly and providing integrated, person-centered care, including expanding utilization of standard home-based care for vulnerable elderly populations; and

- Improved governance and accountability mechanism including strengthened GRM systems

C. SOCIAL RISKS AND IMPACTS

3. **Potential Risks:** The Program does not anticipate any land acquisition and/or any involuntary resettlement, and all interventions, including upgradation/refurbishment of healthcare facilities, will be carried out within the existing footprint of the facilities, without any horizontal or vertical expansion of facilities. The social risk for the PforR Program has been assessed to be 'moderate'. The key potential social issues/risks are:

- Challenges in healthcare delivery in rural, remote areas particularly among the tribal communities and other vulnerable groups.
- Implementation monitoring of POSH Act to be strengthened to address Sexual exploitation and abuse and sexual harassment (SEA/SH) risk and gender-based violence (GBV) for community members and healthcare workers, especially those working at odd hours.
- Need for developing strategies for rationalizing work among frontline workers such as ASHA, ANM, and MPHW, particularly in the context of epidemiological shift from RMNCH toward increased focus on NCD prevention and management, long-term elderly care, and service adaptation for vulnerable groups.
- Awareness and capacities of Jan Arogya Samiti (JAS)*39*/ Rogi Kalyan Samiti (RKS) members regarding their roles and responsibilities (critical for reinforcing accountability measures).
- Existing GRM needs wider publicity for greater uptake, formats and protocols for receiving and recording grievances require streamlining to enhance reporting and monitoring.
- Fast-track recruitment to replace vacant positions to avoid overburdening of existing human resources.

39Jan Arogya Samiti (JAS) is a community-based committee established at SHC/AAM Centers/ Basti Dawakhanas, and PHCs/UPHCs to strengthen citizen participation in managing local health facilities. They serve as a bridge between communities and the health system, promoting accountability, patient welfare, and collective action on public health issues, and play a pivotal role in strengthening community participation and accountability in primary healthcare facilities.

D. COMPONENT WISE ENVIRONMENTAL AND SOCIAL RISKS AND IMPACTS

4. The component wise specific risks **include**:

Component and Key Focus Area(s)	Activities	Potential Environmental Risks and Impacts	Potential Social Risk
RA# 1: Strengthened platforms to deliver high-quality care: Creating integrated, equitable, and accountable platforms for health service delivery to improve NCD outcomes, women's health, and elderly care. Addressing fragmentation to ensure care pathways are seamless from prevention to treatment, and ensuring health services, particularly for the elderly, are resilient to climate-related vulnerabilities.			
Hypertension and diabetes management - by strengthening early detection, follow-up, and complication prevention for NCDs	• Train frontline staff in screening, diagnosis, and treatment of hypertension and diabetes, and ensure a sustained supply of NCD commodities • Enroll diagnosed patients at HWCs and higher facilities for longitudinal care. • Integrate patient data across platforms using ABHA health IDs. • Deploy digital tools to track screenings, prescriptions, referrals, and adherence. • Run community campaigns to boost enrolment and care-seeking	• Increased coverage will lead to increase in healthcare waste and risk of infections.	• Digital connectivity may be an issue in some of the remote areas to provide telemedicine services. • Access to services and referrals in remote tribal areas may be a challenge, and require innovative or expanded outreach activities.
Cervical cancer screening and treatment – by expanding screening coverage and access to treatment for cervical pre-cancers	• Equip health facilities for breast and cervical cancer screening services • Train providers in evidence-based protocols and to ensure timely diagnosis and treatment at secondary and tertiary facilities • Selected higher-level facilities strengthened through equipment upgrades and staff training • Digital systems are deployed to track	• Increased coverage will lead to increase in healthcare waste and risk of infections.	• Lack of Availability of specialists at Secondary/ Tertiary care may be an issue

Component and Key Focus Area(s)	Activities	Potential Environmental Risks and Impacts	Potential Social Risk
	screenings, follow-ups, and treatment outcomes • Use ABHA-based health IDs to enable systematic patient tracking and reduce loss to follow-up • Community engagement initiatives to raise awareness and encourage participation		
Midwife-led and team-based maternity care – to improve maternal and newborn outcomes through respectful, evidence-based care.	• Upgrade high-volume facilities with midwives and specialists. • Promote task-sharing for low-risk vs. complicated deliveries between midwives and specialists • Foster peer learning and patient-centered care to reduce unnecessary interventions. • Sensitize families on benefits of midwife-led care and informed choices. • Build trust in midwife-led services through community engagement	• Improved and streamlined services can potentially reduce infection risks as well as generation of health care waste.	No potential social risk.
Home-based elderly care - deliver standardized, quality home care for vulnerable elderly populations	• Identify individuals using Comprehensive Geriatric Assessment (CGA) tools and train health workers in elderly care. • Training frontline health workers on elderly care protocols, and engaging families through community awareness and standard digital literacy campaigns • Link patients to physiotherapy,	• No environmental risk or impact identified	• Health facilities lack infrastructure, such as a handrail in the corridor to support movement, a dedicated waiting space for the elderly, toilets with universal access features, and someone to facilitate navigation within the larger health

Component and Key Focus Area(s)	Activities	Potential Environmental Risks and Impacts	Potential Social Risk
	counselling, and specialist services. • Strengthen digital infrastructure for monitoring and tele-consultation.		facilities • Home-based care would also have enhanced outreach activities of frontline workers, i.e., ASHAs and ANMs, and needs reorganization with epidemiological shift.
RA# 2: Behavioral interventions for both people and providers: aims to overcome behavioral barriers that hinder timely health-seeking, preventive care, and treatment adherence. It promotes both population-level and provider-level behavior change to foster proactive, prevention-oriented health practices.			
Improve health-seeking behavior to prevent secondary complications of NCDs	• Use annual comprehensive health check-ups to prompt regular patient engagement. • Provide counseling, complication screening, and specialist referrals. • Train providers to deliver preventive, patient-centered care and maintain longitudinal digital records. • Ensure facility readiness through adequate staffing, diagnostics, and digital tracking systems. • Align patient and provider behavior toward proactive, prevention-focused care	• No environmental risk or impact identified	• No potential social risk.

Component and Key Focus Area(s)	Activities	Potential Environmental Risks and Impacts	Potential Social Risk
Improves adolescent health and nutrition behavior change – to reduce anemia and improve adolescent health behaviors through multisectoral school-based interventions	• Use schools as convergence platforms for health, education, and social services. • Conduct quarterly school health and nutrition days for screening, counseling, treatment, and education. • Train and supervise teachers and frontline health workers; monitor behavior via digital dashboards. • Promote healthy diets, physical activity, and adherence to anemia management. • Influence both adolescent and provider behavior to reduce long-term NCD risks	• No environmental risk or impact identified	• No potential social risk
RA# 3: Improved governance and accountability: Strengthening governance, oversight, and accountability across public and private health and social care systems by introducing innovative service delivery models —such as elderly day-care centres—that require new institutional arrangements, operational guidelines, and monitoring mechanisms. Promoting professionalization and standardization of caregiving through enhanced skills, accreditation, and employability, thereby expanding the care economy and improving service quality. And, promoting regulatory oversight and accountability in the private sector.			
Improving governance and operationalizing new models of care for the elderly while professionalizing caregiving	• Establish elderly day-care centers, a new public service in Telangana, with clear operational guidelines, monitoring mechanisms, and oversight structures to ensure quality, responsiveness, and accountability. • Developing standardized caregiver training programs, including curricula, training centers, certification, and ongoing mentorship. • Enhance the skills and employability of	• Increase in healthcare waste at day-care centres and homes and its safe collection. • Increased risk of infections. • Safety of healthcare workers and elderly	• Caregiver service model by private sector providers needs regulation to ensure the quality of services

Component and Key Focus Area(s)	Activities	Potential Environmental Risks and Impacts	Potential Social Risk
	caregivers, improve quality and consistency of care, and foster sustainable, professional workforce development in the state. • Rollout facility readiness assessments and performance monitoring, ensuring that both service quality and governance standards are maintained		
Private Sector Regulation and Quality Assurance – to improve governance, accountability, and quality of care in the private health sector for NCDs.	• Train, sensitize, and certify private providers in standardized treatment protocols for hypertension and diabetes. • Implement patient tracking and reporting systems aligned with public health goals. • Engage professional associations to conduct peer assessments and promote quality assurance. • Foster transparency, compliance, and integration with the broader health system. • Support a regulated private sector that complements public service delivery	• No environmental risk or impact identified	• No potential social risk

1. The State has made significant strides in establishing institutional framework and quality assurance frameworks in health care sector. Separate Commissionerate have been established for primary, secondary and tertiary healthcare. Telangana Medical Services & Infrastructure Development Corporation (TGMSIDC) is responsible for all procurement activities as well as design aspects of civil works.

2. The State is cognizant of healthcare waste management and has been proactive in establishing infrastructure in compliance with BMWM Rules 2016. DoHMFW has set up eleven CBMWTFs across the state. These facilities have been set up and are being operated on through public private partnership by private operators and regulated by the State Pollution Control Board (SPCB).

3. DoHMFW has constituted State Level Advisory Committee (SLAC) and District Level Monitoring Committees (DLCs) in compliance with NGT order dated 26 November 2019 in O.A.No.360/2018 and subsequent orders of CPCB. These committees have been constituted for effective implementation of the provisions of the BMWM Rules across the state.

4. Hospital Infection Control Committee were established in the year 2015 to (i) develop strategies and implement best practices to minimize hospital acquired infections; (ii) Monitor hospital acquired infection rates and investigate outbreaks; (iii) Disseminate hospital acquired infection rates to the care providers and develop a culture of good practices; (iv) Review results and identify areas of improvement and training needs by regularly auditing different areas; and (v) Review and recommend policies / procedures related changes if any. Infection control nurses play the key role in infection prevention and control (IPC) that includes BMWM as well. The Hospital Superintendent ensures that the committee remains fully functional at all times, with complete members, and consistently performs its designated roles and responsibilities without interruption. BMWM is lagging with limited training on BMWM and IPC. Limited information regarding trainings conducted were available with HCFs visited.

5. The QA process document in Quality Improvement Manual appears narrowly focused on cleanliness, with insufficient emphasis on biomedical waste (BMW) management—despite its significance for occupational and patient safety and its status as a regulatory requirement. As a result, the QA framework misses an opportunity to address BMW management by not clearly assigning responsibilities, allocating adequate resources, or defining and monitoring BMW-related activities.

6. The safety committee, established under the Quality Assurance (QA) Procedure, is intended to oversee safety aspects. It is chaired by the Medical Superintendent, with the Head of Anesthesia as Vice Chair, and includes representatives from nursing, laboratory, radiology, and sanitation. Ex-officio members include the District Collector, TGMSIDC representative, and District QA Manager. Key functions of the Committee include (i) Develop a framework for monitoring, managing, and preventing adverse events; (ii) Establish a systematic process to analyze reported incidents within set timelines and issue actionable recommendations; (iii) Provide education and training to advance safety and quality improvement; (iv) Conduct safety audits and assessments and recommend corrective actions; and (v) Advocate at the government level for quality and safety issues beyond hospital resolution. Site visits evidence sub-optimal active presence or functioning; multiple hazards (fire, electrical, slip/trip/fall, infectious exposure) were observed. Given the breadth of safety risks in facility operations, and the absence of clearly defined safety responsibilities within the committee's QA remit, the QA process misses a critical opportunity to systematically manage occupational, patient, and community health and safety risks.

7. TGMSIDC plays a critical role in ensuring that the state's healthcare facilities, including hospitals, clinics, and medical colleges, are adequately equipped, functional, and accessible to the public. The primary functions include development, renovation, and maintenance of medical infrastructure across Telangana, especially in rural and underserved areas. TGMSIDC has developed standard designs and processes including disposal of expired medical consumables, design of BMW storage units at HCF, fire safety in HCFs, ETPs, etc. However, the designs cater to larger hospitals with more than 100 bed capacities. Provision of ETPs is limited to tertiary care hospitals only. There is no standard to address centralized treatment of water in HCFs with regular monitoring. Currently, HCFs are equipped with several household level reverse osmosis units leading to water wastage and no uniform protocol.

8. TGPCB is central to ensuring that healthcare facilities responsibly manage environmental impacts. By enforcing biomedical waste management, water and effluent treatment, air and noise pollution control, and hazardous material handling, TGPCB mitigates adverse effects of healthcare operations, protecting public health and the environment while enabling quality care. TGPCB oversees compliance of HCFs and CBWTFs with the Biomedical Waste Management Rules, 2016, through authorizations, periodic inspections, review of annual reports, and online monitoring of CBWTF operations. It also supports training and capacity building. Non-compliant HCFs and CBWTFs are issued notices and orders.

9. TGPCB facilitated a Memorandum of Understanding (MoU) between the Commissionerate of Health & Family Welfare/MD-NHM and eleven CBWTF operators, signed on November 12, 2024, to provide BMW services for government UPHCs and PHCs for one year. Key provisions of the MoU include monthly payment rates for collection, transportation, treatment, and disposal; performance-based certification by PHC/UPHC Medical Officers and DM&HO; daily waste logbooks; monthly reports; quarterly performance audits with corrective actions; and financial penalties for non-compliance. The reports were not made available. Waste logbooks are manually maintained by HCFs.

10. The state has established a Medical Recruitment Board to manage attrition and ensure continuity of services. Since December 2023, 11,728 personnel have been recruited, including 9,132 nurses, 1,170 doctors, and 1,260 lab technicians. In addition, recruitment is underway for 4,343 posts, with plans to fill a further 2,929 positions, demonstrating a sustained and structured approach to addressing human resource gaps. Additionally, the successive upgradation of health facilities—from Community Health Centres (CHCs) to Area Hospitals and from Area Hospitals to Teaching Hospitals—has facilitated decentralized specialist healthcare delivery. At the same time, these upgrades have created additional staffing requirements, which the department is actively addressing through ongoing recruitment efforts to ensure uninterrupted service delivery.

11. The Sub Centers (SCs) / Ayushman Arogya Mandirs (AAM) in rural and urban areas have a vital role to play in terms of community engagement and creating a demand for health facilities. Each day of the week is systematically designed for each kind of interventions like NCD on Monday and Friday; ANC on Monday; PNC on Thursday; Immunization Wednesday and Saturday and Friday is dry day where the AMM/HWC functionaries goes from door to door to see if there is any stagnant water. ASHA are attached to each sub center collect data on pregnant women, children and elderly people of the area and supported/ supervised by ANMs in the sub-center. Also, helps ANM in monitoring of ANC, NCD, vaccination and any other kind of care that required to be provided by the Sub-center. ASHA support ANM in NCD survey. This in turn contributes to reducing the burden of PHCs and Area Hospitals.

12. ASHAs are community-based volunteers responsible for a population of around 1,000 in rural areas and 1,000–2,500 in urban areas. They undertake outreach activities related to maternal and

child health, family planning, and community mobilization for ANC, PNC, institutional deliveries, immunization, NCD screening, TB and vector-borne disease control, and school health programs. In some instances, ASHAs have also been assigned additional geographical areas due to vacant ASHA positions. In Telangana, ASHAs are paid incentives ranging from ₹9,200 to ₹9,800 per month. Further, the conversion of Sub Centres into Ayushman Arogya Mandirs (AAMs) has introduced an additional human resource in the form of a Mid-Level Health Provider (MLHP)/Community Health Officer, alongside the ANM, thereby expanding staffing capacity and enabling the delivery of a comprehensive package of health services. In this context, the department requires reviewing the existing roles and responsibilities of frontline staff to align with epidemiological shift. Such measures would help address the growing demand for services, respond to the ongoing epidemiological transition, strengthen last-mile service delivery, and ensure coverage of vulnerable populations.

Citizen Engagement and Grievance Redress Mechanism (GRM)

13. The state health program has several mechanisms in place for capturing patient feedback, including interactions with front-line workers such as ASHA and ANMs, mechanisms such as *Mera Aspataal*[40], a complaint and feedback box, and NQAS checklists, further verifying the feedback mechanisms. The Jan Arogya Samiti (JAS) at the SHC/ HWC/ AAM center, and PHC level, and Rogi Kalayan Samiti (RKS) or Hospital Management Society at the CHC, Sub-District Hospitals, and District Hospitals level are the key mechanisms for the citizens' participation in health facility management. It acts as a committee to manage health facility affairs, improve patient care and welfare, and ensure quality services with community involvement. The facilities visited during the assessment suggest that the JAS and RKS exist and meet regularly; however, the members require training on committees' roles and responsibilities to enable them to perform their roles optimally and utilize united funds released through IV finance commission systematically.

