Assam Secondary Healthcare Initiative for Service Delivery Transformation Project
**(P179337)**

# Indigenous Peoples Planning Framework
# (IPPF)

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**By**
**Assam Health Infrastructure Development and Management Society (AHIDMS)**

**ABBREVIATIONS**

| | |
|---|---|
| ADC | Autonomous District Council |
| ANM | Auxiliary nurse midwife |
| ASHA | Accredited social health activist |
| BMW | Bio-medical Waste |
| CERC | Contingent Emergency Response Component |
| CHC | Community Health Centre |
| CMO | Chief Medical Officer |
| CTF | Common treatment facility |
| DH | District Hospital |
| DOHFW | Department of Health and Family Welfare |
| E&S | Environmental and Social |
| ESF | Environmental and Social Framework of World Bank |
| ESS | Environmental and Social Standard |
| FPIC | Free, Prior, and Informed Consent |
| GBV | Gender Based Violence |
| GoI | Government of India |
| GoA | Government of Assam |
| GRM | Grievance Redress Mechanism |
| HCF | Health Care Facility |
| HR | Human Resource |
| HWC | Health and Wellness Centre |
| ICT | Information and communication technology |
| IEC | Information, Education, and Communication |
| IPA | Internal performance agreement |
| IPF | Investment Project Financing |
| IPM | Internal Performance Management |
| IT | Information Technology |
| MO | Medical Officer |
| MOHFW | Ministry of Health and Family Welfare |
| NCD | Non-communicable diseases |
| NGO | Non-governmental Organization |
| NHM | National Health Mission |
| NQAS | National Quality Assurance Standards |
| OHS | Occupation and Health Safety |
| OSC | One Stop Centre |
| PDO | Project Development Objective |
| PHC | Primary Health Centre |
| PMU | Project Management Unit |
| PPE | Personal Protective equipment |
| PPP | Public Private Partnership |
| RKS | Rogi Kalyan Samiti |
| SEA/SH | Sexual exploitation and abuse/Sexual harassment |

# 1 INTRODUCTION

The Government of Assam (GoA) recognizes that improvement of the health systems is paramount for a citizen-centric fully functional service provision. Recognizing the gaps in current services, GoA plans to strengthen the secondary health systems through a series of measures to improve management capacity, access, and quality of the public health sector. The Assam Secondary Healthcare Initiative for Service Delivery Transformation Project (ASSIST) uses a complementary systems approach at multiple levels (state, district, and facility/community) to (i) address meso- and macro-level secondary care issues—improving governance, coordination, and policy level challenges, and (ii) improve portfolio of services and quality of care at the secondary level along with strengthened referral linkages to both primary and tertiary care.

The ASSIST is under preparation in accordance with World Bank's Environment and Social Framework (ESF). In compliance with its requirements under ESS7 on 'Indigenous Peoples/ Sub-Saharan African Historically Underserved Traditional Local Communities', this framework has been developed to provide guidance and establish requirements for screening, consultations, and preparation of Environmental and Social Management Plan (ESMP)-Indigenous Peoples Plan (IPP).

## 1.1 Project Background

The proposed project development objective (PDO) is to strengthen management capacity, utilization, and quality of the secondary healthcare system in Assam.

## 1.2 Project Components

There are three components under ASSIST which will address management capacity, quality, and access to secondary health services. Details of the three components are provided below:

***Component 1: Strengthened management capacity of health systems at state, district, and facility level:*** Subcomponent 1A will finance provision of performance-based grants (Internal Performance Agreement (IPA) grants) to select entities at state, district, and facility level to strengthen management capacity and subcomponent 1B will provide complementary technical support in areas of HRH, pre-service education, health infrastructure and IPA operationalization for improved secondary care access and quality. Sub-component 1B: Technical support and project operating costs to strengthen management capacity. Complementing the IPA approach to improve management capacity, the project will finance technical support at the state level on critical HRH and pre-service nursing education reforms to improve secondary level health worker allocation, availability, and quality, and accrue long term gains for the health sector. This component will also finance technical support to improve monitoring and management of health infrastructure, IPA operationalization, and project operating costs. Under component 1, the project will finance performance-based grants (IPAs under subcomponent 1A), as well as project operating costs and consultancy services (technical support and operating costs under sub-component 1B). **The IPA implementation will be guided by an IPA grants manual developed using extensive stakeholder consultations in the state**. The IPA will include objectives, key results, and indicators reflecting those results, as well as financing tied to the composite performance score of the IPA.

