Annexure

NATIONAL URBAN HEALTH MISSION

FRAMEWORK FOR IMPLEMENTATION

MINISTRY OF HEALTH AND FAMILY WELFARE

GOVERNMENT OF INDIA

MAY 2013

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I - EXECUTIVE SUMMARY

1.1 As per Census 2001, 28.6 crore people live in urban areas. The urban population has increased to 37.7 crore in 2011. Urban growth has led to rapid increase in number of urban poor population, many of whom live in slums and other squatter settlements. As per Census 2001, 4.26 crore people lived in slums spread over 640 towns/ cities having population of fifty thousand or above. In the cities with population one lakh and above, the 3.73 crore slum population (in 2001) was expected to reach 7.66 crore by 2011, thus putting greater strain on the urban infrastructure which is already overstretched**.** As per the United Nations projections, if urbanization continues at the present rate, then 46% of the total population will be in urban regions of India by 2030. While the Jawahar Lal Nehru Urban Renewal Mission is beginning to tackle the urban infrastructure issues, urban health issues need immediate attention, especially in the context of the urban poor. It also needs attention from a public health perspective.

1.2 As per Census 2011, population of India has crossed 121 crores with the urban population at 37.7 cores which is 31.16% of the total population.

1.3 Despite the supposed proximity of the urban poor to urban health facilities their access to them is severely restricted. This is on account of their being "crowded out" because of the inadequacy of the urban public health delivery system. Ineffective outreach and weak referral system also limits the access of urban poor to health care services. Social exclusion and lack of information and assistance at the secondary and tertiary hospitals makes them unfamiliar to the modern environment of hospitals, thus restricting their access.

The lack of economic resources inhibits/ restricts their access to the available private facilities. Further, the lack of standards and norms for the urban health delivery system when contrasted with the rural network makes the urban poor more vulnerable and worse off than their rural counterpart. Many components of the National Rural Health Mission cover urban areas as well. These include funding support for the Urban Health and Family Welfare Centres and Urban Health Posts, funding of National Health Programmes like TB, immunization, malaria, etc., urban health component of the Reproductive and Child Health Programme including support for Janani Suraksha Yojana in urban areas, strengthening of health infrastructure like District and Block level Hospitals, Maternity Centres under the National Rural Health Mission, etc. The only limitation has been the fact that norms for urban area primary health infrastructure were not part of the NRHM proposal, setting a limit to support for basic health infrastructure in urban areas, under the NRHM. Municipal Corporations,

Municipalities, Notified Area Committees and Nagar (Town) Panchayats were not units of planning under NRHM, with their own distinctive normative framework.

1.4 The urban poor suffer from poor health status. As per NFHS III (2005-06) data under 5 Mortality Rate (U5MR) among the urban poor at 72.7, is significantly higher than the urban average of 51.9, More than 46% of urban poor children are underweight and almost 60% of urban poor children miss total immunization before completing 1 year. Poor environmental condition in the slums along with high population density makes them vulnerable to lung diseases like Asthma, Tuberculosis (TB) etc. Slums also have a high-incidence of vector borne diseases (VBDs) and cases of malaria among the urban poor are twice as high as other urbanites.

1.5 In order to effectively address the health concerns of the urban poor population, the Ministry proposes to launch a National Urban Health Mission (NUHM). The Mission Steering Group of the NRHM will be expanded to work as the apex body for NUHM also. Every Municipal Corporation, Municipality, Notified Area Committee, and Town Panchayat will become a unit of planning with its own approved broad norms for setting up of health facilities. The separate plans for Notified Area Committees, Town Panchayats and

Municipalities will be part of the District Health Action Plan drawn up for NUHM. The Municipal Corporations will have a separate plan of action as per broad norms for urban areas. The existing structures and mechanisms of governance under NRHM will be suitably adapted to fulfill the needs of NUHM also.

1.6 The planning process as per broad approved norms for urban areas will be started in all Municipal Corporations, Municipalities, NACs and Town Panchayats in the current financial year. The District Health Society will function as the coordinating body at the district level for urban health also. Urban Health Mission will be implemented through the Health Department in the urban local bodies except the very large ones where in the view of the State Government this can be handed over to the Municipal Corporation or any other urban local body. In such cases, a society will be formed and registered in the concerned urban body for implementing urban health activities, which will receive funds from the State Health Society. SHS and the society formed in the designated urban local body will enter into a bipartite MOU regarding the implementation of NUHM and periodical reporting and review of the progress.