40 The Mera Aspataal app is a patient feedback system, part of the National Health Mission, that uses a multi-channel approach (like SMS, a mobile app, and web portal) to collect patient feedback on healthcare services. This feedback is then used by the government to analyze and improve the quality of care provided in public and empaneled private hospitals.

supports telehealth services and ensures that patients receive adequate home-based follow-up care, thereby bridging gaps between facility-based and community-based health services.

Rogi Kalyan Samiti (RKS): The Rogi Kalyan Samiti (RKS) / Hospital Management Society in Telangana is a registered committee that acts as a group of trustees for public health facilities (like Community Health Centres, Sub-District Hospitals, and District Hospitals) to manage the hospital's affairs, ensure quality services with community participation, and maintain accountability and transparency and responsiveness in healthcare delivery. Its primary role is to upgrade and modernize services by ensuring the proper use, timely maintenance, and repair of hospital buildings, equipment, and machinery. RKS also manages financial resources by generating funds through user fees, donations, and grants, and has the autonomy to utilize these for hospital improvements and smooth functioning.

Beyond service delivery and financial management, RKS strengthens accountability and transparency by displaying Citizens' Charters and operationalizing grievance redressal mechanisms to address patient complaints. Members typically include local Panchayati Raj Institutions (PRIs) representatives, community members, School Principal/headmaster, a civil society member/ NGOs, elected representatives, Health facility staffs, and government officials. It fosters community participation to ensure that hospital management reflects community needs. The Samiti supervises the implementation of national and state health programs under the National Health Mission and organizes outreach services such as health camps. It also prioritizes patient welfare by providing subsidized food, medicines, drinking water, and cleanliness, while arranging referral services for poor patients when necessary. Additionally, RKS undertakes minor construction, expansion, and scientific waste management, and improves boarding and lodging facilities for patients and attendants. Overall, the RKS model empowers local management bodies to make decisions that enhance service quality, accountability, and community trust in public health facilities.

While both JAS and RKS have financial autonomy, in practice, funds are often controlled at the district level and released only upon proposals, limiting flexibility. While JAS/RKS has the potential to enhance grassroots health governance and trust, its effectiveness depends on greater awareness among members, timely fund release, and regular capacity-building to ensure it fulfills its role in improving service quality and accountability.

14. In addition, the proposed Program also has as part of RA 1, the program planned community awareness campaigns to encourage enrollment, timely care-seeking, and adherence to prescribed regimens as part of DLI 1), and community engagement to raise awareness and encourage women's participation in screening Program interventions (DLI 2). RA 2 further addresses behavioral barriers limiting health-seeking, preventive care, and adherence to treatment through the SBCC and IEC campaign. In addition, the Program proposes to further strengthen the patient feedback mechanism to improve health outcomes and enhance citizen trust.

15. **Grievance redressal mechanism.** There are multiple channels to receive, resolve, and manage grievances for DoHMFW, including (1) Prajavani system; (2) 104 call center; and (3) Written complaints at DMHO/ BMHO, and at the facility level using complaint boxes.

- As per the *Indian Public Health Standards Guidelines 2022*. (8.7.6. Grievance Redressal), "There should be a robust grievance redressal mechanism. Apart from any centralized system introduced by the state (e.g., call centre) there should also be a method to lodge local complaints. (e.g. complaints box, receipt provided for a complaint letter or an opportunity to meet the CHO). These should be acted upon in a timely manner and feedback provided to the complainant, wherever possible. In addition, there should be a time limit to resolve registered grievances; and if not complied with, should automatically be escalated to the next higher

level. This will strengthen efficiency, accountability and quality of services being delivered."

- **The Prajavani System**: The Prajavani system (the CM portal) in Telangana is a Centralized Public Grievance Redress and Monitoring System for citizens to register grievances and receive assistance from the administration (https://prajavani.cgg.gov.in). It is a structured, one-stop platform for citizens to submit complaints, with a system for tracking and resolving them. Key features include the issuance of a unique reference ID for each grievance, assigning complaints to relevant departments, including DoHMFW, and regular follow-ups by a dedicated team to ensure timely action.

- Citizens can also personally submit their petitions at the Mahatma Jyothiba Phule Prajabhavan every Tuesday and Friday, fostering direct interaction with the administration. To streamline the process, departments with a high volume of grievances operate specialized desks at the venue, manned by senior officers who provide immediate assistance. These petitions are meticulously recorded and uploaded to the *Prajavani* Portal (https://cpgrams.ts.nic.in), ensuring a seamless, transparent, and efficient resolution process.

- Under the Prajavani program, there is a weekly public grievance redressal system where citizens can directly submit their complaints to the District Collector and other district-level officials usually held every Monday at the Collectorate offices in all districts of Telangana. Each complaint is logged into a dedicated online portal (https://cpgrams.ts.nic.in) and assigned a unique ID for tracking. Officials are directed to resolve the issues in a time-bound manner, typically within a week, and upload the Action Taken Report (ATR) online.

- In addition to the physical meetings, many districts, including Hyderabad and Mahabubnagar, have introduced online/WhatsApp-based grievance submission facilities to make the process more accessible, especially for the elderly, disabled, and working individuals.

- The Mera Aspataal App is a patient feedback system, part of the National Health Mission, that uses a multi-channel approach (like SMS, a mobile app, and web portal) to collect patient feedback on healthcare services. This feedback is then used by the government to analyze and improve the quality of care provided in public and empaneled private hospitals.

- **The 104 call center**: The 104 call center in Telangana operates as the Medical Health Support Services (MHSS) by the EMRI Green Health Services in partnership with the state government under the National Health Mission (NHM), a 24/7 health contact center for the public, aiming to provide medical information, advice, counseling, and a grievance redressal mechanism. Apart from seeking information on health-related services, people can also lodge complaints against any public health facility, government healthcare institution, or personnel, which are then forwarded to the relevant Directorates/ officials for resolution. Once the resolution is achieved, it is closed.

- In addition to the above, one can also give **written complaints at DMHO/ BMHO**, **and at the facility level using complaint boxes.** People can also give written complaints to DMHO/ BMHO at their offices, and one can also submit a written complaint in the complaint boxes in the facility. Many health facilities, especially the bigger facilities, also have a Grievance Redress Committee, which opens these boxes periodically for resolutions. However, this system lacks documentation of the complaints and the nature of the resolutions in any file/ register, and hence, cannot be tracked, escalated, compiled, and/or reported.

- While there are multiple systems for grievance redressal, it is currently fragmented and needs integration at the departmental level for tracking performance, uptake, and efficiency. Grievance Redressal Committees are constituted at district level under chairmanship of district collector. GRM needs to be publicized widely, formats and protocols for receiving and recording grievances need strengthening and integration of multiple systems will provide greater clarity for state level authority to monitor, track and resolve pending grievances.

- **Grievance Mechanism for GBV and SEA/SH**: The current mechanism for GBV and SEA/SH is through the internal complaint committee (ICC) as per the Sexual Harassment at Workplace Act. While the ICC has been established as mandated in PHC and above facilities, and needs further strengthening.

CORE PRINCIPLE 1 - ENVIRONMENTAL AND SOCIAL MANAGEMENT

Summary findings: Applicable

1. India (and its states, including Telangana) has an adequate legal framework for environmental health and safety, backed by a set of comprehensive laws, regulations, technical guidelines, and standards, which apply nationwide and to all the environmental effects identified in the Program. Furthermore, DoHMFW and its Directorates have a well-established institutional arrangement with necessary standards and guidelines, following the respective legal and regulatory provisions for the delivery of healthcare services in rural and urban areas. Over the decades, it has gradually evolved into a comprehensive system that is generally consistent with the PforR principles.

2. The Program activities and the identified environmental and social effects do not require standalone environmental and social impact assessment. Since the Program does not propose and intends significant civil works or infrastructure creation, there is no exclusive process to screen and assess environment and social impacts before undertaking any Program-supported activities. The risks and impacts associated with renovation/upgradation works, if any, shall be small and temporary (increase in dust, noise, and debris). A clear exclusion criteria/negative list has been developed for the Program that the expenditure framework will not support, and this includes any kind of major construction.

3. The key risk associated with the implementation of the Program is the incremental increase in healthcare waste, IPC, OHS, universal access, and life & fire safety. With the objectives of providing quality care and better service delivery generation of healthcare waste is projected to grow incrementally over the years and its improper management poses risks related to infection to community and staff. To manage increased patient load and outreach, infrastructure will have to be made energy efficient and climate resilient, have provision for safe water supply & sanitation, life & fire safety, and universal access including provisions of waiting areas, elderly/disable friendly facilities.

4. The state has established a Medical Recruitment Board to manage attrition and ensure continuity of services. Since December 2023, 11,728 personnel have been recruited, including 9,132 nurses, 1,170 doctors, and 1,260 lab technicians. In addition, recruitment is underway for 4,343 posts, with plans to fill a further 2,929 positions, demonstrating a sustained and structured approach to addressing human resource gaps.Furthermore, the successive upgradation of health facilities—from Community Health Centres (CHCs) to Area Hospitals and from Area Hospitals to Teaching Hospitals—has facilitated decentralized healthcare delivery. At the same time, these upgrades have created additional staffing requirements, which the department is actively addressing through ongoing recruitment efforts to ensure uninterrupted service delivery.

5. Sub Centers (SCs) and Ayushman Arogya Mandirs (AAMs) play a pivotal role in community-level health engagement through structured weekly interventions like NCD screening, ANC/PNC care, immunization, and environmental surveillance. ASHAs, attached to each sub-center and supervised by ANMs, are central to patient follow-up, and service delivery, including hypertension and diabetes—helping reduce the burden on higher-level facilities. This highlights the urgent need for rationalizing frontline health worker roles, aligning with the epidemiological shift.

6. Assessment of JAS and RKS suggests serving as key platforms for community participation in health facility management across various levels—from SHCs and HWCs to PHCs and District Hospitals—aiming to enhance patient care, welfare, and service quality. Although these committees are functional and meet regularly, members require capacity building on their roles and responsibilities to promote greater involvement.

Key Gaps and Recommendations:

- There is need for strengthening capacity in DoHMFW, and TGMSIDC for addressing Environment and Health Safety (EHS), including Occupational Health Safety (OHS), of healthcare workers, construction workers and community members.

- A dedicated cell for management of BMW is required to have a 360 degree approach towards healthcare waste management and not just BMMW. BMW is being collected from across the State and treated & disposed through the eleven CBMWTFs being operated by private operators. However, DoHMFW with SPCB need to strengthen their capacities to monitor functioning of these treatment facilities. Several health care centers are experiencing irregular collection of waste. Bar coding is limited to vehicle tracking and access is solely with SPCB. CBMWTFs visited lacked onsite management. The monitoring system relies on self-reporting by HCFs and CBMWTFs, and inspections of HCFs and CBWTFs for compliance are being carried out on need basis by SPCB officials. With healthcare waste expected to increase, there is a requirement of robust management system supported by real time digital tracking and a good tariff system.

- The Chemical / liquid waste from Laboratory, blood banks, etc., should be pre- treated / disinfected. After pre-treatment, health care facilities must treat the wastewater either through their own ETP or they can discharge into public sewer connected to a terminal STP. Majority of the existing health care facilities do not have provision of either inhouse ETP nor connected to sewer system with terminal STP. Only tertiary care hospitals have provision of ETPs or are under consideration.

- State is not procuring any mercury-based healthcare equipment. Since procurement of such equipment falls at a low procurement threshold to be managed by individual HCFs, there is no record of the mercury-based equipment in use, and that has been replaced. HCFs have been disposing replaced equipment and any mercury spills as yellow waste to CBMWTFs which is against the Rules.

- Provision of energy efficiency measures are encouraged but not integrated in the procurement documents. Indian Council for Green Buildings (ICGB) guidelines may be incorporated in building construction works, procurement of equipment meeting certain energy efficient requirements should be made part of the procurement process. Further, supply of potable water in HCFs is ensured through multiple household-based RO units and there is no centralized treatment unit. Additionally, there is no water quality monitoring system.

- At present, there is no formal mechanism adopted for screening and identifying any potential environmental and social issues before undertaking any civil works. However, given the nature of the works, the impacts are predictable (dust, noise, debris) and temporary. Requisite measures can be worked into the bid documents and contract bill of quantities (such as fencing, screens, watering, low-noise equipment, compliance with national and state labor laws).

- The state has established a Medical Recruitment Board to manage attrition and ensure continuity of services. However, fast tracking of recruitment is required to fill the gaps to avoid overburdening existing staff.

- ASHAs are central to health care service delivery, including NCD-related services envisaged under the Program along with other state and national programs such as MCH etc., given the multiple programs that likely to expand the scope of work for ASHA, it is suggested to undertake rationalizing frontline workers' roles among ASHAs, ANMs, and MPHWs based on proper review of current work profile to align actual duties with formal guidelines in line with the epidemiological shift for smooth service delivery.

- JAS and RKS members lack clarity about their roles and responsibilities, resulting in required performance and weak accountability. There is a need to create awareness about members' roles and responsibilities and build capacity for improved accountability and transparency.

CORE PRINCIPLE 2 - NATURAL HABITATS AND PHYSICAL CULTURAL RESOURCES

Summary findings: Applicable

7. The Program will support upgrade and refurbishment of infrastructure. Any civil works involving renovation of existing health care facilities will be carried out within the existing footprint of the existing facilities. Therefore, it is assessed that the Program-supported expenditures do not pose any risk to natural habitats and physical and cultural resources from the perspective of renovation works. However, there will be an increase in liquid waste, both infectious and non-infectious from health care facilities (disinfectants, reagents, wastewater). The existing health care facilities, except some of tertiary care HCFs, still do not have ETPs installed, and effluents that are being disposed without any formal connection to STP or ETP system. This poses an indirect risk of contamination of natural drainage systems and groundwater if not disinfected adequately and disposed in a sanitary manner.

Key Gaps and Recommendations

- The liquid waste is being pre- treated / disinfected before disposal, but majority of HCFs are not connected to sewerage network/ STP or have standalone ETPS.

- Testing of wastewater is necessary to understand the efficiency of pre-treatment and nature of wastewater.

CORE PRINCIPLE 3 - PUBLIC AND WORKER SAFETY

Summary findings: Applicable

8. The renovation and rehabilitation work for health care facilities will be taken under the Program. While TGMSIDC follow the legal and regulatory provision for labor, occupational health and safety (OHS) and Community health and safety (CHS), the contractors and sub-contractors of the agencies sometime overlook this provision during execution of the work. Given that there will be several packages of such works in the state, there is an opportunity to strengthen the labor law compliance, OHS practices, uses of PPE, and environmental mitigation controls (dust, noise, and waste management) through trainings which can be standardized at the state level.

9. Incremental increase in BMW is expected due to improved outreach of health care. It is expected that BMW generation at health care facilities, including laboratories, blood banks, etc., will increase. Health care workers and the public would be exposed to risks associated with exposure to BMW and associated infections. In addition, wastewater, liquid wastes (blood, etc.), and uncollected BMW pose threats to communities in exposing them to pathogens and vector-borne diseases.

10. In some of the HCFs visited, BMW collection, especially at sub-centers is being done by ASHA and ANM workers whereby they transport the waste in uncontrolled environment to PHCs. There is no MoU with CBMWTF Operators to collect waste in HCFs below PHCs. This poses serious infection risks to these workers.

11. Home-based geriatric care is being encouraged through the Program. This entails management of healthcare waste at household level, which is outside institutional setup. Further, health and safety of the healthcare workers and patients will have to manage through proper protocols and guidelines and their implementation.

Key Gaps and Recommendations

- Procurement documents and implementation practices need to be updated on occupational risk management and good environmental mitigation practices for dust and noise control.

- Adequate systems to manage BMW are required for effective collection and management of BMW.

- The Department currently does not have a centralized system of capturing and monitoring incident reporting due to BMWM and vaccination of staff under IPC.

- HCF staff (sanitation, housekeeping, and cleanliness) need periodic trainings in safe handling of BMW, operation of equipment, use of PPE (depending on the type of cleaning reagents used and type of room), ERP and L&FS.

- Guidelines on geriatric care should include provisions of OHS and BMWM.

CORE PRINCIPLE 4 - LAND ACQUISITION

Summary findings: Not Applicable

12. While the system and capacity for land acquisition and resettlement exists within the GoT, any investment requiring land and involuntary resettlement will be excluded under the Program. Any

repair and renovation work will be within the existing footprint of the HCFs. However, the usual process followed by GoT is to follow the laid-out procedures under 'The Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation, and Resettlement Act, 2013 (and further amendments)', and based on the request by the DoHMFW to the Revenue Departments through the District Collector following the procedures as laid out in the Act and the rules.