***Component 2: Improved access to and quality of essential services in existing secondary facilities:*** The component will finance a multipronged approach to improving quality in district hospitals. The component will finance repairs and renovation of select secondary care facilities for NQAS certification and select health entities for improved structural quality. The component will support improvement in HRH availability and quality in the 25 district hospitals for improved secondary care access and quality. Overall, this will improve access to and quality of essential services in existing secondary facilities through: (a)

provision of technical assistance, training, and design and implementation of quality tracking tools, (b) contracting-in of services to fill clinical positions and other clinical services, (c) contracting out of non-clinical services, (d) strengthened nursing colleges attached to DHs, and (e) repairs and renovations of existing secondary facilities and nursing colleges attached to DHs. Additionally, this component will support innovations to improve health systems efficiency focusing on equitable access and quality.

***Component 3: Enhanced access and structural quality of secondary care through upgradation of select facilities to district hospitals*** The third component will support infrastructure development to address improvements in structural quality in compliance with national standards and improve the overall functionality of existing health infrastructure to improve patient flow and experience. This component will invest in: (a) upgradation of up to 10 community health centers (CHCs) and sub-district hospitals (SDHs) to DH following national guidelines and provision of medical equipment and goods to enhance equitable access to secondary care, and (b) incremental operating costs of these newly upgraded facilities to improve structural quality of secondary care. Site selection for these upgradations is based on equity and technical criteria, upgradation will be based on national standards. The bed strength in these DHs for upgradation will follow the IPHS 2022 norms and factor in projected population growth for the next 30 years to meet future needs. The infrastructure development and renovation proposed in the project under this component will be responsive to local needs and will follow the principles of Green Hospitals and Human-centered design.

### 1.3 Objectives of Indigenous Peoples Planning Framework (IPPF)

The purpose of the Indigenous Peoples Planning Framework (IPPF) is to establish the requirements of ESS7, organizational arrangements, and design criteria to be applied to subprojects or project components to be prepared during project implementation when IP may be present in, or have collective attachment to, the project area. Following identification of the subproject or individual project components and confirmation that IP are present in or have collective attachment to the project area, a specific plan i.e., ESMP-IPP, proportionate to potential risks and impacts, is prepared. Project activities that may affect IP do not commence until such specific plans are finalized and approved by the Bank.

The IPPF will cover all activities under the project and would focus on creating an 'enabling environment' through intensive and extensive awareness creation among community members, mandating their participation in planning, management, and operations, ensuring equity in all project interventions and equities. The objectives of IPPF are to:

- avoid or minimize adverse impacts on the IP/tribal community and to suggest appropriate mitigation measures;
- ensure that the project engage IP communities/tribal people in all relevant stakeholder consultation sessions throughout the entire process of planning, implementation, and monitoring of project.
- identify the views of IP/tribal people regarding the proposed project and ascertain broad community support for the project; and
- ensure that project benefits are accessible to the IP/tribal communities living in the project area

### 1.4 Legal and Policy Framework

The Acts / Policies that are applicable in the project includes (i) Panchayati Raj Act 1953, 73rd Amendment 1994; (ii) National Policy on Tribal Development, 1999; (iii) 6th Schedule of Constitution (Article 244); (iv) Tribal Sub Plan; and (v) Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006.