1.7 The treatment of seven metropolitan cities, viz., Mumbai, New Delhi, Chennai, Kolkata, Hyderabad, Bengaluru and Ahmedabad will be different. These cities are expected to manage the NUHM through their Municipal Corporations directly. Funds will be transferred to them through the State Health Society on the basis of their PIPs approved by the GoI.

1.8 Planning process in urban areas will be more complex as in many cases capacity building for public health activities needs to be taken up in urban local bodies. Also, the possibility of seeking partnerships with the non-governmental sector needs to be explored very closely as urban areas have the advantage of large scale presence of non-governmental providers of health care. The planning process will also have to undertake large scale community level activities. The identification and involvement of Non-Governmental organizations in community processes will have to be developed in the preparatory planning process itself. The initiatives under the National Urban Health Mission will seek to strengthen the public health thrust in urban local bodies, besides providing for cost of health care for the urban poor. The focus of the National Urban Health Mission will clearly be on alleviating the distress and duress of the urban poor in

seeking quality health services.

1.9 Thus during the Mission period all 779 cities with a population of above fifty thousand and all the district and state headquarters (irrespective of the population size) would be covered. This will be in partnership with the NRHM's efforts so far to ensure that there is no duplication of services. Urban areas with population less than 50,000 will be covered through the health facilities established under the National Rural Health Mission (NRHM).

1.10 The NUHM would have high focus on:

1.10.1 Urban Poor Population living in listed and unlisted slums

1.10.2 All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, and other temporary migrants.

- Public health thrust on sanitation, clean drinking water, vector control, etc.

- Strengthening public health capacity of urban local bodies.

1.11 The National Urban Health Mission therefore aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. This will be done in a manner to ensure that well identified facilities are set up for each segment of target population, which can be accessed conveniently. Partnerships with all efforts made for community

buildings under various urban area programmes will be accessed to ensure full utilization of created infrastructure. Similarly, the communitisation process will draw heavily on the existing community organizations and self – help groups developed through other initiatives.

1.12 Acknowledging the diversity of the available facilities in the cities, flexible city specific models led by the urban local bodies would be needed. The NUHM will leverage the institutional structures of NRHM for administration and operationalisation of the Mission. It will also establish synergies with other

programmes with similar objectives like JnNURM, SJSRY, and ICDS to optimize the outcomes.

1.13 The National Urban Health Mission will provide flexibility to the States to choose which model suits the needs and capacities of the states to best address the healthcare needs of the urban poor. Models will be decided through community led action. For strengthening the extant primary public health systems, NUHM based on the key characteristics of the existing urban health delivery system proposes a broad framework rationalizing the available manpower and resources, improving access through a communitised risk pooling mechanism and enhance participation of the community in planning and management of the health care service delivery by ensuring a community link volunteer (Accredited Social Health Activist-ASHA/Link Workers from other programs like JnNURM, ICDS etc.) and establishment of Rogi Kalyan Samitis (RKS), ensuring effective participation of urban local bodies and their capacity building along with key stakeholders, and by making special provision for inclusion of the most vulnerable amongst the poor, development of e-enabled monitoring system. The quality of the services provided will be constantly monitored for improvement (IPHS/ Revised IPHS for Urban areas etc.).

1.14 All the services delivered under the urban health delivery system through the Urban-PHCs and Urban-CHCs will be universal in nature, whereas the outreach services will be targeted to the target groups (slum dwellers and other vulnerable groups). Unlike rural areas, Sub-centres will not be set up in the urban areas as distances and mode of transportation are much better here. Outreach services will be provided through the Female Health Workers (FHWs), essentially ANMs with an induction training of three to six months, who will be headquartered at the Urban PHCs. These ANMs will report at the U-PHC and then move to their respective areas for outreach services (including school health) on designated days. They will be provided mobility support for providing outreach services. On other days, they will conduct Immunization and ANC clinics etc. at the U-PHC itself.

1.15 Empowerment of community through awareness generation, whereby they are able to demand services from the Health System will be an important area of emphasis in the NUHM. An effort to ensure a change in the health seeking behavior of the community where they get into the habit of accessing the

health facilities rather than expecting everything at their doorsteps will be made.

Diagram: Urban Health Care Delivery Model

1.16 The NUHM would encourage the effective participation of the community in planning and management of health care services. It would promote a community health volunteer - Accredited Social Health Activist (ASHA) or Link Worker (LW) in urban poor settlements (one ASHA for 1000-2500 urban poor population covering about 200 to 500 households); ensure the participation by creation of community based institutions like Mahila Arogya Samiti (50-100 households) and Rogi Kalyan Samitis. However, the States will have the flexibility to take the work of motivating community from the Mahila Arogya Samitis (MAS) and in that case recruiting an ASHA may not be necessary. The performance-based incentives can be credited to the account of MAS in that case, which can be used to enhance the revolving fund or distributing some honorarium to the most active members. Existing women groups under the JnNURM etc. and other like structures can be adopted for implementation of NUHM. Self-help groups of women made under programmes of urban development department etc. can also play the role of MAS.