CORE PRINCIPLE 5 - INDIGENOUS PEOPLES AND VULNERABLE GROUPS

Summary findings: Applicable

13. There is a need for improved strategies tailored to vulnerability conditions to ensure the delivery of quality healthcare services across districts. The Multidimensional Poverty Index41 (MPI) 2023, based on three equally weighted dimensions – Health, Education, and Standard of living – which are represented by 12 indicators such as nutrition, child and adolescent mortality, maternal health, years of schooling, school attendance, cooking fuel, sanitation, drinking water, electricity, housing, assets, and bank accounts. The district-wise values of multidimensional poverty suggest that Kumuram Bheem Asifabad, Jogulamba Gadwal, Adilabad, Vikarabad, Kamareddy, Mahabubnagar, Medak, and Wanaparthy districts have a higher poverty rate than the state average. Most of these districts also overlap with high tribal populations42 and are part of ITDA areas and prioritized for health care delivery with additional measures as described in the section below.

14. Telangana's tribal health programs in Telangana mainly have four key programs (both state initiatives as well as GoI initiatives through the Ministry of Tribal Affairs) and includes **Giri Poshana**[43] to combat malnutrition through supplementary food, **Rajiv Aarogyasri Scheme**, which provides hospitalization insurance for families below the poverty line, **PM Janjatiya Unnati Gram Abhiyan (PMJUGA)** targets villages where the ST population is more than 500 or more than 50% to enable infrastructure and improve the socio-economic condition of tribal communities by adopting saturation coverage for tribal families in tribal majority families and aspirational districts, and **Aadi Karmayogi Abhiyan**[44].

The state also implements relaxed norms under the National Health Mission (NHM) for public health facilities in tribal areas, which include establishment of health facilities to cater smaller population and increased Mobile Medical Units (MMUs). Under the PM Janjatiya Unnati Gram Abhiyan (PMJUGA), in Telangana, there are 37 MMUs in place providing services and including 32 MMUs

41 Niti Aayog 2023. Available at https://www.niti.gov.in/sites/default/files/2023-08/India-National-Multidimentional-Poverty-Index-2023.pdf

42 The Scheduled V area in Telangana is spread over 9 districts (Adilabad, Asifabad, Mancherial, Warangal, Mulugu, Mahbubabad, Khammam, Bhadradri-Kothagudem and Nagarkurnool) covering 85 Mandals (30 fully & 55 partly) and 1,174 villages. These are covered under five Integrated Tribal Development Agencies (ITDA) areas, namely ITDA Utnoor, ITDA Bhadrachalam, ITDA Eturunagarm, ITDA Mannanur, and ITDA Plan areas. The Particularly Vulnerable Tribal Groups (PVTGs) in Telangana include Chenchu, Thoti, and Konda Reddis. The government implements special schemes to address the specific needs of these communities, focusing on areas like housing, education, health, and livelihoods.

43 Targeting children (3-6 years), adolescent girls, pregnant women, and lactating mothers in tribal areas of Telangana to reduce stunting, wasting, and anemia and improve overall health indicators.

44 A national initiative by the Ministry of Tribal Affairs, the program aims to build a cadre of 20 lakh "change leaders" across one lakh tribal-dominated villages in India, including those in Telangana, to improve the last-mile delivery of government schemes. It is a grassroots governance revolution that seeks active collaboration from all stakeholders—government departments, civil society, and tribal communities—to ensure tribal India moves from the margins to the mainstream.

serving 471 villages across 48 Blocks/ Mandals of the four ITDA areas. Under the Aadi Karmayogi Abhiyan, (a) 37 Bike Ambulances are stationed across 28 Blocks/ Mandals of Bhadrachalam, Eturunagaram, Utnoor, Mannanur ITDA areas; (b) Birth Waiting Rooms have been established across 12 PHCs and CHCs in the four ITDA areas; (c) collaborating with NGOs such as Indigenous Development Organization(I-DO), Rural Development Trust (RDT), and Apollo group to provide health care services, including running four MMUs in the ITDA areas; and (d) Established a Help Desk with different local tribal language capabilities45 at Rajeev Gandhi Institute of Medical Sciences(RIMS), Adilabad, to facilitate medical assistance and support for tribal patients. Establishment of 73 multipurpose centres equipped with an ANM to cater to health needs of tribal population. Placing of ANM in 618 Ashram residential schools to promote preventive as well as curative health care for children. Deputation of Medical Officer from CoHFW in tribal welfare department to promote convergence to ensure equitable last-mile access to services for all marginalized population. Despite these persistent efforts, there exist challenges in-terms of institutionalized service uptake among tribal community, and adverse climate conditions sometimes, hamper service delivery.

15. In addition, initiatives like the one-stop tribal welfare hub in Kumuram Bheem Asifabad integrate health services with education and cultural preservation, and the Ministry of Tribal Affairs initiative in collaboration with the Tribal Research Institute, Telangana, which organizes workshops to discuss the importance of indigenous health practices and create research repositories for them.

16. There are 37 Multi-Service Day Care Centers (each covering 50 beds/ beneficiaries) established in all 33 districts. The old age homes under the co-management approach are being established to set up and operate facilities with funding shared between the government and selected NGOs. There are 274 old-age homes (ranging from 25 to 50 beds, with a few exceeding 50 beds) currently functioning in the state, operated by private organizations and the Government.

17. While the program focuses on improving new models of care for the elderly, establishing elderly day-care centers, and professionalizing caregiving, which is a good initiative, given the shift in demography. However, a field visit to some of the health facilities and existing geriatric wards suggests that it requires both physical and other support to facilities with dedicated seating spaces for the elderly, toilets with features like grab handle etc., universal access measures such as handrails along corridors to ease the movement of the elderly, and a mechanism to help the elderly navigate the facility services. Furthermore, advancing the home-based caregiver model will necessitate establishing appropriate regulatory frameworks to enable private sector participation in accordance with standards set by the state's health department.

18. The state health program has multiple mechanisms to capture patient feedback, including through frontline interactions with ASHAs and ANMs, platforms like Mera Aspataal, complaint boxes at health facilities, etc. Community participation is also institutionalized through JAS, RKS, and Hospital committees, which manage health facility affairs across various levels. While these committees are functional and meet regularly, many members of JAS/RKS lack clarity on their roles and responsibilities. As part of RA1, the program plans community awareness campaigns to boost enrollment, care-seeking, and women's participation in screenings, while RA2 targets behavioral barriers through SBCC and IEC efforts. The program also aims to strengthen feedback systems to enhance health outcomes and citizen trust. While the GRM is functional, there is a need to enhance it further, given that it is quite fragmented, and multiple systems need integration at the Department level for tracking performance, uptake, efficiency, and periodic reporting and monitoring.

Key Gaps and Recommendations (to improve social inclusion for other vulnerable groups)

45 Deputed 13 paramedical and support staff from various PHCs under ITDA Utnoor to man the Help Desk

- Telangana has made notable strides in expanding health services to tribal and remote populations, yet some gaps persist despite deploying Mobile Medical Units (MMUs) and establishing new Multi-Purpose Centers.

- While the program aims to improve care for the elderly, the health facilities often lack basic accessibility features like handrails, toilets with features like grab handles, and seating spaces for the elderly. Also, the home-based caregiver model will necessitate establishing appropriate regulatory frameworks to enable private sector participation in accordance with standards set by the state health department.

- As mentioned in the section above, the JAS/ RKS members require awareness and capacity enhancement towards their role and responsibilities, and there is a need to further strengthen the GRM system, given that it is quite fragmented and multiple systems need integration at the Department level for tracking performance, uptake, efficiency, and periodic reporting and monitoring.

CORE PRINCIPLE 6 - SOCIAL CONFLICT

Summary findings: Not Applicable

19. The Program footprint does not include any areas that are considered fragile or disputed. The nature of Program investments is such that they are not likely to lead to or exacerbate social or resource conflicts. Also, intentional exclusion of any groups based on caste, religion, and/ or geography due to the Program activities is not expected at the state, district, or village level.

A. SUMMARY OF FIELD LEVEL OBSERVATIONS AND DISCUSSIONS

1. As a part of ESSA preparation, consultations were undertaken with key officials of DoHMFW and its Directorates, including NHM, TVVP, DME, TGMSIC, State Program Management Unit (SPMU); along with key officials from Women and Child Development (WCD), Tribal Welfare Department, and State Pollution Control Board.

2. Field visits to districts and consultations were also undertaken and included: Visits to HCFs in Adilabad, Nizamabad, Mahbubnagar, Warangal, and Hyderabad districts. These included discussions with the District Medical Officer of Health (DMOH) and district and HCF staff, visits to HCFs, including SHCs/ AAM centers, Basti Dawakhana, PHCs, U-PHCs, CHC, Area Hospital, DH, GGH, and Teaching Hospital, as well as a visit to a CBWTF. Consultations were also undertaken with ASHA, ANM, JAS, and RKS members, along with Panchayat members, tribal leaders, etc.

3. The facilities visited across various districts include: In Mahbubnagar - Sub centre at Rudraram, CHC Koilakonda, PHC Janampet, Area Hospital Jadchera, Mahabubnagar Teaching Hospital; In Warangal - Urban PHC Deshaipet, PHC Sangeym, District Hospital Narsempet, Basti Dawakhana - Christian Colony, and Kakatiya Medical Waste Company; in Adilabad - Ayshman Arogya Mandir (AAM) center in Nagalkonda, PHC Gudihathnoor, DH/CHC Utnoor; and in Nizamabad - Basti Dawakhana Khanapur, UPHC Dubba, District General Hospital Nizamabad; and in Hyderabad - UPHC Tilaknagar, and Sarojini Devi Eye Hospital (Teaching Hospital) in Hyderabad. A detailed summary of key discussions and consultations, along with observations from the field visits, is presented in Annexure 6.

4. Interaction with Civil Society groups[46] informed the assessment especially on issues of citizen engagement, inclusion, last mile connectivity and SEA/SH. After the consultation, the organizations shared data on their niche expertise, locations where they have mobilization teams and areas in which they can support implementation of the Program.

B. MULTI-STAKEHOLDER ESSA CONSULTATION WORKSHOP

5. A multi-stakeholder workshop will be organized before close of Appraisal. It will cover participants from all key stakeholder groups, including representatives from DoHMFW and its Directorates, other stakeholder departments including WCD, Tribal Welfare Dept., State PCB, civil society organizations, academia, and beneficiary community groups; and district-level officials among others. The purpose of the workshop will be to seek their feedback and suggestions on the ESSA findings and to gather feedback and refine recommendations to strengthen environmental and social risk management and sustainability. The ESSA will be revised/updated considering the suggestions and feedback received during the multi-stakeholder workshop and disclosed on DoHMFW website. Details will be provided in Annexure 7.

46 Kasturba Gandhi National Memorial Trust, Heritage Foundation, Bhumika Women's Collective, HelpAge India, Darpan Foundation and ARMAN. They work on a series of issues like adolescent girls, children, rescue homes, Sakhi Centres, skill development, mental health, geriatric care, POSH, SHE teams, advocacy, emergency relief, sexual health and human rights, women, reproductive health, maternal health.

C. DISCLOSURE

6. The draft ESSA was publically disclosed at the World Bank website and at the DoHMFW website (including a translation of the Executive Summary in local language) to serve as the basis for discussion and receipt of feedback and comments. The revised version will be disclosed before the multi-stakeholder consultation workshop. The ESSA will be finalized based on feedback and comments, including those received during the multi-stakeholder state-level workshop. The Final ESSA will be redisclosed on the World Bank's website and the DoHMFW website prior to negotiations.

A. HIGHLIGHTS: FINDINGS AND RECOMMENDATIONS

1. The ESSA concludes that the Program has moderate environmental risk and moderate social risk. The systems are in line with the Core Principles and Key Planning Elements as defined in the World Bank Policy for PforR. The process and criteria for monitoring, enforcement, and reporting on environmental and social measures will be part of overall Program reporting. The above requirements, processes, and systems will be included in the Program Operations Manual. Monitoring and supervision of the ESSA implementation will be a part of World Bank implementation support.

Environmental Gaps

2. Home-based geriatric care will result in health care generation at household level which shall be outside the institutional area of HCFs. This will require management through training of healthcare providers. Additionally, safety of health care providers as well of patients will be of concern.

3. In accordance with Minamata Convention, the state has issued orders and is no longer procuring mercury-based equipment. However, old mercury-based equipment is still in use. Further, given the procurement thresholds, such equipment is procured by HCFs at decentralized level. As a result, there is no centralized record of mercury-based and digital equipment in use and replaced. there is also no mention of disposal of mercury-based equipment in condemnation policy of the DoHMFW.

4. Currently, mercury waste is being handed over the CBMWTFs as yellow category waste which is not the correct practice.

5. There is no mechanism to track immunization of health care providers or any IPC related incident reports. All this is managed at district level. DoHMFW conducts immunization drives to cover health care providers for Hepatitis B vaccinations which is budget and demand driven.

6. Bar code system for monitoring BMWM is limited to SPCB use and monitors only vehicle tracking. Its use is not mandatory as many of the HCFs reported that Operators are not using bar code.

7. Currently, the contracts/MoUs with CBMWTFs require further streamlining and standardization. There is bilateral MoU between Operator and secondary and tertiary care HCFs, whereas a tripartite MoU between Commissionerate, SPCB and Operator for primary care facilities. No HCFs below PHCs are serviced by Operators. Tariff structure is different and coverage is variable resulting in non-standard tariffs within government HCFs as well as with private HCFs. The periodicity of collection of 48 hours is usually not followed by Operators in the HCFs visited. However, the MoU performance is not monitored – neither by SPCB not by DoHMFW. The contracts can benefit from strengthened performance standards and mandatory adoption of bar code.

8. Since Operators do not service HCFs smaller than PHCs, ASHA and ANM workers were found to be transporting waste to PHCs in unsafe manner.

9. MoUs also require regular trainings to be imparted by the Operators to HCFs. No record of the same could be shared.

10. TGMSIDC has standard design for BMW Storage but only for more than 100 bedded hospitals. The storage units in many hospitals visited were found to be in dilapidated conditions.

11. Quality of water supply in HCFs is being ensured through multiple household-based RO units. There is no centralized treatment unit in HCF and no water quality monitoring protocol in place.

12. Effluent from hospitals is being discharged either into drains or into environment depending on the location of the HCFs and not necessarily meeting the BMWM Rules. There is no testing of effluent being conducted. Provision of ETPs is limited to tertiary care hospitals only.

Social Gaps

13. Adequate human resources are critical for rendering uninterrupted health services. While the state has taken several steps*47* to address gaps, recent upgrades of health centers—from CHCs to Area Hospitals, and then to Teaching Hospitals—have further increased the demand for personnel. The department has tried to address these gaps through establishing medical recruitment board however, there is need for fast-tracking recruitment to ensure uninterrupted service delivery. Meanwhile, the proposed Program includes measures to strengthen care related to NCDs.

14. Telangana has made notable strides in expanding health services to tribal and remote populations, yet challenges in rural, remote areas particularly among the tribal communities and other vulnerable groups persist. While MMUs and bike ambulances improve outreach, uptake of institutional healthcare among is low. Under the Program, the focus on tribal population is being addressed through DLR1.3, 4.2, and 4.3 to increase coverage of tribal patients for hypertension and diabetes related care, and for home based elder care.

15. ASHAs are central to health care service delivery, including NCD-related services envisaged under the Program along with other state and national programs such as MCH etc., given the multiple programs that likely to expand the scope of work for ASHA, it is suggested to undertake rationalizing frontline workers' roles among ASHAs, ANMs, and MPHWs based on proper review of current work profile to align actual duties with formal guidelines in line with the epidemiological shift for smooth service delivery.

16. JAS and RKS members lack clarity about their roles and responsibilities, resulting in weak accountability. There is a need to create awareness about members' roles and responsibilities and build capacity for improved accountability and transparency.

17. While the program aims to improve care for the elderly, the health facilities often lack basic accessibility features like handrails, toilets with features like grab handles, and seating spaces for the elderly. Also, the home-based caregiver model will necessitate establishing appropriate regulatory frameworks to enable private sector participation in accordance with standards set by the state's health department.

18. There is a need to further strengthen the GRM system, given that it is quite fragmented, and multiple systems need integration at the Department level for tracking performance, uptake, efficiency, and periodic reporting and monitoring.

47 Telangana is one of the few states which has established Medical Recruitment Board. Telangana has initiated one of the largest health workforce expansions: 11,728 healthcare staff recruited since December 2023; 4,343 additional posts under recruitment (by June 2026); 2,929 future recruitments planned as well as key additions: 9,132 nurses; 1,170 doctors; 1,260 lab technicians

19. The current mechanism for GBV and SEA/SH is through the internal complaint committee (ICC) as per the Sexual Harassment at Workplace Act. While the ICC has been established as mandated in PHC and above facilities, it largely exists on paper and functions as a checkbox for NQAS certification, and hence needs strengthening.