## 2 IMPACT ON INDIGENOUS PEOPLE

### 2.1 Implementation Area

Certain locations in Assam falls under the VI Scheduled Area under the constitution of India and has six statutory tribal autonomous councils. **About 12.4 percent of the state's population are scheduled tribe population, comprising of 14 recognized Plain Tribe communities and 15 Hills Tribe communities**. While the geographical coverage of the project is the entire state, **preliminary screening reveal that specific investments related to upgradation of 10 lower-level health care facilities (HCFs) to District Hospitals (DHs) will not be carried out in the VI Scheduled Areas of Assam**. Nonetheless, where relevant, site-specific Environmental and Social Management Plan- Indigenous Peoples Plan (ESMP-IPP) will be prepared for investments relying on the procedures embedded in this Indigenous Peoples Planning Framework (IPPF).

### 2.2 Type of Impacts

Positive Impacts. By improving the quality of secondary health services, enhancing participatory approaches and increasing accountability, it is expected that more people will access health services. IP/Tribals communities, with other key stakeholders, will be among the primary beneficiaries of the project. Further, linking beneficiaries in remote and far-flung locations with appropriate levels of care, through a functional referral and follow-up mechanism, will reduce time taken in accessing health services. The IP/tribal communities will not only benefit from improved access to health care system, but also from improved health seeking behavior as citizen engagement and community participation are hardwired into the project. Further, the project will provide opportunities for representation of indigenous groups in community organizations/platforms in district hospitals such as *Rogi Kalyan Samiti (RKS),* which plays a pivotal role in citizen interface.

Potential adverse impacts on Tribal Groups. **No land acquisition, physical displacement, relocation or involuntary resettlement impacts on IP are anticipated under the project, and no adverse impacts on tribal lands (sixth schedule areas), resources and livelihoods are envisaged**. Any project activity requiring acquisition of private land and/or physical relocation of IPs, or activities that may have adverse impacts IP cultural heritage will be included in the negative list of activities ineligible for financing under the project. Initial screening reveals that the 10 selected DHs for upgradation does not have intervention in the sixth scheduled area, however a DH each from sixth scheduled districts of Baksa, Chirang and Kokrajhar have been selected for repair and renovation. The proposed investments i.e., upgradation of 10 existing CHCs and SDHs to DHs, repair and renovation of 25 existing DHs and nursing institutions attached to DHs will be on government/municipal land and within the boundaries of existing facilities.

### 2.3 Exclusion Criteria

Activities that require Free Prior Informed Consent (FPIC)/significant risks related to Indigenous Peoples (IPs) will be excluded from the project.[1]

[1] As per ESS7, Borrower is required to obtain FPIC of the affected tribal community when project will (a) impact lands and natural resources traditionally owned, used, or occupied by tribes; (b) cause relocation of tribal community; or (c) have significant impacts on tribal community's cultural heritage.

## 2.4 Process of preparing an Environmental and Social Management Plan- Indigenous People Plan (ESMP-IPP)

The following are steps for preparation of ESMP-IPP for sub-projects where it can be concluded that IP/tribal communities are present in, or have collective attachment to, the project area:

| *Sl. No.* | *Action* | *Responsibility* |
|---|---|---|
| *1* | *Information disclosure*<br>The project will disseminate project information to all stakeholders through various means, such as community level meetings, mass media, project brochures/posters and a dedicated project site on the internet. | SPMU |
| *2* | *Screening*<br>A screening will be conducted to determine if indigenous/tribal families or communities are present or have collective attachment in the area of influence of the proposed projects. Where indigenous/tribal communities are found to be present or have collective attachment in the area of influence of the project, it is to note that the ESS 7 will be applicable, and the following steps will be taken even if no negative impact is likely to occur.<br><br>The determination as to whether a group is to be defined as IP/Tribal peoples is made by reference to the presence (in varying degrees) of four identifying characteristics:<br>▪ *Self-identification as members of a distinct tribal cultural group and recognition of this identity by others;*<br>▪ *Collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories;*<br>▪ *Customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and*<br>▪ *Any tribal language, often different from the official language of the country or region.* | Architectural firm under the guidance of SPMU |
| *3* | *Environmental and Social Assessment (ESA), preparation of sub-project specific ESMP-IPPs including consultation with the IP/Tribal Communities*[2]<br>If based on the screening, the Bank concludes that tribal communities are present in, or have collective attachment to, the project area, environmental and social assessment will be conducted to evaluate the project's potential impacts on the indigenous/tribal population and an ESMP-IPP is prepared in accordance with the requirements of this framework. The environmental and social assessment and preparation of ESMP-IPP will entail:<br>• Identifying key stakeholders among IP/tribal community and establishing an appropriate framework for their participation in the selection, design, implementation, and monitoring and evaluation of the relevant project activities; | SPMU / EPC Contractors |