B. PROGRAM EXCLUSIONS

20. The Program will exclude activities that do not align with the World Bank policy on eligibility requirements for PforR financing. The Program will not finance any high and substantial risk activity that may have significant adverse environmental and/or social risks/impacts. Activities that are likely to have significant adverse impacts and are sensitive, diverse, or unprecedented on the environment and/or affected people will be excluded. The following high-risk activities will be excluded from support under the proposed PforR Program expenditure. The following high-risk activities will be excluded from support under the proposed PforR Program expenditure based on environmental and social risks:

I. Any activity that may involve land acquisition or have potential involuntary resettlement;
II. Any activity that may involve changes in land use or access to land and/or natural resources;
III. Use of child or bonded or forced labor or labor involved in any hazardous activities;
IV. Destruction or damage to any physical and cultural resources;
V. Any activity which could lead to marginalization of, or conflict within or among, social groups
VI. Activities involving asbestos-containing materials (AC roofing sheets, AC pipes, and so on), such as construction, demolition, dismantling
VII. Any activity that would have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation or common property resources; or cause or have significant impact on them.

C. RECOMMENDATIONS

21. The ESSA recommendations focus on strengthening the implementation arrangements, program procedures, risk mitigation practices/protocols, and monitoring and reporting systems on E&S aspects, as well as core training programs to build the technical and operational capacity. While some of the recommendations are mainstreamed as part of the results framework and DLRs, as mentioned above, most of the remaining recommendations are to be incorporated in the program operations manual (POM), and a higher-level action is recommended as part of the program action plan (PAP).

Environmental Recommendations

i. Guidelines and training modules for standard home-based care for vulnerable elderly to be developed under the Program should include provisions for healthcare waste management and health & safety of healthcare workers as well as patients.
ii. To effectively phase put and manage mercury-based equipment, DoHMFW should take stock of such equipment. The condemnation policy should be updated to send the discarded equipment to the manufacturer or an alternative and not to CBMWTF as yellow category waste.
iii. Improve capacity on IPC and health care waste management through regular trainings. Monitor content and periodicity of trainings on BMWM by CBMWTF Operators.
iv. DoHMFW should consider developing a policy to track immunization of all health care workers as well as any incidents through a centralized platform.
v. Strengthen bar coding system for BMW collection to expand its applicability to real time

tracking of collection, transportation and treatment/disposal.

vi. Contracts/MoUs of CBMWTFs to be standardized and streamlined for:
    a. Performance based standards
    b. Full coverage of defined service area by each Operator
    c. Mandatory use of bar code
    d. Tariff structure factoring economics of the BMWM.
    e. Regular trainings to HCFs on BMWM

vii. Condition assessment of BMW storage units of less than 100 bedded hospitals and prioritize refurbishment/upgrade of units

viii. Include management of water supply and effluent discharge thereby promote climate smart hospitals through:
    a. Installing a centralizing water treatment unit in HCFs (starting with >100 bedded HCFs) and having a water quality monitoring protocol
    b. Expanding coverage of effluent treatment as per BMWM Rules to primary and tertiary care hospitals in a phased manner.

Social Recommendations

ix. Last mile workers: Given that ASHAs are central to health care service delivery, including NCD-related services envisaged under the Program, a study is proposed to be conducted covering ASHA, ANM, & MPHW in line with epidemiological shift (revised focus).

x. Local institutions: To strengthen accountability and transparency measures at the primary health care facilities, JAS and RKS members need to be made aware of their roles and responsibilities, and a mechanism needs to be developed for periodic training of JAS and RKS members. Additionally, the SBCC strategy will help these members communicate closely with the community and understand their issues that will be represented with required health officials (IRI 7).

xi. Accessibility: The health facilities need to incorporate basic accessibility features like handrails, toilets with features like grab handles, and seating spaces, etc. for the elderly and disabled population into their repair and upgradation measures. Under the program, the DLI 4 and 7 will develop the operations guidelines and protocol for elderly care that also includes the design of day care centre for elderly that will address the access issues for vulnerable elderly.

xii. Home based care: The home-based caregiver model is encouraging but requires establishing appropriate regulatory frameworks to enable private sector participation in accordance with standards set by the state's health department and shall be part of the overall strategy for the caregiver model. The operational guidelines under DLI 7 have special emphasis on care economy and certification of care giver, this will not only develop the professional and also address the regulation around the unorganized sector of care givers in the State.

xiii. Grievance redressal: The existing GRM system requires strengthening for uptake, access, responsiveness, tracking and periodic reporting and monitoring. An integrated GRM system, including SEA/SH will be developed - establish a focal point in state and districts, digitize processes, spread awareness on the existing systems, revise SoPs, streamline responsibility matrix, systemize IT reporting formats, monitor as a part of the project, review performance, and if needed establish a separate call centre for program activities that will allow the program beneficiaries to raise their concerns. The results framework will track GRM systems improvement, complaints received and resolved including ICC, SEA-SH.

xiv. Social Inclusion (Tribal districts/communities): Scheduled Tribes constitute 9 percent of Telangana's population, approximately 31.78 lakh people. Tribal regions continue to grapple

with multidimensional poverty and development deficits[48] including inadequate health infrastructure despite MMUs and new Sub Health Centers. The project will identify gaps in health services and outputs in tribal areas and propose recommendations to be adopted for improved outcomes during the tenure. This also requires factoring in the intra-tribe diversities and trajectories of accessing and availing health services.

D. E&S PROGRAM ACTION PLAN

22. From the recommendations made above, the following actions are being proposed for inclusion in the Program Action Plan towards addressing key/critical identified gaps between the Program systems and PforR core principles. The remaining recommendations will be addressed through inclusion in the Program Operations manual.

Action Description	Responsibility	Timing		Completion Measurement
Development of approach and strategy for improving and tracking services for the vulnerable	DoHFW	Continuous	Within 12 months of effectiveness	Year 1: Gap assessment including intra-group disparities and development of Targeted Inclusion Action Plan Year 2: implementation of Targeted Inclusion Action Plan Year 3 onwards: Report on improved access and outcomes amongst the vulnerable
System strengthening to improve last mile service delivery (by frontline health workers) in line with the epidemiological shift	DoHFW	Recurrent	Within 24 months of effectiveness	Year 1: Study for mapping current systems, targets, outputs, gaps and goo practices Year 2 onwards: Organize training, create last mile support systems to fill the identified gaps and upscale good practices
Improved bio-medical waste management contracts and practices with service providers as per standards in all levels of health facility	DoHMFW	Other	Within 36 months from effectiveness	Standard contract documents with details of service standards and pricing as per level of health facility issued; waste tracking through barcode; industry standards for service and regular quality training

48 Telangana Socio Economic Outlook, 2024, Government of Telengana

ANNEX 1: LIST OF REFERENCES

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ANNEX 2.1: CHECKLIST FOR INTERACTION WITH KEY IMPLEMENTING AGENCIES UNDER D oHMFW

General questions:

- Organogram, role and responsibilities
- Past or current experience of working on the similar on World Bank operations
- Any reports on E&S.

Social*49*:

I. Policy, designated staff, budget and reporting on social risk management
II. Number of staff (m/f)
III. Does the organization also hire consultants and specialists? Is there a formal contract on joining? Are the terms of reference and conditions of engagement (emoluments/ compensation, work-hours, benefits, leave, etc.) clearly defined in these contracts? (Please share a recent sample/ example).
IV. What compensation given to staff/consultant/contracted workers in case of incidents related to BMW
V. Kind of channels/ mediums are available for registering grievances within the institution for healthcare workers including staff, doctors, nurses, ASHA workers and others share their grievances?
VI. Existing public awareness generation campaigns
VII. Experience of engaging with citizens/ stakeholders particularly on behaviour change
VIII. Targeting and access for the vulnerable: any mapping and any reporting on the same
IX. Is there any system for conducting patient experience survey
X. GRM systems available for stakeholders (including statewide grievance redress mechanism that covers all departmental programs/ schemes (e.g. CM Helpline, State Public Grievance Redress Cell)?
XI. How is general awareness created about GRM presence and procedures to access them
XII. Describe and share the total number of grievances received and redressed in last six months (medium and channel wise)
XIII. Does the organization have an Internal Complaints Committee (ICC), in compliance with the Prevention of Sexual Harassment at Workplace (POSH) Act? Are employees aware about the committee, its functions and procedures? Please share the number of POSH related grievances received and redressed in the past 2 years.
XIV. Is the unit/department adequately staffed with qualified and experienced personnel to deal with GBV, SEA and SH risks and incidents?
XV. Social management for civil works: labor management and management of temporary adverse impacts on staff and patients.

Environment:

I. Policy/SOPs, designated staff, budget and reporting on environmental risk management
II. Environmental management framework being followed by TGMSCL in their procurement – civil works and equipment.
III. Are there any Standard Operating Procedure (SOP)/Framework for Universal access and Life & Fires Safety (L&FS) in medical facilities*50*? If yes, please share a copy

49 The social assessment will capture patterns of differentiated access resulting from inter-state variations based on geography (rural/urban), vulnerable groups (SC/ST/women) and any other socio-economic exclusionary barriers that prevent beneficiaries from accessing health care. The social assessment will also cover gender (including Gender Based Violence) and mechanisms of citizen engagement (including Grievance Redressal Mechanism), both of which are corporate requirements for the Bank. Issues related to any temporary adverse impacts due to civil works as well as labor management will also be assessed.

50 This includes, but is not limited to, (a) enhanced measures for trauma centers with high oxygen demand; (b) those serving people with mobility issues/elderly/vulnerable, ICU and neo-natal units, that may need special procedures/additional infrastructure to evacuate (or shelter in place) during emergency situations; and (c) coordination with relevant stakeholders including fire department and other first responders.

IV. Fire safety policy requirements in buildings and medical oxygen plants.
V. Policy on water and sanitation in HCFs.
VI. Water conservation measures in HCFs
VII. BMWM: annual budget allocation and utilization
VIII. BMWM: BMW storage facilities in HCFs
IX. How are BMWM aspects of NQAS relevant to current practices in state
X. Existence of BMWM committees
XI. Compliance of NGT orders
XII. BMWM training: Training material, who imparts training, training calendar, budget allocation

ANNEX 2.2: CHECKLIST FOR SITE VISITS AT HEALTH FACILITIES

Type of facility	Whom to meet	Checklist of questions (Social)
Ayushman Arogya Mandir (AAM)/Sub Centre	• Doctor • Administrator • Technicians • Nurses	• Number of doctors and nurses available in the centre? • Are there any women doctors? • Average number of patients who come for screening and treatment? Break up of men and women. • Eligibility of patients screened for cancer. • What are the most common issues/diseases that women come to the centre? • How many older patients do they get per week? • Do they have an outreach program? If no, how do they mobilise people to come for screening? • Have the nurses etc. received any special training to deal with older patients? • How many older adults are enrolled in the Sanjeevani groups? Is there a GRM system? Please explain • How does incidents of GBV and SEASH reported?
Primary Health Centre & Urban Primary Health Centre	• ASHA workers • Doctors • ANMs	• Number of doctors and nurses available in the centre? • Are there any women doctors? • Number of ASHA and ANM workers? • Number of midwives? Have they received any special training? • Do they go to the community for awareness raising? • Number of patients treated per day? • Adequate medicines available? • Does the PHC register for NCDs like hyper tension etc. • Eligibility of patients screened for cancer? • Have the ASHA workers and ANMs get any special training for screening of patients for cancer? • Do they conduct any outreach program to raise awareness for screening?
Community Health Centre (CHC)	• Doctors • Nurses • Members of NCD committees • Administrators /technicians	• Number of doctors and nurses available in the centre? • Are there any women doctors? • Number of nurses/midwives? • Adequate medicines available? • Are there NCD Committees? If yes, membership (M/F) • How are they selected? • Have they received any trainings especially to midwives for safe delivery?

		• Has the rate of safe deliveries improved? • What are their functions? • Role played by NCD committee members in enrolling patients for hypertension, screening for cancer etc. • Issues faced by them if any. • Is there a trauma registration system? • Have the ANM/SN and MO received training on geriatric care Is there a GRM system? Please explain • How does incidents of GBV and SEASH reported?
Area Hospitals	• Doctors • Nurses • Administrators	• Number of doctors and nurses/midwives available in the centre? • Are there any women doctors? • Number of nurses? • Adequate medicines available? • Who manages the NCD Committees and how? • Do they conduct any outreach program to raise awareness for screening? • Any special awareness program for elderly population? • Any special doctors for geriatric care and or counselling? Is there a GRM system? Please explain • How does incidents of GBV and SEASH reported?
District Hospitals	• Doctors • Nurses • Technicians • Administrators • Ward boys	• Number of doctors and nurses/midwives available in the centre? • Are there any women doctors? • Number of nurses? • Adequate medicines available? • Who manages the NCD Committees and how? • Do they conduct any outreach program to raise awareness for screening? • Any special awareness program for elderly population? • Any special doctors for geriatric care and or counselling? • Is there a GRM system? Please explain • How does incidents of GBV and SEASH reported?
Teaching Hospitals	• Doctors • Administrators	• Does the hospital have adequate number of doctors? • Are any special training done to deal with elderly people? • Number of students enrolled each year? • Separate hostel for boys and girls. • Is there a GRM system? • How does incidents of GBV and SEASH reported?
Primary	• Men	• What is the average waiting time for each patient?

stakeholders/Patients and Students	• Women • Older Adults (M/F)	• How were they made aware of the screening program? • If there are no women doctors does the women patients feel “safe” to go to a male doctor for screening for breast cancer etc. • Are there proper facilities like drinking water, toilets (M/F) in the waiting area? • Is there a channel by which a patient can raise a complain and or grievances? • How are complains dealt with? • How are harassment reported? • Overall satisfaction of the patients? • What is the out of pocket expenses? • Does the hospital have adequate teaching facility? • What are the average number of hours of duty for junior doctor/student • Is there a complain mechanism for students?

ANNEX 3: RATIONALE FOR SELECTION OF DISTRICTS FOR SITE VISITS

S. No	District	Population			Sex Ratio	% SC	% ST	Schedule area	Health Ranking	Final rationale for selection
		Total	R	U				(yes/no)		
1	Adilabad	708,972	541,226	167,746	989	14	32	Yes	4	High ST population. Scheduled area and forested areas.
2	Bhadradri Kothagudem	1,069,261	730,178	339,083	1008	13	37	Yes	2	
3	Hanumakonda	1,062,247	498,618	563,629	997	20	3		19	
4	Hyderabad	3,943,323	0	3,943,323	954	6	1		31	Fully urban district, heavy private sector penetration, very low health ranking.
5	Jagitial	988,913	767,577	221,336	1036	17	2		9	
6	Jangoan	534,991	463,634	71,357	997	21	12		15	
7	Jayashankar Bhupalapally	416,763	374,376	42,387	1004	22	9	Yes	27	
8	Jogulamba Gadwal	609,990	546,813	63,177	972	20	2	Yes	17	
9	Kamareddy	974,227	850,605	123,622	1033	16	8		13	
10	Karimnagar	1,005,711	696,727	308,984	993	19	1		16	
11	Khammam	1,401,639	1,084,811	316,828	1005	20	14		26	
12	Kumuram Bheem Asifabad	515,812	428,828	86,984	998	16	26	Yes	23	
13	Mahabubabad	774,549	698,173	76,376	996	13	38	Yes	20	
14	Mahabubnagar	905,660	639,209	266,451	988	14	11		8	Ranked as most vulnerable for climate change
15	Mancherial	807,037	453,190	353,847	977	25	7		12	
16	Medak	766,153	707,299	58,854	1027	17	10		3	
17	Medchal Malkajgiri	2,460,095	209,828	2,250,267	957	9	2		33	
18	Mulugu	294,671	283,178	11,493	1015	16	29	Yes	14	
19	Nagarkurnool	852,483	764,653	87,830	968	21	12		1	
20	Nalgonda	1,618,416	1,250,113	368,303	978	18	13		7	
21	Narayanpet	562,148	520,396	41,752	1008	16	5	Yes	6	

22	Nirmal	709,418	557,736	151,682	1046	15	11	Yes	30	
23	Nizamabad	1,571,022	1,106,272	464,750	1044	14	7		17	
24	Peddapalli	791,836	487,823	304,013	992	19	2		11	
25	Rajanna Sircilla	552,037	435,145	116,892	1014	18	4		28	
26	Ranga Reddy	2,426,243	1,026,113	1,400,130	950	14	6		32	Large vulnerable migrant population, Urban areas, very low health ranking
27	Sangareddy	1,527,301	997,336	529,965	965	18	6		24	
28	Siddipet	1,012,065	873,013	139,052	1008	19	2		21	
29	Suryapet	1,099,560	928,521	171,039	996	19	13		29	
30	Vikarabad	946,109	821,140	124,969	1000	19	10		20	
31	Wanaparthy	587,041	494,753	92,288	959	16	8		2	
32	Warangal	737,148	510,057	227,091	995	16	14		25	Most backward district as per NITI Ayog which includes both social and environmental vulnerabilities
33	Yadadri Bhuvanagiri	770,833	647,668	123,165	974	18	6		10	

ANNEX 4.1: RELEVANT NATIONAL AND STATE LAWS AND POLICIES APPLICABLE TO THE PROGRAM

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
1	**The Constitution of India (especially, Articles 15, 16 and 46)**	The Indian Constitution (Article 15) prohibits any discrimination based on religion, race, caste, sex, and place of birth. Article 16 refers to the equality of opportunity in matters of public employment. Article 46 directs the state to promote with special care the educational and economic interests of the weaker sections of the people, particularly of the Scheduled Castes and the Scheduled Tribes and also directs the state to protect them from social injustice and all forms of exploitation.	Relevant to the overall Project
2	**Workmen's Compensation Act, 1923 & Rules 1924**	The Act provides for compensation in case of injury by accident arising out of and during employment.	As some of the activities require repair and renovation of existing infrastructure of HCFs and hence will involve construction activities.
3	**Minimum Wages Act, 1948**	This Act provide for fixing minimum rates of wages in certain employments and requires the employer to provide to every worker engaged in a scheduled employment to be paid wages at a rate not less than the minimum rate of wages fixed by such notification for that class of employees in that employment without any deductions except as may be authorized within such time and subject to such conditions as may be prescribed.	The Minimum Wages Act is applicable, and the contractor is mandated to provide compliance as per the act.
4	**Payment of Wages Act 1936; and Equal Remuneration Act 1976:**	The payment of wages act lays down as to by what date the wages are to be paid, when it will be paid and what deductions can be made from the wages of the workers.	These Acts are applicable, and the contractor will be mandated to provide compliance as per agreed terms of payment of Wages.
5	**The Child and Adolescent Labour (Prohibition & Regulation) Act, 1986; and Notification of the Child Labour (Prohibition and Regulation)**	This act prohibits the engagement of children below 14 and 15 years in certain types of occupations and regulates the condition of work of children in other occupations. No child shall be employed or permitted to work in any of the occupations set forth in Part A of the schedule, processes set forth in Part B of the schedule which includes building and construction industry. The 2016 amendment also prohibits the employment of adolescents in the age group of 14 to 18 years in hazardous occupations and processes and regulates their	Applicable to hiring contract labour for construction activities

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
	Amendment Act, 2016 and Rules 2017	working conditions where they are not prohibited.	
6	**Prevention of Sexual Harassment at the Workplace Act, 2013**	The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act was passed in 2013. It defined sexual harassment, laid down the procedures for a complaint and inquiry and the action to be taken. It broadened the Vishaka guidelines, which were already in place.	Relevant to public health workers and contract workers in participating states under the EHSD Program
7	**Right to Information Act, 2005**	Provides a practical regime of right to information for citizens to secure access to information under the control of public authorities. The act (a) sets out obligations of public authorities with respect to provision of information; (b) requires designating a Public Information Officer; (c) sets out process for any citizen to obtain information/disposal of request, and so on; (d) provides for institutions such as Central Information Commission/State Information Commission.	Provides framework for disclosing information to the public
8	**Infection control**	IMEP is a policy framework which lays out detailed guidelines for infection control in subcenters, PHC, CHC.	Highly relevant and applicable in all health care facilities.
9	**Bio-medical Waste Management Rules, 2016**	Schedule 1: Categorization and Management Schedule 2: Standards for treatment and disposal of BMW Schedule 3: Prescribed Authority and duties Schedule 4: Label of containers and bags and transportation of BMW The provisions under the rules provide for both solid and liquid medical wastes. Liquid waste should be treated with 1% hypochlorite solution before discharge into sewers. Hospitals not connected to municipal waste-water treatment plants should install compact on-site sewage treatments (that is primary and secondary treatment, disinfection) to ensure that wastewater discharges meet applicable thresholds.	Highly relevant. • As per accreditation requirements, health care facilities need to develop Standard Operating Procedures (SOPs) in the handling of medical solid, liquid, and radioactive wastes. • On solid BMW, there is a good overall capacity and compliance. On liquid BMW, there are significant gaps in treatment and disposal of wastewater from hospitals. • The requirements in Ministry of Environment and Climate Change (MoEFCC) Notification - G.S.R.234 (E), dated March 28, 2016, are found to be equivalent to the World Bank Group EHS Guidelines for Healthcare Facilities as they cover good international industry practice such as labelling and symbols for hazardous materials and waste, waste reduction, segregation, storage, transportation (manifest), treatment and handling (with autoclave, incineration), health workers' OHS, and public health and safety. The effluent standards are

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
			also equivalent or better than the World Bank Group EHS Guidelines for Health Care Facilities (performance monitoring); for example, 100 mg/L (India) and 250 mg/L (World Bank Group Guidelines) for COD.
10	**Construction and Demolition Waste Management Rules, 2016**	Waste comprising building materials, debris, and rubble resulting from construction, remodelling, repair, and demolition of any civil structure	Relevant as there will be construction waste generated. CPCB guidelines on Environmental Management of Construction and Demolition Waste Management in India (2017) will be applicable.
11	**E-waste (Management and Handling) Rules 2011 as amendment up to 2018**	To address leakage of e-waste to informal sector at all the stages of channelization. The 2016 Amendment brought health care facilities (with turnover over INR 20 crores or more than 20 employees).	Relevant as it is applicable for consumers or bulk consumers. The disposal of e-wastes to be done at the specified collection centers and reported annually.
12	**Plastic Waste Management Rules 2016**	All institutional generators of plastic waste shall segregate and store the waste generated by them in accordance with the Solid Waste Management Rules and hand over segregated wastes to authorized waste processing or disposal facilities or deposition centers, either on its own or through the authorized waste collection agency.	Relevant as hospitals are generators of large quantity of plastics, including non-reusable types.
12	**E-waste (Management) Rules, 2016**	Shall apply to every manufacturer producer, consumer, bulk consumer, collection centers, dealers, e-retailer, refurbisher, dismantler, and recycler involved in manufacture, sale, transfer, purchase, collection, storage, and processing of e-waste or electrical and electronic equipment listed in Schedule I, including their components, consumables, parts, and spares which make the product operational but shall not apply to (a) used lead acid batteries as covered under the Batteries (Management and Handling) Rules, 2001 made under the Act; (b) micro enterprises as defined in the Micro, Small and Medium Enterprises Development Act, 2006 (27 of 2006); and (c) radioactive wastes as covered under the provisions of the Atomic Energy Act, 1962 (33 of 1962) and rules made thereunder.	• Relevant as it is applicable for consumers or bulk consumer. The disposal of E-wastes to be done at the specified collection centers and reported annually. • All programs, where e-waste is generated including electrical/electronic equipment • As per rules, the manufacturer has to collect back e-waste and channelize for collection/disposal; producer (seller of the assembled product under own brand) shall arrange end-of-life disposal under extended producers responsibility and create awareness on this; collection centers established by producer/dealer (lighting agencies/dealers) can also collect e-waste on behalf of dismantler, refurbisher, and recycler including those arising from orphaned products.
13	**Water (Prevention and Control of Pollution) Act**	Provisions are largely to prevent air and water pollution by not releasing untreated effluents and harmful emissions. Most provisions	• Relevant and largely complied with; gaps exist in disposal of liquid wastes from health care facilities.

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
	1974 **Air (Prevention and Control of Pollution) Act 1981** **Environment Protection Act (and Rules), 1986 and 1996**	are already discussed under the Bio-Medical Waste Rules.	
14	**Solid Waste Management Rules, 2016**	Apply to every municipal authority responsible for the collection, segregation, storage, transportation, processing, and disposal of municipal solid wastes.	• Relevant. Majority of wastes generated from health care facilities, laboratories, and PoE health organizations is general solid waste, for example, paper, packaging, dry leaves, food wastes and needs to be collected, stored, handled, and treated separately from hazardous wastes. • Storage, transport, handling, recycling/reuse, disposal of solid wastes including packaging materials under all Program activities.
15	**Building and Construction Workers Act, 1996**	An act to regulate the employment and conditions of service of building and other construction workers and to provide for their safety, health, and welfare measures and for other matters connected therewith or incidents.	• Relevant to public health workers, contracted workers employed by PWD for refurbishment of HCFs and frontline workers
16	**Insecticides Act 1968**	This act governs the use of registered insecticides and non-use of banned insecticides. It is relevant to all health facilities and hostels that undertake pest control operations	• Applicable to maintenance and cleaning of new toilet/water, sanitation, and hygiene (WASH) structures and also for vector control • Exclusion of banned insecticides • Safe storage of insecticides, spill management, and safe usage
17	**National Building Code 2016 and Relevant Standards of the Bureau of Indian Standards (BIS)**	The code provides regulations for building construction by departments and public bodies. It lays down a set of minimum provisions to protect the safety of the public about structural sufficiency, fire hazards, and health aspects. The code mainly contains administrative regulations, development control rules, and general building requirements; fire safety requirements; stipulations regarding materials, structural design, and construction (including safety); building and plumbing services; signs and outdoor display structures; guidelines for sustainability, asset and facility	• Relevant for any building being constructed or upgraded, maintaining safe work, construction typology standards, and guidance, mitigation/management measures, training, monitoring • Life and fire safety • Structural safety

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
		management, and so on.	
18	**Construction Standards and Disaster Related**	• Disaster Management Act, 2005 National Policy on Disaster Management 2009 • National Disaster Management Guidelines - Hospital Safety 2016	• Codes for construction in disaster-prone areas • National policy (2009) focuses on prevention, mitigation, preparedness, and response • Universal access • Electrical safety • Structural safety • Fire safety • Emergency response plans • It describes the institutional and financial arrangements, capacity development, knowledge management and so on
19	**The Hazardous and Other Waste Management Rules, 2016**	The Hazardous and Other Waste Management Rules, 2016 provide for generation, collection, treatment, transport, import, storage, and disposal of hazardous wastes. Improper storage, handling, transportation, treatment, and disposal of hazardous waste result in adverse impact on ecosystems including the human environment.	Relevant to all health programs
20	**The Occupational Safety, Health and Working Conditions Code, 2020**	This code on occupational safety, health, and working conditions applies to all establishments with 10 or more workers and includes building and construction workers. It is applicable to all infrastructure works supported under the Program. The Occupational Safety, Health, and Working Conditions Code ('Code') is enacted to consolidate and amend the laws regulating the occupational safety, health, and working conditions of the persons employed in an establishment and for the connected and incidental matters. The code also lists benefits to the interstate migrant workman such as the benefits of the insurance and provident fund benefits either in the native state or the state of employment, portability of benefits of the interstate migrant worker for building or other construction work out of the building and other construction cess fund in the destination state where such interstate migrant worker is employed. It also mandates free health checkups for workers age 45 for prescribed industries such as factories, mines, plantations, and those employed in hazardous process.	Relevant for all workers and construction activities
21	**The Epidemic Diseases**	The Epidemic Diseases Act 1897 provides for better prevention of the	To ensure safety of communities, workers, and project staff

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
	Act 1897 **The Epidemic Diseases (Amendment) Ordinance, 2020**	spread of dangerous diseases. The Epidemic Diseases (Amendment) Ordinance, 2020 was promulgated on April 22, 2020. The Ordinance amends the Epidemic Diseases Act, 1897. The act provides for the prevention of the spread of dangerous epidemic diseases. The ordinance amends the act to include protections for health care personnel combating epidemic diseases and expands the powers of the Central Government to prevent the spread of such diseases.	especially during this period of COVID-19 pandemic. The ordinance includes provisions for protection of health and safety of health workers from the acts of violence and aggression during management of COVID-19 response in the health facilities and communities.
22	**Pre-Conception & Pre-Natal Diagnostic Techniques Act, 1994**	The Act provides for prohibition of sex selection, before or after conception, and for regulation of pre-natal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders and importantly for prevention of their misuse for sex determination leading to female foeticide.	The Act is relevant to ensure its strict compliance and monitoring, while providing reproductive health related services under the program in the state.
STATE			
Sl. No.	**Applicable act/ regulation/ policy**	**Objective and provisions**	**Relevance to the Program and Key Findings**
1	**Telangana State Scheduled Castes and Scheduled Tribes Special Development Fund (Planning, Allocation and Utilization of Financial Resources) Act, 2017.**	For the accelerated development of SCs and STs in the state, with an emphasis on achieving equality focusing on economic, educational and human development alongwith ensuring their security and social empowerment and promoting equity among SCs and the STs, through allocation of development funds in proportion to the SC/ ST population of the state to bridge the 'gaps in development'.	The Act provides for an assessment of the human development gaps between the SC/ST population and other social groups, to provide targeted budgetary support as development funds to ensure equitable growth, including for improvement of health services in habitations with SC/ ST population.
2	**Telangana Panchayati Raj Act, 2018**	The Act provides for the constitution of Gram Panchayats, Mandal Praja Parishads and Zilla Praja Parishads across the state as part of the three- tier panchayati raj system in accordance with the 73rd constitutional amendment. As per the Act, subjects related to management of sanitation, public awareness about family welfare, public health-hygiene, abolition of child and bonded labor, identification of vulnerable households and monitoring the	Raising awareness about health issues, monitoring the implementation of public health and family-welfare oriented government schemes falls within the purview of the rural local bodies, including taking '*preventive and remedial measures connected with any epidemics or communicable diseases*'. Preparation of cross-sectoral perspective and annual village development plans covering health issues is also the duty of the

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
		implementation of development schemes in their jurisdiction will fall within the purview of the local Gram Panchayats.	Gram Panchayats.
3	**Telangana Heritage (Protection, Preservation, Conservation and Maintenance) Act, 2017**	The Act provides for the conservation, preservation, restoration and maintenance of tangible and intangible heritage of Telangana. Any excavations at sites, other than the ones already protected, shall be carried out under the supervision of the department in the prescribed manner and shall be the custodian for recording, publishing, storage and exhibition of such antiquities and finds.	Any chance finds during civil works under the project will be handled according to the Ancient Monuments and Archaeological Sites and Remains Act, 1958 and this state Act.
4	**Telangana Labour Welfare Fund Act, 1987**	For the establishment of a Labour welfare fund and constitution of a Labour Welfare Board in the State to promote welfare of workers and their families. The fund is to be used for setting up welfare centres, community necessities, home industries and subsidiary occupations for women and unemployed persons, vocational training of workers, medical aid.	Relevant for the public health professionals and construction workers engaged by the project and those requiring medical aid owing to occupational accidents/ incidents.
5	**State Policy on Patient's rights and responsibilities, December 2017**	The policy is designed to inform patients receiving health care services from TVVP employees of their rights and responsibilities. These include providing patients and their family information about the services displaying user-friendly signages, display of patient's rights and model citizen charter, communication in an understandable format and language, information about about safe and effective use of medicines, their potential side effects, diet and nutrition requirements as well as access to clinical records. Service providers are required to treat patients and family members with respect and dignity, ensure the privacy and confidentiality of patients and their health records, involve them in decision-making, inform them about the treatment costs and ensure informed consent.	This is relevant since the project aims at overcoming behavioral barriers that limit health-seeking, preventive care and focuses on improving governance and oversight of public health care systems.
6	**State Policy on Quality at the Telangana Vaidya Vidh ana Parishad Hospitals, Dec 2017**	The policy is to ensure quality improvement at TVVP Hospitals to ensure best possible care for patients, through structured quality assurance and continuous monitoring by District Quality Assurance Committee. It aims at healthcare services using best scientific and ethical standards, continuous upgrades to quality of medical practice and development of develop simple and innovative technologies for prevention, diagnosis and treatment of diseases. The policy defines service standards, SoPs and management controls and metrics to	This is relevant since the project aims at improved governance, oversight and public accountability for the health care systems in the state.

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
		assess process and outcome of services provided.	
7	**State Policy on Grievance Redressal Mechanism for health staff, Dec 2017**	Purpose of this policy is to provide procedures to encourage free communication between employees and their management and satisfactorily redress individual or collective grievances arising during the course of their employment. It outlines a 3-stage process through which grievances of TVVP employees are to be handled.	This is relevant as strengthened health care services are likely to increase workload of all, including secondary and tertiary service-providers, potentially leading to increased grievances regarding service conditions.
8	**Telangana State Rights of Persons with Disabilities Rules, 2018**	The rules create state and district level institutional mechanism to plan for rehabilitation and empowerment of persons with disabilities, assist implementation of schemes for their empowerment, monitor implementation and redress complaints related to their discrimination and non-compliance with the Policy.	Relevant for patients and public health workers with disabilities.
9	**Telangana Nurses, Midwives, Auxiliary Nurse Midwives and Health Visitors Act, 1926.**	The Act aims at governing the employment and service conditions of frontline health-care providers through the creation of a State Council- by regulating and supervising the practice of their profession by the Nurses, Midwives, Auxiliary Nurse Midwives and addressing their grievances.	Relevant for ensuring appropriate working conditions and welfare of the frontline workers in the state.