[2] Free Prior Informed Consent is not required in this project as tribal community will not be adversely impacted.

| | | |
|---|---|---|
| | • Assessing the demographic, socio-economic, cultural and other relevant characteristics of ethnic population on and near the project sites, establishing social baseline and identifying potential barriers to their full participation in benefiting from project activities;<br>• Reviewing relevant legal and institutional framework applicable to indigenous/tribal community;<br>• Based on assessment, proposing specific measures to ensure that affected indigenous/tribal people will, meaningfully and in a culturally appropriate manner, participate in project activities and benefit from the project. The measures and actions to be developed under each sub-project to benefit indigenous/ tribal communities should be in consultation with them. The ESMP-IPP should annex the minutes of consultation and present the key findings in the main text of the ESMP-IPP along with the timing for such consultations and finalization of sub-project specific activities as agreed with the community and tribal leaders.<br>• Developing implementation strategies to assist indigenous/tribal communities to voice grievances and have them addressed in ways that are socially sound, in line with the procedures described in this IPPF.<br>• Any sub-project that results in any kind of adverse impact on indigenous/ tribal community / families will not be considered for financing under the project.<br>• The breadth, depth, and type of analysis in the social assessment shall be proportional to the nature and scale of the proposed project's potential effects on the indigenous/ tribal community, whether such effects are positive or adverse.<br>• In addition, any other elements specified in the ESMF for preparation of an ESMP will be included in the ESMP-IPP. | |
| *4* | *Disclosure*:<br>The social assessment report and draft ESMP-IPP will be made available to the affected indigenous/ tribal communities in an appropriate form, manner, and language. To disseminate the draft ESMP-IPP, the project will (i) translate the draft plan in local language; (ii) hard copy will be given to the indigenous/ tribal community in the sub project area, tribal leaders and autonomous council; (iii) a copy will also be made available at the selected hospital/medical facility; and (iv) the plan will be explained in the *gaon sabha* (village meeting) with sufficient prior notice.<br><br>Post finalization of the ESMP-IPP, the document is also made available to the affected indigenous/ tribal communities in the same manner as the earlier draft documents. The documents will also be disclosed on the AHIDMS website and the World Bank external website. | SPMU |

### 2.5 Elements of Environmental and Social Management Plan-Indigenous Peoples Plan (ESMP-IPP)

The ESMP-IPP applicable in scheduled areas will include the following elements in addition to provisions specified in the generic ESMP provided in the ESMF:

- Description of the project objective and activities, in particular on project activities that will be conducted for the site;
- Summary of the Social Assessment including the results of the consultation with the IP/tribal community, and verification of their broad community support for the project;
- Mechanism to ensure that IP/tribal communities can meaningfully participate in the project activities and maximize their benefit from the project.
- Institutional mechanism to ensure that project benefits will be shared with the IP/tribal community and that the project activities will not interfere with their way of living and cultural identity. The mechanism should include participation of tribal leaders and representation of tribal administration.
- Mechanism through which affected IP/tribal communities can voice concerns and grievances and have them addressed.
- Mechanism and benchmarks for monitoring, evaluating, and reporting on the implementation of ESMP-IPP.
- Financing plan for ESMP-IPP implementation.