ANNEX 4.2: NATIONAL GUIDELINES RELEVANT TO THE PROGRAM

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
1	PM-ABHIM Operational Guidelines	PM-ABHIM operational guidelines cover the guiding principles, implementation mechanisms, planning, appraisal, and approval process of HCWs and BPHUs under the Program.	Relevant. The guidelines provide information on eligible expenditure, guiding policies (such as BMWM Rules, 2016). and factors to be considered while planning.
2	XV-FC Technical and Operational Guidelines	The technical and operational guidelines are intended for state and district Program managers, and the representatives of state and district rural and urban local bodies to plan new infrastructure under PM-ABHIM.	PM-ABHIM health centers follow the guidelines of the XV-FC. This provides the layout of the health care centers and the needed infrastructure for maintaining environment health, safety, and cleanliness.
3	NQAS Operational Guidelines For Improving Quality In Public Health Facilities	To strengthen and improve quality of care and provide recognized/accepted standards, measurement system, and quality improvement interventions in congruence with universal quality and safety goals	Relevant - sets standards for infection control
4	*Swachhata* Guidelines	These guidelines have been developed for states to use in maintaining cleanliness in their health facilities. Quality in public health facilities encompasses much more than hygiene and cleanliness.	Relevant to all health care facilities under PM-ABHIM
5	*Kayakalp* Award Scheme	Aim of the initiative is to improve and promote the cleanliness, hygiene, waste management and infection control practices in public health care facilities and incentivize the exemplary performing facilities. The scheme is intended to encourage and incentivize public health facilities in the country to demonstrate their commitment for cleanliness, hygiene, and infection control practices. Initiated from district hospitals in 2015, the scheme expanded to the PHC level (2016) and then covered all urban health facilities by 2017.	• To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, sanitation, and infection control. • To incentivize and recognize public health care facilities that show exemplary performance in adhering to standard protocols of cleanliness, infection control, and sanitation. • To create and share sustainable practices related to improving cleanliness in public

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
			health facilities which lead to positive health outcomes.
6	Swachh Bharat Mission	Swachh Bharat Mission, Swachh Bharat Abhiyan, or Clean India Mission is a country-wide campaign initiated by the GoI in 2014 to eliminate open defecation and improve solid waste management	Relevant to the Program - preventing inappropriate SWM disposal and encouraging good sanitation and hygiene practices.
7	National Disaster Management Authority Hospital Safety Guidelines	The guidelines on hospital safety have been developed to ensure health care centers are structurally and functionally safer from disasters, such that the risks to human life and infrastructure are minimized.	Relevant • To ensure structural safety of hospitals (especially of critical facilities) • To ensure that all professionals involved in the day-to-day operation of hospitals are prepared to respond to disasters • To ensure that every hospital in the country has a fully functional and regularly tested Hospital Disaster Management Plan
8	Indian Public Health Standards for Primary Health Care Facilities	Indian Public Health Standards for subcenters, PHCs, CHCs have been used as the reference point for public health care infrastructure planning and upgrade in the states and union territories.	Relevant - provides the standards and guidelines for critical EHS parameters such as firefighting, storage of insecticides, BMWM, and infection control at the primary health care facility level (refer annex 3)
9	Pradhan Mantri Janjati Unnat Gram Abhiyan (PMJUGA)	A comprehensive development scheme of the Government of India aimed at improving the socio-economic lives of over 5 crore tribal people living in tribal-dominated villages and aspirational districts. Under this scheme, better infrastructure, economic opportunities, and services like education, health will be provided in more than 63,000 villages. This campaign is based on the success of Pradhan Mantri Janjati Adivasi Nyay Maha Abhiyan (PM-Janman) which aimed at improving the socio-economic condition of Particularly Vulnerable Tribal Groups (PVTGs).	Relevant – the scheme provides for deployment of Mobile Medical Units (MMUs) in remote tribal villages; establishing specialized sickle cell treatment units and Centers; strengthening healthcare infrastructure in tribal regions to improve access and services; promoting early childhood education and improving nutrition, along with establishing nutrition gardens to

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
			provide access to fresh vegetables and medicinal plants in tribal areas.
10	Aadi Karmayogi Abhiyan	A nationwide initiative by the Ministry of Tribal Affairs (MoTA), Government of India, focused on empowering tribal communities through responsive governance and grassroots leadership. It aims to build a cadre of 20 lakh "Aadi Karmayogis" (change leaders) who will ensure the last-mile delivery and saturation of government schemes in over one lakh tribal-dominated villages across 30 States/UTs.	Key aspects related to healthcare include: (a) Train existing health workers, social activists, and government officers to effectively implement schemes at the local level; (b) ensuring the issuance of Ayushman Bharat health cards to eligible tribal citizens; (c) incorporates large-scale screening for diseases prevalent in tribal areas, such as Sickle Cell Disease; (d) supports establishment and functionality of local health centers, like Ayushman Arogya Kendras, to provide basic medical needs within the villages.

ANNEX 4.3: RELEVANT STATE SCHEMES APPLICABLE TO THE PROGRAM

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
State Government Schemes			
1	Aarogyasri Health Insurance Scheme	Aarogyasri is a comprehensive health insurance scheme primarily aimed at Below Poverty Line (BPL) families. It covers major surgeries and treatments through cashless services in empanelled private and public hospitals. This scheme has significantly reduced catastrophic health expenditures for low-income families and has enhanced access to tertiary care. Telangana expanded coverage through the **Aarogyasri Health Card**, especially for serious illnesses like cancer, cardiac surgeries, and renal diseases.	Comprehensive health insurance scheme primarily for Below Poverty Line (BPL) families, mainly belonging to SC and ST categories.
2	MCH Kit Scheme	The MCH **Kit** scheme is a flagship maternal and child health initiative aimed at reducing maternal and infant mortality and promoting institutional deliveries. It provides **financial incentives** (up to ₹13,000 for female children and ₹12,000 for male children) to pregnant women for delivering in government institutions and receiving antenatal/postnatal care. In addition, a kit worth ₹2,000 containing essential items (clothes, soap, baby oil, mosquito net, etc.) is given to newborns. The scheme also includes transport support and nutrition counseling.	Reducing maternal mortality by promoting institutional delivery. The kit consists os essential mother and childcare items, along with financial assistance, to pregnant women who deliver in government hospitals.
3	Arogya Lakshmi	This scheme provides **one full nutritious meal per day** to pregnant and lactating women through Anganwadi centres. It covers over 2.5 lakh beneficiaries and includes eggs, milk, rice, dal, and vegetables, significantly contributing to improved **maternal nutrition** and reducing anaemia. Implemented in convergence with the Women and Child Welfare Department, it supports better pregnancy outcomes, especially in rural and tribal districts.	Providing nutrition to pregnant and lactating women especially in rural and tribal areas.
4	Telengana Diagnostics	To address inequities in access to diagnostic services, the **Telangana Diagnostics** initiative offers **free diagnostic tests** at government health facilities. State-run laboratories are being equipped with advanced tools for blood tests, imaging, and pathology services. The scheme supports early diagnosis, treatment compliance, and reduces out-of-pocket expenses	Addressing inequalities and the availability of diagnostic services, especially in remote areas
5	Kanti Velegu	Kanti Velugu is a **mass eye screening program** aiming for “Avoidable Blindness-	Promoting eye check-ups and

Sl. No.	Applicable act/ regulation/ policy	Objective and provisions	Relevance to the Program and Key Findings
		Free Telangana." The initiative covers all citizens and includes free vision screening, spectacles distribution, and surgeries for those with cataracts or other visual impairments. As of 2023, millions have been screened, particularly in rural and backward areas, significantly improving access to ophthalmic care.	screening for blindness, particularly in rural and backward areas.
6	Basti Dawakhana	Inspired by the Mohalla Clinics model, **Basti Dawakhanas** have been established in urban slums and densely populated areas of Hyderabad and other cities. These provide **free outpatient consultations, basic diagnostics, and medicines**. The model reduces the burden on tertiary hospitals and improves access to primary care for the urban poor.	Extending health care services closer to homes in urban areas and, in the process, reducing the burden on tertiary care hospitals.
7	Nutrition Kit for Anaemic Women	Telangana has piloted a scheme to distribute **special nutrition kits** to anaemic women, particularly adolescent girls and pregnant women in vulnerable districts. The kit includes iron-rich foods, folic acid supplements, and health education materials.	Addressing malnutrition, particularly among adolescent girls and pregnant women.
8	Tribal Health and Mobile Medical Units	In tribal and hard-to-reach areas, the state has deployed **Mobile Medical Units (MMUs)** and community health outreach under the Integrated Tribal Development Agency (ITDA). These provide regular health check-ups, immunization, maternal care, and health awareness.	Extending health services in hard-to-reach areas, particularly in tribal districts.
9	Giri Poshana	A Telangana government initiative in India that provides supplementary nutrition to tribal children and women. It aims to improve the health and nutritional status of tribal communities by supplying fortified food products made from local crops like millets and pulses to beneficiaries through Anganwadi centers. The target population includes children between the ages of 3 and 6, and tribal women who are pregnant or lactating, to address malnutrition and improve health parameters like stunting, wasting, and anemia in tribal communities. It also promotes the use of climate-resilient crops and supports local farming by creating a demand for their produce.	This includes food is distributed through Anganwadi centers in ITDA areas and focusing on aspirational districts. It provides nutritionally balanced, ready-to-cook and ready-to-eat products formulated from local crops, including millets, pulses, and groundnuts.

ANNEX 4.4: HEALTH SCHEMES IMPLEMENTED IN COORDINATION WITH OTHER DEPARTMENTS

S.NO	Department Name	Mandate	Scope & work	Name of the Health schemes / Activities	Population coverage
1	Department of Social Welfare	Women's Empowerment and Child Protection	Services availble under Child Protection & Women Empowerment Child Protection Women Empowerment • 35 Children Homes • 181-Women Helpline • 17 Sishugruhas • 36 Sakhi One Stop Centres (OSC) • 33 District Child Protection Units • 13 State-run Women Institutions • 33 Child Helpline units • 18 Swadhar Grehs • 01 Child Helpline WCD Control Room • 2 Ujjwala Homes • 33 Child Welfare Committees • SHEW (State Hub for Empowerment of Women) • 33 Juvenile Justice Boards • 07 Juvenile Homes • 01 State Child Protection Unit • 01 State Adoption Resource Agency	The department's extensive outreach covers 149 ICDS Projects and 35,700 Anganwadi Centres, benefi ting around 4 lakh pregnant and lactating women and 14 lakh children under six years annually.	3,32,678 pregnant and lactating women, 10,04,408 children aged 7 months to 3 years, 4,69,654 children aged 3 to 6 years, and 8,947 malnourished children across the state.
2	Department for Empowerment of Persons with Disabilities, Senior Citizens and Transgender Persons	Persons with Disabilities	All persons with disabilities under the National Trust Act with valid disability certificate having UDID Card or UDID enrolment .number(with pwd certificate) will be eligible and included. Treatment can be taken from any hospital.	The ADIP (Assistance to Disabled Persons for Purchase/Fitting of Aids/Appliances) scheme aims to provide aids and appliances to persons with disabilities. Eligibility criteria include Indian citizenship, a 40% disability certificate, and a monthly income (including dependents) not exceeding Rs. 20,000. Recipients should not have received similar assistance within the past three years, with a one-year limit for children under 12.	

S.NO	Department Name	Mandate	Scope & work	Name of the Health schemes / Activities	Population coverage
		Transgender Persons		transgender clinics will be set up in all district hospitals in collaboration with the Telangana AIDS Control Society. A helpline (155326) will offer support on transgender-related schemes and services.	
3	Women Development & Child Welfare	Health and nutrition of women and children	Primarily focuses on improving the health and nutrition of women and children, especially among vulnerable and marginalized groups, while additionally promoting the empowerment, protection, and overall well-being of women and children. Mission Saksham Anganwadi and Poshan 2.0 deliver comprehensive Anganwadi services, including supplementary nutrition, ECCE, health education, immunization, and referrals. POSHAN Abhiyaan addresses malnutrition by creating a convergent ecosystem that promotes nutrition, health, and community participation. The Scheme for Adolescent Girls targets malnutrition among girls aged 14–18 through nutritional support, IFA supplementation, health check-ups, education, and skill development. Mission Shakti focuses on women's safety, security, and empowerment throughout their lifecycle, offering targeted support for marginalized and vulnerable groups. Mission Vatsalya aims to protect children in	• Anganwadi Services • Arogya Lakshmi / Supplementary Nutrition Program • Supervised supplementary feeding program (SSFP/ CMAM) • Early Childhood Care and Education • Poshan Bhi Padai Bhi • POSHAN Abhiyaan • Integrated Child Development Services (ICDS) • Scheme for Adolescent Girls (SAG) • Mission Vatsalya - Provides education, healthcare through Child Care Institutions (CCIs). • Beti Bachao Beti Padhao (BBBP)	30 lakhs coverage (Pregnant and lactating mothers, children 0-6 years and adolescent girls (14-18 years)

S.NO	Department Name	Mandate	Scope & work	Name of the Health schemes / Activities	Population coverage
			need of care, aligning with SDGs and emphasizing family-based and inclusive childcare under the principle of "leave no child behind."		
4	Department of Road Transport	Emergency Health Care	To provide transit healthcare and treatment on a 24*7 basis to patients/ emergency patients, with the goal of successfully treating the trauma/ injury or arranging for timely transportation of the patient to the next point of definitive care at the nearest and appropriate identified Public and Private healthcare facility.	108 Emergency Medical Ambulance Services (EMAS)	1 Ambulance for 1 Lakh Population
5	Department of Rural Development and Panchayati Raj	15th Finance Commission health grants	Health grants may be utilised for Health facility construction works, trainings salaries of 1089 MLHPs. conduct Health camps ay sub centres and PHcs.	Improved access Ayushman Arogya Mandir (erstwhile Health and Wellness centre), with health service access closer to community.	2.2 cr rural population
6	Municipal Administration and Urban Development	Mahila Arogya Samithi's & XVFC	Formation of Mahila Arogya Samithis Under the Urban Health Facilities existed in the Telangana state (UPHCs) involving them in the National Health programmes and ASHA will be the menber secretary in the each MAS group, aalong with the Health activities also involve in the Water and Sanitation programmes. urban health facilities construction.	National Urban Health Mission with implementing partner is Mission for Elimination of Poverty in Municipal Areas	1180474

S.NO	Department Name	Mandate	Scope & work	Name of the Health schemes / Activities	Population coverage
8	vii. Department of Tribal Welfare		quality outreach services in interiors to render maternal and child health services and epidemic control. to cater to the pregnanat women in hard to reach villages, BWH is there with in the Healthcare facility premises.specialists from plain area deputed to Tribal areas to provide specialty care.to improving the socio-economic conditions of Particularly Vulnerable Tribal Groups (PVTG) and increased access to Health care especially in areas where there is no health facility within 5 km radius.ST population access to Health Care in areas where there is no health facility within 10 km radius	MCH Epidemic Teams,Birth Waiting Rooms, Specialist Health Camps, PM Janman, DA JGUA	2904471

ANNEX 5: NUMBER OF HEALTH CENTRES IN TELANGANA

ANNEX 6: SITE VISITS AND CONSULTATIONS

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
1.	08 April	DoHMFW, Hyderabad	15 (State PCB, Operators CBMWTFs)	To understand the operational modalities of healthcare waste management in the state. Details on the MoUs with Operators, rate contracts, BMWM processing, bar coding of waste, etc. were discussed.
2.	9 April	DoPH&FW, Hyderabad	8 (Director, Joint Director, Consultants)	The role of WB can be critical in helping identify good practises and gaps so the performance can be improved in the purview of existing system. Introducing WB, PforR and ESSA, understanding the institutional mechanism, visions and challenges of the Dept., balancing care for the communities as well as the care workers.
3.	9 April	TVVP, Hyderabad	4 (Commissioner)	Out of 183 secondary care hospitals, 156 are functional while the remaining are under development. Additional 75 hospitals under trauma care are under construction. Capacity of hospitals varies between 30, 50 and 100 beds, with all being Kayakalp and NQAS certified. There is a need for timely provisioning of positions to fill the HR gaps in all hospitals.
4.	9 April	Directorate of Medical Education, Hyderabad	6 (Director, Administration)	There are 34 Medical colleges (1 in pipeline), 28 Private colleges, 64 teaching institutions, 47 government hospitals. Each medical college is associated with a hospital except for Osmania Medical College which is associated with 9 hospitals. Further, there are 34 nursing colleges, each one associated with medical college. There are Scholarships and access to financial support for students. Discussion on HR, healthcare waste management, Rule of Reservation, Academic curriculum (district residency program, family adoption program), school and college of Nursing, AALANA centre, Grievance Cell, Anti-ragging Committee, Compliance Report. Integrated health facility management system (IHFMS) in place. No BMWM Cell, but BMWM committed at hospital level. BMWM largely governed by Commissionerate. Outsourced manpower for sanitation, security, patient care and pest management @ 45 staff/100 bed.
5.	9 April	Teaching Hospital, Sarojini Devi Eye Hospital, Hyderabad	10 (Faculty, Administration team)	A of 500 which includes Doctors, Technicians, Teachers, Students, other workers. As a tertiary reference centre, there are 7 operation theatres, 50-70 surgeries every day, awareness camps and Press media coverage on festivals, observation of national and international days, school camps. There is an active Internal Complaints Committee. Need for equipment (simulators) in skill labs. IC committee functional. BMW storage unit exists and waste collected every 48 hours by Operator @ INR 10.5/bed/day. No bar coding used. Not regularly purchasing bags. No ETP with pretreated effluent flowing into municipal drains.
6.	10 April	Ameerpet UCHC, Rangareddy	10 (Medical Superintendent,	50 bedded hospital with request to be upgraded to 100 beds. Average daily footfall in OPD is 500 patients and monthly IPD admissions are 500-600. Staff strength is 50 regular and 60 contractual – all immunized. Has functional BMWM and IC committees. BMW collected every 48 hours. Record

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
			Nurses)	maintained in register as well as bar coded and later reported to district officer. Contract with Operator made at district level. Payment made by hospital to DMoHS @ INR 9408/month. BMW bags to be procured from Operator but constraints of funds. Monthly trainings on BMWM by BMWM and IC committees. Both digital and mercury-based equipment in use. SOP for mercury spills followed. GRM in place. In house composting of solid waste.
7.	10 April	Vanasthapali Area Hospital (SDH), Rangareddy	10 (Medical Superintendent, faculty, Nurses)	100 bed strength, servicing 5-6 lakh population, NQAS certified. Has 16 departments including dialysis. OPD footfall is 800-1000 per day and 300 monthly deliveries. Staff strength – 40 regular, 180 contractual - >50% female. BMWM and IC committees functional. Digital and mercury-based equipment in use. No spills but SOP in place. No cancer treatment; only screening. Bore well water supply with recent sanction of piped water supply. Tanks cleaned quarterly. No disinfection. Household RO units in use. Water test samples sent to local lab. BMW collected every 24 hours by Roma Industries. No digital records, only manual of BMW collected. Collection rate INE 195/bed/month +12% GST, decided by Commissionerate, payment to Operator by TVVP. Bags provided by Operator at no extra charge. BMWM trainings by BMWM and IC committees, none by Operator. Solid waste collected by Greater Hyderabad MC. Effluent pretreated with 1% sodium hypochlorite and released to open drain after 30 min retention. GRM in place through use of complaint boxes – 3-4 boxes on every floor.
8.	10 April	Urban PHC, Tilaknagar Hyderabad	10 (MO, Nurses, Patients)	Caters to 56000 people, about 100 OPD patients/day and 70 in Aarogya Mahila; have a staff of 32 out of which 28 are contracted including 5 ANM and 20 ASHAs. BMW collected every 48 hours by Roma Industries @ INE 5000/month; paid by Commissionerate. No bar coding. Previous Operator, Sattva, was using bar coding. General practice is that Operator collects only yellow and red category waste. Sharps disposed into sharp pits within hospital premises. GHMC collecting solid waste on daily basis. Grievance registers are maintained. Accessibility for PwD.
9.	10/4/25	DoPH&FW, Hyderabad	Paul Sunderaj, TGMSIDC	Handle procurement of equipment, products and civil works. 11 divisions and 2 circles, E&S is integrated in procurement documents, no sub-contracting allowed- checks and balances during bill clearance. E-upkaran is the unified portal for all procurement.
10.	11 April	DoPH&FW, Hyderabad	Communication Team	Mass Education Media is the hub for all communication located in the Commissionerate Office – it includes Deputy Director, Senior Administration, IEC consultant. Chief Information Officer maintains the content on website and twitter. Communication is based on events and specific health days- it's not contiguous or data driven and uptake of it is not reviewed.
11.	11 April	TGMSIDC, Hyderabad	5 (officials of TGMSIDC)	Discussed institutional setup, procurement of equipment, civil works, provisions of life & safety, universal access, ETP/STP, BMW storage unit, and water supply in hospitals. Condemnation policy of

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
				mercury-based equipment and radio diagnostic equipment's OHS was also discussed.
12.	28 May	Rudraram Sub Centre, District Mahabubnagar under Nawabpet PHC	Community Health Officer, ASHA, ANM, JAS members and beneficiaries (Also accompanied by District Staff like District Poject manager, District Quality Manager and DMHO/ADMHO)	The centre serves population of over 4000; witnesses about 50-60 cases per day. It also has basic first aid to treat victims of domestic abuse but there is a reluctance from the patient to report to the police. The centre has adequate stock of emergency medicine but there is a problem things like containers/plastics to dispose medical waste etc. ASHA visits every house in the three villages once or twice a month to screen for pregnancy through urine test. The centre has adequate stock of emergency medicine. • No color coded waste bins for BMW are followed. BMW bags purchased from own money, no budgetary provisions. No bags are purchased from CBWTF, the BMW is collected and transported once a week to PHC without weighing and no record is maintained. • Hub-cutter available and in use for cutting needle tips. • IPC & HCW training was received once six months ago through Zoom from District Office, the details of which are not available. Staff has not received IPC, BMW training-no knowledge of Hypo solution preparation • IEC posters including 5S are present at the facility areas. • The facility does not use Mercury based devices. The BP apparatus, thermometers and thermal scanner are digital. The tube lights are LED only. • The ABC type Fire extinguisher in the facility is empty, no fire escape plan and training is there. • Drinking water is purchased on regular basis from external vendor. Piped public water supply there, filled to overhead tank and used for washing purposes. Septic tank is there. No power backup for electric supply is in place. However, the electric cuts are few and for 10 to 15 minutes only.
13.	28 May	CHC, Koilakonda, District Mahabubnagar	Medical Officers, Staff nurse, Lab technician, Pharmacist, Support Staff, JAS members and beneficiaries	The facility is newly constructed has a large infrastructure with provision of about 60 beds. It also has an OT. On a regular day, the centre is visited by more than 100 patients but adequate staff is required to make MHN service efficient. During the visit the centre was managed by one doctor who was an anaesthetist. • No system of color-coding of waste bins for BMW is followed as color coded bags are not available from CBWTF due to costs involved. BMW is collected in cartons, sent 2 to 3 times a week to CBWTF without weighing and information of type of BMW waste. • Functionaries require training on IPC and BMW. • The facility carries out 15 to 20 deliveries per month. Monitoring is required to ensure the placenta is collected by CBWTF on the day of delivery or as appropriate.

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
				• Drug store follows FIFO procedure, indents medicines every three months, the expired drugs are very rare, and sent back to CDS. The cold chain temperatures were found to be maintained. • In pathology laboratory, the white box for collection of needles was used, however mixing of swabs and general was observed. • The laboratory handles approximately 150 malaria slides per month. However, no arrangement of disinfection of liquid waste from lab is there, the waste is directly let into external drain. • In the casualty room, the oxygen cylinder is present with case and trolley. However, the Oxygen concentrator is not functioning. • Septic tank is present for sewage treatment. • Adequate power back up should be made available as night time power cuts occur frequently lasting 3 to 4 hours.
14.	28 May	AH, Janampet, District Mahabubnagar	Medical officer, Nurse/ANM, ASHA, Lab technician, Pharmacist, Support Staff, JAS members and beneficiaries	Serves 40,000 population. OPD functions are from 9 AM to 4 PM but it has a 24/7 Emergency and Trauma. This Area Hospital has been recently upgraded from a CHC to an Area Hospital. It has new building and of about 100 beds. At all times the occupancy rate is about 75-80%. The staff strength in terms of doctors, para medics and support staff are proposed to upgraded to the capacity of hospital with 100 beds. Apart from five doctors, the hospital has 22 nurses and 2 ANMs on contract. Serves 100 OPD patients per day and 15 deliveries per month. • There is a ramp present at the main entrance along with patients waiting area with seats. Ambulance is available at the facility for patient transport. • Fire exit is marked in the main passageway but was locked and blocked outside with vegetation. One fire extinguisher- ABC type was found to be empty with overdue checked in date. No fire detection system in emergency area. • In the injection room, unsegregated mixed waste was observed in yellow bags. BMW register- was observed to be maintained from 2023 to March 24 only i.e. around QA Certification of the facility. BMW is transported daily by Shwetansh CBWTF from the facility. Hub cutter was in use for needles handling and management. • IEC materials were found displayed, covering areas e.g. IPC, Fire safety and BMW management. • Liquid waste in the laboratory was managed by use of 1 % Hypochlorite solution. • No expiry medicines are there. There is a separate tray for storage of Methylated spirit in the pharmacy. • The use of Mercury has been phased out from the facility and replaced with the use of digital instruments.

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
				• Power back up by Inverter is present but presently non-functioning due to battery under repair. • Septic tank and bore well are present and used. • Oxygen is given to the patients through cylinders only • A complain box is available in the hospital for people to put in written complaints. It receives about 4-5 complaints per month on issues like lack of waiting chairs for OPD patients etc. • The hospital has set up a POSH and SH committee a year ago. However, they have not undergone any training or briefing about their roles and responsibilities and till date there has been no meeting of the committee. There is a need for proper budget sanctioning for housekeeping and stationary. • Hospital gets funds from the Arogyashree Insurance Scheme and other national programs with the flexibility to use the resources as per local need. However, there has been delay in timely disbursement of funds which are required for effective maintenance of health facility. • The CCTV cameras at common places were not functional during the visit
15.	28 May	Mahabubnagar District Teaching Hospital	Faculty, Residential Medical Officers, Medical Superintendent and Administration team, Infection Control Team, ICC members	This is the largest hospital in the district providing tertiary care. It has 650 beds and is attached to the Medical College of the District, and has treated 6,96,074 total OPD cases and 58,895 IP in 2024. The Medical College has 175 seats and is fully residential. It is a multi-specialty hospital providing palliative care for the elderly as well as physiotherapy. The hospital also has facility for day care for patients coming in for chemotherapy. The hospital also is the hub for Gynecology OB and Pediatrics in the district. Supply of drug and surgical equipment and consumables are adequate in the hospitals. For grievances, a complaint box is available in the hospital though people mostly gives verbal complaints to the RMO. The number of the RMO is displayed for people to call up in case of any complaints • In Casualty, unsegregated BMW was observed • Microbiology and Blood Bank units treated liquid wastes through disinfection with 1% Hypochlorite solution before discharging into external water drain. • Equipment gaps for fire safety at ICU were observed • The hospital has two oxygen plants. One 13000LPM Oxygen Plant is functional. The plant has adequate hazard communication arrangements e.g. locked entry and IEC covering fire safety instructions at the entrance. The other one is not functional due to non-availability of generator and wirings. • The state team advised the RMO to follow up with with state officials for operationalisation of additional Liquid Oxygen Plants, if needed.

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
16.	28 May	Badepally (Jadcherla) Area Hospital, Mahbubnagar	Medical officer, Nurse/ANM, ASHA, Lab technician, Pharmacist, Support Staff, JAS members and beneficiaries	The area hospital is a 100 bedded new facility upgraded from 30 bedded Community Health Centre. Now the facility is serving 70 to 80 indoor patients. • The facility manages BMW through services from M/s Shwetansh & Co, the CBWTF transporting wastes from the facility for treatment and disposal, on alternate days. • The manifests of BMW transportation were present and regular, with weight and types of wastes clearly mentioned. The facility maintains BMW register. • Mixed wastes should be disposed as general waste but instead observed to be disposed in black in bag in the dressing room. • Infection Prevention and Control (IPC) Training once a week by ICN and record is present. • In the Laboratory, the liquid waste system present but non-functioning along with an overfilled white sharps container • In the X ray unit, the Lead fortified doors were present. The radiographer was working with no Personal Dosimeter and lead apron. However, the lead shield was present for operating X-ray machine • The X-ray unit does not generate physical films, only soft copy is provided, thereby reducing waste films. • The facility had received a notice from Telangana Pollution Control Board for operating without valid consents (Water and Air) and BMW Authorization and without STP vide Notice No. 23 /TGPCB/ROH/GDWL/HCE/CFO/2024-888, Dated 28/10/2024. The follow up action needs to be further ascertained. • Dialysis unit has 10 beds, where daily 15 to 20 cases are treated. Approximately 1 to 2 ltr waste water is generated per case that is drained out directly into the external drain without prior disinfection. • In the Pharmacy, First In First Out (FIFO) system is in place to reduce drug wastage and lead time for availability. The expired medicine Enalapril Maleate (expired date1st April 2025) was stored separately in Expired Medicine box, to be sent to CDS. • The facility does not have ETP/STP of its own. • There are two lifts in the facility. In both lifts, there is no signage and information covering capacity, emergency actions, phone numbers and fitness certificate. • In the Casualty area, the smoke detector and filled fire extinguishers are present. • In the specialized neonatal care unit, the smoke detectors and Fire extinguisher are present. However, there is only one entry and exit and no fire safety signage are in place.

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
				• While Fire safety training was conducted by the fire department few months ago, but the details of training along with photograph were not available with the facility. • The facility has Ambulance service for patient transportation.
17.	29 May	Mahabubnagar	District Medical Officer	In the consultation it was pointed out that is some shortage of personnel, however, the state team assured that the process of recruitment has begun for Medical Officers and other staff. In addition, the pending JAS budget is also expected to be released to MO account. The housekeeping sometimes done by the municipality and the PRI on special request.
18.	30 May	Urban PHC, Deshaipet, District Warangal	Medical Officers, Staff nurse, Lab technician, Pharmacist, Support Staff, ASHA, ANM, JAS members and beneficiaries	The centre is NQAS certified and receives about 50-80 outpatients per day. Like all the facilities in the state each day of the week is marked specifically for some special day. They also receive a few cases of HIV. In these cases, they work with a local NGO especially with truck drivers in the active age. The JAS committee exists and they regularly meet every third Saturday of the month. The committee is supposed to get Rs.1,75,000 per annum as an untied fund has been disrupted since 2023 that effects functioning of committee. The grievance recording system from the patients is mainly verbal. Internal complaints from the team are sent to the MO in writing. • The facility has only one entry and exit • The facility lacked availability of coloured BMW Bags due to budgetary issues. • For last one and half years, BMW was collected by CBWTF once a week and No records existed about the type and quantity of wastes transported. The BMW Storage area existed but unused. • The fire safety communication and provisions e.g. fire exits, directional signage for escape, Fire emergency plan, alarm etc not in place. The fire extinguisher-ABC type was present, filled but without inspection date. • Laboratory Technician need training on liquid waste management for ensuring proper disposable of contaminated liquid. • The pharmacy practiced FIFO procedures. The near expiry medicines tray was found to be separate from expired tray. The expired medicines whenever observed were transported to CBWTF. Cold chain temperatures for vaccines storage were maintained within the range as required. • The Medical Officer should be advised to use digital BP monitoring instead of Mercury BP Apparatus. MO should be made aware of disposing procedure of mercury based equipment to avoid consequences. • Training on IPC and BMWM were reported to have been conducted before NQAS certification only in 2023. No records were available for the duration thereafter.