## 3 STAKEHOLDER CONSULTATION AND DISCLOSURE

### 3.1 Steps to meaningful consultations

Since project will be implemented all over the state, the consultation will be carried out with the representatives of tribal administration, tribal-focused NGOs, Autonomous Councils and the Department of Tribal Affairs during the detailed design, implementation and operational phase and their broad community support will be documented. In areas with tribal population in minority, separate consultations with indigenous/tribal households (women and men) and groups will be organized to identify the priorities and strategies for ensuring tribal inclusion in the project interventions and accessing project benefits. Periodic meetings will also take place in tribal hamlets/ villages for information sharing and review during the preparation and implementation stages, minutes of which will be recorded and reproduced when required (e.g., for monitoring and review purposes). The consultations and information dissemination with the indigenous/tribal communities will be in a culturally appropriate format, easily accessible manner and in a local language which is understandable to the stakeholders. Further, such interactions will be free of external manipulation, interference, coercion, discrimination, and intimidation.

The project will ensure that feedback and comments received by indigenous/ tribal communities through multiple channels- project email, dedicated telephone numbers and in-person are acknowledged by registering them in a logbook and will be addressed in an appropriate and timely manner. In addition, a beneficiary satisfaction survey will be carried out under the project, for which an independent consultant will be onboarded. The first survey will be conducted after two years of implementation, and the second survey in the last year of implementation. Adequate representation of indigenous people and other vulnerable groups will be ensured during the survey using a sound methodology.

### 3.2 Grievance redressal

The ASSIST project will adopt and strengthen an integrated 24x7 *Sarathi* Health Information Helpline Service for grievance management. The grievance management system has been operational since November 2010, using free and dedicated telephone number 104. At present, 5 service improvement officers (SIO) have been engaged at the Helpline to register and facilitate resolution of grievances.[3] To

[3] Once the complaint is registered in 104 Helpline, a unique identification number is generated, and the SIO will log the complaint in the online grievance register and acknowledge the receipt of the complaint through a phone call or text message to the complainant. The registered

strengthen the existing GRM system, the following measures will be adopted: (a) Increase the scope of the Helpline by allowing project related complaints pertaining to its planning, preparation, construction and operation[4]; (b) Improvement of escalation process for resolution (c) Maintain confidentiality and anonymity of complainant, when requested; (d) Awareness creation and information dissemination about *Sarathi*, particularly in remote and hard to access areas; (e) Differentiation of complaints that are related to the project vs. other complaints; (f) Capacity building of the Helpline operator and SIOs on SEA/SH and GBV response mechanism; and (g) Improvement in referrals to different implementing departments and agencies relevant to the project.[5] For more details refer to the project's Stakeholder Engagement Plan.

The current grievance mechanism is designed taking into consideration the socio-economic and cultural attributes of indigenous/tribal communities. For instance, *Sarathi* is toll-free, allows for lodging of verbal complaints[6], and provides multi-lingual support[7]. Further, indigenous communities can opt for legal recourse if not satisfied with the results of grievance redress by *Sarathi*. Such a person can approach the Courts, under the laws of the Country, and the verdicts of the Courts will be final, as per the judicial processes established in India. [8] **To make it accessible, information on *Sarathi* will be disseminated among indigenous/tribal communities, traditional institutions and NGOs representing the interest of indigenous/tribal communities.**

## 4 CAPACITY BUILDING

The project will focus on enhancing capacity of all stakeholders to ensure the project is inclusive and the benefits meet the requirements of all social groups including indigenous/tribal groups. Trainings will be provided to AHIDMS staff, consultants (EPC, DPR, etc.), and contractors to:

- Identify the views and priorities of various communities including indigenous groups concerning the quality and constraints of secondary health services through a participatory consultation process.
- Incorporate design elements to make the project interventions socially inclusive and universally accessible.
- Address concerns, grievances, and feedback of indigenous groups in a culturally appropriate manner.
- Screen and mitigate/avoid adverse impacts on indigenous communities and other vulnerable groups.

complaint will then be sent to the nodal officers designated at NHM and district health facilities for redressal. The resolution is communicated to the complainant. The SIO will close the grievance if he/she is satisfied with the resolution. The Helpline will aim to complete investigation within 45 working days of the grievance first being logged. If beneficiary is not satisfied with the response, the SIO re-opens the case and sends the complaint again to the NHM nodal officer with beneficiary feedback remarks.