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
				• IEC material was displayed covering IPC and BMW Management aspects. • The facility had a ramp build at the entry but the length was observed to be short and slope was higher angled. • The facility has a piped water supply line and a septic tank. The electrical back up for vaccine cold chain was available.
19.	30 May	BMWM Company in District Warangal	Kakatiya Mediclean Company	• The Common Biomedical Waste Treatment Facility was established in 2003. The facility was built on a privately owned areas of 5.63 acres, of which the constructed area comprises of one acre land. • The CBWTF operational performance for 2024 as per Annual Report submitted to TGPCB included following: Provided services to 12043 beds of 904 HCFs, Total BMW treated 1168 kg/day, Waste categories generated or disposed on monthly average basis: Yellow 29547 kg /month Red 3023 kg/month Blue 2333 kg/month and White 106kg/month General waste-NA Recyclable wastes sold to authorized dealers after treatment-65555kg/annum Ash generated-1932 kgs/month ETP sludge generated-72 kgs/month • The facility has a valid Consent for Operation (CFO), Hazardous waste Authorization and BMW authorization from the Telangana State Pollution Control Board vide Order No: 883/TGPCB/HO/WGL/CFO-BMWM-2025, dated 29/3/2025, valid up to 17th May, 2030. • The key treatment facilities at the site include two Incinerators, 150kg / hr and second spare one of 100 kg / hr capacity, Effluent Treatment Plant of 25 KLD capacity, six transport vehicles fitted with GPS and vehicle washing area, wastes storage areas, office area, workers rest areas and green area. • The Incinerator ash and sludge generated during treatment are transported for disposal to M/s Hyderabad Waste Management Project, the last consignment sent 26th February, 2025. • The facility has a total of 42 workers, with 20 hired from neighbouring areas, and the treatment operations are conducted on one shift only during the night. • The facility has functional Continuous Online Emissions Monitoring System installed in the

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
				incinerators for real-time monitoring of emissions by the facility as well as PCBs. • The vehicles are fitted with Geo-positioning System (GPS) for vehicular tracking on real-time basis, connected with PCBs. • The key concerns of the facility managers towards treatment of Government Health Facilities included low treatment rate of Rs 7.5 per bed per day rate stagnant since 2016 resulting in the pending 2.23 crore of payment dues, reduced transportation of autoclavable, recyclable wastes from the facilities and poorly segregated wastes received from the facilities. Regular payments are being received from private HCFs. • The State PCB conducts quarterly visits for air quality sampling and analysis and monthly visits for general inspection
20.	30 May	PHC, Sangem, District Warangal	Medical officer, Nurse/ANM, ASHA, Lab technician, Pharmacist, Support Staff, JAS members and beneficiaries	• The facility has received NQAS Certificate valid from 23/12/2022 to 21 /12/2023. The facility has eleven beds capacity. It is a 24/7 hospital managed by single doctor. In the evening only the staff nurse is there to take care of any medical emergencies. The centre has facility for an OT and a labour room but they do not do any deliveries as Government Teaching hospital (CKM) is located within 15 KM from the PHC and people preference to deliver in this hospital over PHC resulted in underutilisation of OT and labour room. e. In case of domestic violence they work with a number of NGOs who work closely with the community. However, similar to other facilities in the district, there is no dedicated budget for housekeeping. consumables. Staff currently support these costs from other resources, and the absence of JAS funding for this purpose remains a recurring concern. The ASHA visits the community regularly and have developed a rapport with the people and therefore there is a level of trust between them and the community members which has helped them to raise awareness about NCD. • Temporary storage area for BMW consisting of three round metal bins was found to be located out in the garden, open and uncovered, without signage and access control. • Once in 7 to 10 days transportation of BMW by CBWTF was reported, the last pick up being on 13th May 2025 • In the laboratory, colour coded waste bins were present and segregation of wastes was found to be practiced. The liquid waste management system was present and working, though automatic analyser wastewater was not connected to LWM and was directly let out. • Use of both Mercury and Digital apparatus such as thermometer and BP apparatus was in practice in the facility. The availability of Mercury spill kit and knowledge of hazards and its usage was lacking. • The fire safety arrangements consisted of a fire extinguisher near the entrance that was empty

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				and without inspection date. • The facility has a deep borewell for water supply and soak pit, septic tank for effluent treatment.
21.	31 May	Narsampet District Hospital (Teaching)	Faculty, Residential Medical Officers, Medical Superintendent and Administration team, Infection Control Team, ICC members	The facility has current bed capacity of 80 beds that is soon increasing to 220 beds as required for operationalization of the Medical College in separate location. The facility was upgraded from a CHC to a District Hospital to a Medical College Hospital within 6 months. The staff strength that is required for Medical College should be provided. Narsampet hospital gets patients from states as Warangal being an industrial town attracts a lot of migrant labourers. As a grievance recording mechanism an aggrieved person can call the RMO on his/her number. This number is displayed in the hospital. All Committees like JAS, Hospital Development Committees, POSH/SH, GRM, Anti ragging have been constituted but meetings are not conducted regularly. There are no CCTV cameras installed in the centre. Fire safety mechanism need to be strengthened. • BMW management practices were in place in the injection room of the medical college with segregation and use of coloured bins. In the labour room the placenta is collected into yellow bag, injection needles in corrugated white box and daily transported by CBWTF. • Blood bank unit was found to practice liquid waste management of wastewater using 1% hypochlorite solution. • In the Medical OPD, use of Mercury BP apparatus was found and no knowledge of spill management and availability of spill kit was there. The Dental OPD was using composites and no mercury-based material as dental filling material. • Dialysis unit has seven beds capacity and approx. 22 to 25 dialysis are done daily in four shifts. However, the liquid waste management of wastewater using 1% hypochlorite solution of wastewater generated from dialysis was absent and the wastewater was directly drained out. • Two oxygen concentrators are there in the labour room and functioning. A filled Oxygen cylinder was also present but not secured with chian. • Construction work is undertaken for construction of Blocks A, B and C of the Medical College and hospital. The contract for construction is awarded to M/s . The order for the work dated did not reveal inclusion of construction of supporting facilities e.g. Sewage Treatment Plan, Biomedical waste storage area, fire and emergency response facilities etc. Visit to the construction areas revealed absence of safety arrangements e.g. barricading work sites, hazards signage, safety supervisors, etc. One lift was observed to be under construction in Block A; the passage way was used by children and patients without barricading and hazards signage. The ICU area had only single entry and exit for escape. The unit had one fire extinguisher only and lacked smoke detectors and fire alarm system. The fire escape plan was nowhere displayed in the facility.

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				• The facility had an Infection Control Round register; Immunization registers and Health check-up records. • The security arrangements at the site provided through thirty contractual workers were reported to be functional during the working hours i.e. 9.00 AM to 4.00 PM only.
22.	31 May	Christian Colony Basti Dawakhana	Medical officer, Nurse/ANM, ASHA, , Support Staff, JAS members and beneficiaries	The health facility present within the city of Warangal covers 5104 population living nearby, providing OPD, Diagnostics collection services and teleconsultation service. There is one doctor and one nurse in the facility. It gets about 40-50 patients every day mostly NCD cases of people who are of the age 40-60 years. The facility collects 5 to 15 blood samples per day and sends those daily to the Diagnostic Hub. They have a system pf prioritizing them based on the severity of the symptoms. There are 2 Asha workers affiliated to them who visits each family in the area to register NCD cases. The centre does not have ANC facility and they don't do vaccination. However, they provide support to elderly for diabetes and hypertension especially for people who cannot travel far. Biomedical waste is collected once a week from the facility. They have regular supply of medicine which is collected from UPHC by the nurse from the centre. However, they do not have supply of plastics to dispose biomedical wastes. • Large sized BMW Colour coded bins are available for BMW collection and once a week BMW is sent to PHC. No BMW record is available at the facility • Fire safety arrangements consist of one Fire Extinguisher with expiry dated 6/9/2023. • There is a ramp available at the entrance, opening into the side door. However, the path from the facility main gate through the garden lacks smooth wide concrete pathway up to the building entrance.
23.	28 July	Office of Commissioner of Health and Family Welfare, Hyderabad	Nodal Officer, Tribal Welfare	There are 621 Ashram schools for Tribal children. Through WhatsApp groups daily tracking and response on health issues or tribal families is maintained. There is a trust deficit which makes it challenging to work with communities.
24.	28 July	Office of Commissioner of Health and Family Welfare, Hyderabad	Deputy Director, CHEFW	Various mechanisms of GR/ helplines are available in the health sector: Indirect GRM: Mass media reporting on medical lapses; ICC; Anti-corruption bureau; Citizen charter service delivery; Public Relation Officer; Prajavan Secretariat in every district – every Monday; Direct CM portal; CP GRAMS; E-Sanjeevani; Tele Manas counselling; Aadi Karmyogi – dedicated health App. There are 31028 sanctioned ASHA posts of which 28000 are occupied. In 2023 a five-day training was organized for ASHA workers. There are 4246 ANM posts of which 2580 are in position.

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
25.	29 July	Gandhi Medical College	12 (Principal, 4 Faculty and 5 students)	1250 UG and 650 PG students, last 5 year 60% students are women. Mechanisms to prevent ragging (Mentorship support, Anti-ragging squad, night rounds I hostels) exist. Scholarship provisions are there and even NGO support. Under the ALIMI and Vidya Daan programs, students work with communities. For preventions against GBV there are duty rooms, lighting, WhatsApp security groups, security personnel, functional ICC.
26.	29 Oct	Ayushman Arogya Mandir (AAM) center in Nagalkonda, Adilabad	AAM – including MO, 2 ANMs, and other staff; 6 ASHAs; JAS members, Ex-Sarpanch, Panchayat Secretary, and about 15 community members	Challenges in service delivery in tribal areas – many areas difficult to reach, no ambulance can reach – bike ambulance are in place to reach areas, Autorickshaws are the primary form of transportation for this area. Generally, mothers come to birth waiting centres in due time for delivery. At DH/GGH, while there are place to stay for patients/ mothers, there are no place for ASHA which the community prefers as accompaniment when they are in the health centres. ASHAs carry out Rapid surveys for the department. They shared that they get good support from MO and ANMs to ASHA. ITDA has initiated Help Desk at tertiary care hospitals with a dedicated room and one doctor appointed as liaison officer, along with 5 facilitators who know different tribal languages of the area to support tribal patients coming for checkup/ treatment.. Grievances are verbally told and resolved and there is no documentation. Although JAS members are occasionally trained their capacities are limited. Providing regular and effective trainings on their roles and responsibilities are critical to enhance their overall functioning. • The sub-center features an autoclave that is used to sterilize medical instruments, etc. It is not used to treat biomedical waste. • Bar codes are not applied to biomedical waste. This is the responsibility of the PHC once waste reaches PHC. • sub-center temporarily stores all healthcare liquid waste generated in a tank containing hypochlorite solution for 1–2 hours of retention before releasing it into the drainage system. • There are no STPs or septic tanks at this facility. There were toilet facilities in the sub-center. Thus, the liquid waste being generated would receive no treatment before being released into the environment. • A logbook was maintained that included the quantity of BMW by category • The Asha workers have been trained in how to handle waste. However, the process for them is a risk. Asha workers collect the waste from the baskets, transferring it to a plastic box. This box is then transported to the PHC. The Asha workers may be sharing autorickshaws with others as they transport this waste. In addition, a thermocol box is not the most stable method to store the waste. In the case of an accident, there will be BMW being littered in public. The risk for Asha workers is also high.

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				• Yearly checkups are done for Asha workers that include health checks and immunization.
27.	29 Oct	PHC Gudihathnoor, Adilabad	PHC MO and staff; 15 ASHAs; 4 ANMs; 4 JAS members; and District level officials	For ASHAs, every day of the week is scheduled meticulously and focuses on specific tasks and home visits. Untied funds for maintenance were articulated as an issue. AHSA assist ANM in outreach and during NCD survey. ASHAs are paid 9200 – 9800 per month. Complaint boxes exists and every Monday it is opened but no documentation of complaints; grievances are also told verbally and resolved and there are no documentation. JAS members require training their roles and responsibilities; ICC exist but no GBV cases have been reported so far. MMUs are there and support the delivery of services in PVTG areas. A lot of tasks done by ANMs and ASHA require use of mobile phones and mobile data cost Sri Medicare Services is the CBMWTF Operator that collects, weighs, and transports the BMW to the treatment facility. • BMW segregation practiced. HCF has BMW storage. There is no barcoding system. • A septic tank is for sewage collection at this facility. However, in a previous instance, the septic tank overflowed, and brand-new septic tanks were installed. • Puncture-proof containers were available at this facility. • BMW is collected every alternate day. • Logbook of BMW collected maintained. • This facility had records for conducting checkups on their staff. However, the latest checks that they could provide were in 2022.
28.	29 Oct	CHC/DH Utnoor, Adilabad	DH Staffs including MOs; Staff Nurses, and District level officials	Recently upgraded to DH from CHC, NQAS certified, have blood bank (except for blood plasma) and have district level laboratory hub in their campus. Have all committees including ICC, BMW and infection control etc formed part of NQAS certification, however meetings are not regular; majority of the doctors know local language as they belong to local area. • Septic tanks cleanings are not being monitored closely, they have received permission from TSPCB to manage BMW, Daily audits are being conducted to ensure proper management of BMW. • BMW is collected on alternative days. However, there are financial constraints from the hospital's side that impact waste collection. No bar coding of waste done. Log books maintained manually. • Sanitation workers that collect this waste are provided with masks and PPE. They also receive training from nurses. • This facility includes segregated bins by category and possesses puncture-proof containers for white waste.

S. No.	Date (in 2025)	Location in Telangana	Participants	Discussion Points
29.	30 Oct	Khanapur Basti Dawakhana, Nizamabad	MO, ANM and other staff; JAS members	GRM system - No complaint boxes – the grievances come to ANM or come through ASHAs are brought to MO's notice for resolution; sample collection are done and sent to TG diagnostic hub; waiting area is good need some audio-visual mechanism for IEC and old age patients; Newly formed JAS – need awareness on roles and responsibilities. • A van comes from the UPHC to collect the waste. No bar-coding practice. Log books maintained manually for total waste collected and not by category of BMW. • A septic tank was installed at this facility in August 2022. However, they do not schedule any cleanings for the septic tank. The tank is cleaned when there is slow flushing or backflow in the toilets
30.	30 Oct	UPHC Dubba, Nizamabad	MOs, Staff Nurses, ANMs, JAS members; and District level officials	NQAS certified facility; JAS committee quite active. There is a need for untied funds that can be used for maintenance and minor expenditures. Complaint boxes exist and grievances comes directly – no documentation; no ICC exists; elderly care require hand rail etc; contingent worker handles the BMW and medical check are periodically conducted; HCF NQAS certified and has applied for renewal of BMW certificate to Pollution Control Board certificate.
31.	30 Oct	District General Hospital, Nizamabad	MS, MOs, Staff nurses, other technical staffs	Large facility with 750 bedded; 10 bedded geriatric ward; need disabled friendly and old age measures such as handrails dedicated waiting areas etc; geriatric ward is being used for small treatment – not fully equipped; separate line for PWD and senior citizen at the ticket counter; complaint boxes exists.
32.	31 Oct	Office of Commissioner of Health and Family Welfare, Hyderabad	PMU officials; Tribal welfare officials; Officials in change for Disaster management and climate change, BMWM; GRM, 104	Discussion rationalisation of work among frontline workers to meet emerging epidemiological shift and log-term elderly care. Existing GRM system and improvement required; BMW –Sub-center level staff need training on transportation of BMW from sub-center to PHC. schemes targeting tribal health and future needs; Old age homes and its management – and need for regulation; old age care giver mechanism and regulation
33.	4 Dec	Office of Commissioner of Health and Family Welfare, Hyderabad	7 NGOs representatives, PMU and WB	Representatives from: • Kasturba Gandhi National Memorial Trust (KGNMT) – Adolescent girls, children, rescue homes, Sakhi Centre, skill development, mental health. • Heritage Foundation – geriatric care • Bhumika Women's Collective – gender-based violence, POSH, SHE teams • HelpAge India – healthcare, age care, livelihoods, advocacy, emergency relief • Darpan Foundation – sexual health and human rights, • ARMAN – women, reproductive health, maternal health. Inputs and suggestions: attach PHCs with local medical colleges and relook at the community

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				interface curriculum to make it more meaningful; behaviour change campaigns and gender strategy to focus on women and girls but also on men and boys; for mental health support, schools need trained counsellors; Regional Medical Practitioners are an important stakeholder. In addition, the participants shared their expertise related to research, training and mobilization.
34.	29 Jan	Office of Commissioner of Health and Family Welfare, Hyderabad	2 ASHA workers, 2 ANM (including Senior Nurse), 2 JAS members (Panchayat representative and SHG member) and two medical officers	The participation of JAS members in meetings is sub-optimal though JAS meetings are prefixed on 21st of every month in the state. ASHA and ANM are very active and collectively complete tasks. Each ANM in rural areas, must Supervise 20 ASHA and nearly 50,000 population. The work distribution and targets for ASHAs and ANMs in urban and rural areas are dramatically different. IT and support need to be strengthened to meet their work requirements.
35.	29 Jan	Office of Commissioner of Health and Family Welfare, Hyderabad	Nodal Officer for Health at from Tribal Welfare Department	Efforts to reach tribal areas and population through a series of schemes and interventions but having another push through the project will be a welcome move as it will help review the gaps, different strategies required for outreach to particularly vulnerable and highly remote areas. The team at the Tribal Welfare Department will support any new step to improve outcomes for health in Tribal areas by helping in field mobilization, data collection and implementation of interventions.

ANNEX 7: ESSA MULTI-STAKEHOLDER STATE LEVEL CONSULTATION

To be Added