[4] E.g., project related information, land related, permits and clearances, non-disclosure, failure to communicate or deliver on agreed action plans, or benefits that are considered culturally inappropriate, SEA/SH complaints related to the project, etc.

[5]Directorate of Health Services (DHS), Directorate of Medical Education (DME), Atal Amrit Abhiyan Society & Pradhan Mantri Jan Arogya Yojana, Director of AYUSH, National Health Mission (NHM), Health Facilities, DHS office at district level, including organisations offering survivor-centric services e.g., 181 Helpline, One-Stop Centres, department's Internal Complaints Committee (ICC) for complaints related to Workplace SEA/SH.

[6]As per World Bank's ESS7 Guidance Note, some IP/SSAHUTLC may prefer verbal, as opposed to written, methods of expressing grievances.

[7] Assamese, Bengali, Hindi and English

[8]Laws such as the Recognition of Forest Rights Act, 2006 and the Scheduled Caste and Scheduled Tribe (Prevention of Atrocities) Act, 1989 safeguards the interest of indigenous groups. Wrongfully dispossessing any member of the Scheduled Castes or Scheduled Tribes from their land or premises or interfering with the enjoyment of their rights, including forest rights, over any land or premises or water or irrigation facilities or destroying the crops or taking away their produce is subject to punishment under the said Act.

## 5 MONITORING AND EVALUATION

Throughout the implementation of the project, the social specialist at the SPMU will monitor the project compliance with ESS7. The site-specific ESMP-IPP will be prepared as part of the detailed design/ DPR under the guidance of social specialist at the SPMU. The HCF In-charge and PMC will monitor the site-specific ESMP-IPP implementation and report on monthly basis to the SPMU. The SPMU social specialist will also conduct periodic site visits for monitoring. In addition, the sub-project will follow the norms and reporting as applied under the national/ state laws and guidance.

The project will provide quarterly updates on the progress of the project to the World Bank and will publish an annual report every year (coinciding with the financial year of the state), capturing the civil works progress made under the sub-projects.

## 6 BUDGET

| | |
|---|---|
| Preparation of ESMP-IPPs (where needed) for sub-projects* | |
| Capacity building, IEC and BCC activities | 300,000 USD |
| Note: *Will be part of the sub-project detailed project report and budget | |

ANNEX- 1

At present, Assam has 35 administrative districts. The districts are further placed under five regional divisions namely Barak Valley, Central Assam, Lower Assam, North Assam and Upper Assam. The state has **three autonomous** councils under Sixth Schedule of the Indian Constitution, which are *Bodoland Territorial Council*, *Dima Hasao Autonomous District Council* and *Karbi Anglong Autonomous District Council*. **Six other statutory autonomous councils** have been constituted under the State Act for social, economic, educational, ethnic and cultural advancement of the Scheduled Tribe (ST) communities living in core areas as well as in satellite areas covering many districts of Assam. These are: *Rabha Hasong Autonomous Council, Mising Autonomous Council, Tiwa Autonomous Council, Deori Autonomous Council, Thengal Kachari Autonomous Council* and *Sonowal Kachari Autonomous Council.*

**The tribal population is 38,84,371, which is 12.4% of the total population of Assam (31.2 million).** The tribal in Assam constitute 3.72% of total tribal population of the country. The State has registered 17.4% decadal growth of tribal population in 2001-2011 which is slightly higher than the overall decadal growth for the state. The overall sex ratio among tribal people in Assam is 984, which is marginally less than the national average of 990. The tribal population in Assam is predominantly rural with 94.4% residing in rural areas particularly in the districts of Dima Hasao, Karbi Anglong, Dhemaji, Baksa, Chirang, Udalguri, Kokrajhar, Lakhimpur& Goalpara.

Major tribes of Assam are Bodo (35.1%), Mishing (17.52%), Karbi (11.1%), Rabha (7.6%), Sonowal Kachari (6.5%), Lalung (5.2%), Garo (4.2%), and Dimasa tribes (3.2%). They constitute 90 % of the ST population of the state. The other tribal people in Assam are Deori, Hajong, Thengal Kachari, Khasi, Jaintia, Mech, Chakma, Mizo, Hmar, Kuki tribes, Naga tribes, Barmans (in Cachar), Man (Tai speaking), Khampti and Singhpho tribes.

**Health Indicators as per the NHFS-5**

Among women who had a live birth in the five years preceding the survey that was delivered in a health facility, scheduled tribe women (53%) were more likely than women from any other caste/tribal group of women (42-52%) to receive financial assistance under Janani Suraksha Yojana (JSY). The continuing high levels of undernutrition are still a major problem in Assam. Differences in the levels of malnutrition are more pronounced in tribal areas. Early childhood mortality rate is highest among persons belonging to the scheduled caste (42.2), followed by the scheduled tribes (41.3). The NHFS revealed that less than 55% of women in major tribal districts such as Udalgiri, Dima Hasao, Goapara and Kokrajhar were likely to have made four or more antenatal care visits. Further, only 33.1% of tribal children have received any immunization. This low access to health care services among indigenous/ tribal communities can be attributed to several factors such as lack of awareness, poor access to transportation and health facilities, financial constraints, and cultural factors.[9]

[9] Government of Assam (GoA) has initiated a Tribal Reproductive and Child Health (RCH) Programme in the state. Objective of the programme is to (a) reach the institutionally uncovered and underserved areas comprising of vulnerable tribal population (b) providing accessible, free and quality health care services to the pregnant women, children and other weaker section of the society by conducting outreach health camp.

# Annex II

**Screening Format for Environmental and Social Risks/Impacts on Indigenous Groups**

The Screening checklist is applicable to any civil work activities leading to repair, renovation, expansion and/or construction of district hospitals, and secondary health facilities under the project. This form is to be used by architectural firm to rule out any adverse environment and social impacts due to program intervention under the guidance of the State Project Management Unit (SPMU) to screen for the potential environmental and social risks and impacts on indigenous groups in a proposed sub-project.

| | |
|---|---|
| Name of the District | |
| Name of the Block/ Town | |
| Category of Health Facility | DH/SDH/CHC |
| Name of facility | |

(Please provide answer to each sub-part of the question as far as possible)

| Sl.No. | Key Question | Answer | | Due diligence/ Actions |
|---|---|---|---|---|
| | | Yes | No | |
| 1 | Is the Health Facility located in a sixth scheduled area (tribal)? | | | If yes, prepare ESMP-IPP to ensure inclusion and participation through meaningful consultations tailored to scheduled tribes and project benefits are made accessible to the scheduled tribes in a culturally appropriate manner. |
| 2 | Are there socio-cultural groups present in or use the project area who may be considered as forest dwellers, hunter-gatherers, pastoralists, or other nomadic groups? | | | If yes, prepare ESMP-IPP to ensure inclusion and participation through meaningful consultations tailored to the indigenous groups and project benefits are made accessible to these groups in a culturally appropriate manner. |
| 3 | Is there any risk/ impact/ disturbance to forests and/ or protected areas because of subproject activities? | | | If yes, any interventions should be avoided. |
| 4 | Is the Health Facility within 100 meters of any cultural, historic, religious site/ buildings? | | | If yes, any interventions should be avoided[10]. |

[10]Ancient Monuments and Archaeological Sites and Remains (Amendment and Validation) Act, 2010 there is ban on construction within 100 metres of a centrally protected monument and regulated construction within 100-200 metres construction. Any construction activity within 100-200 meters of the monument requires ASI permission.

| Sl.No. | Key Question | Answer | | Due diligence/ Actions |
|---|---|---|---|---|
| | | Yes | No | |
| 5 | Is the Health Facility between 100 - 200 meters of any cultural, historic, religious site/ buildings? | | | If yes, due permission to be taken from ASI for any construction. Where there is no impact, chance finds procedures would be applicable and ASI norms would need to be followed. |
| 6 | Will the sub-project result in physical displacement and relocation of scheduled tribes from traditional or customary lands? | | | If yes, any interventions should be avoided. |
| 7 | Will the sub-project result in economic displacement of Scheduled Tribes? | | | If yes, any interventions should be avoided. |