1.17 NUHM would proactively reach out to urban poor settlements by way of regular outreach sessions and monthly health, sanitation and nutrition day. States would be encouraged to involve NGOs to facilitate communitization process, build the capacity of ASHA and MAS and carryout IEC/BCC activities. It mandates special attention for reaching out to other vulnerable sections like construction workers, rag pickers, sex workers, brick kiln workers, rickshaw pullers and street children. This could be done through the public healthcare systems or through PPP or other innovative models deemed suitable by the states. ANM will also be provided with mobility support to reach out the un-reached area and vulnerable population with outreach session. Communication facility in the form of Closed User Group (CUG) will be made available.

1.18 The NUHM would provide annual grant of Rs.5000 to the MAS every year. This amount can be used for conducting fortnightly/monthly meetings of MAS, sanitation and hygiene, meeting emergency health needs etc. To build the

capacity of MAS quarterly orientation workshops on the subject of the Group organization, governance and management of the group, Leadership skills etc. would be organized in the first year, and thereafter once a year.

1.19 In case, ASHA is recruited, she will be required to organize orientation meetings of the MAS or else, this work can be handed over to NGOs also.

1.20 The National Urban Health Mission would leverage as far as possible the institutional structures of the NRHM at the National, State and District level for operationalisation of the NUHM. However, in order to provide dedicated focus to issues relating to Urban Health the institutional mechanism under the NRHM at various levels would be strengthened for NUHM implementation.

1.21 The National Urban Health Mission would promote the role of the urban local bodies in the planning and management of the urban health programmes. The NUHM would also incorporate and promote transparency and accountability by incorporating elements like health service delivery charter, health service guarantee, concurrent audit at the levels of funds release and utilization.

1.22 NUHM would aim to provide a system for convergence of all communicable and non-communicable disease programmes including HIV/AIDS through integrated planning at the City level. The objective would be to enhance the utilization of the

system through the convergence mechanism, through provision of a common platform and availability of all services at one point (U-PHC) and through mechanisms of referrals. The existing IDSP structure would be leveraged for improved surveillance. The management, control and supervision systems however would vest within the respective divisions but urban component /funds within the programmes would be identified and all services will be sought to be converged /located at U-PHC level. Appropriate convergences and mechanisms for co-locations and strengthening would be sought with the existing systems of AYUSH at the time of operationalisation. ***NUHM will not provide for contractual staff of AYUSH as is the case with NRHM.***

1.23 NUHM will specifically address the peculiarities of urban health needs, which constitutes non-communicable diseases (NCDs) as a major proportion of

the burden of disease. The primary health care system being envisaged under NUHM will screen, diagnose and refer the cases of chronic diseases to the secondary and tertiary level through a system of referral. Hence, strengthening of healthcare facilities in secondary and tertiary care also needs substantial upgradation.

1.24 The effective implementation of the above strategies would require skilled manpower and technical support at all levels. Hence the National Urban Health Mission would ensure additional managerial and financial resources at all levels.

1.25 The urban areas need a thrust on enhancing public health capacity of urban local bodies. The NUHM will systematically work towards meeting the regulatory, reformatory, and developmental public health priorities of urban local bodies. It will promote convergent and community action in partnership with all other urban area initiatives. Vector control, environmental health, water, sanitation, housing, all require a public health thrust. NUHM will provide resources that enable communitization of such processes. It will provide resources that strengthen the capacity of urban local bodies to meet public health challenges.

Urban Health Care Facilities

States/ UTs wise Urban and Slum Population in India 2001

S. No.	India/States/ UTs	Number of cities/ towns reporting slums	Total urban population	Population of cities/ towns reporting slums	Total Slum Population	Percentage of slum population to total	
						Urban Population	Population of cities/ towns reporting slums
	1	2	3	4	5	6	7
	India	**640**	**283,741,818**	**184,352,421**	**42,578,150**	**15.0**	**23.1**
1	Andhra Pradesh	77	20,808,940	16,090,585	5,187,493	24.9	32.2
2	Assam	7	3,439,240	1,371,881	82,289	2.4	6
3	Bihar	23	8,681,800	4,814,512	531,481	6.1	11
4	Chattisgarh	12	4,185,747	2,604,933	817,908	19.5	31.4
5	Goa	2	670,577	175,536	14,482	2.2	8.3
6	Gujarat	41	18,930,250	12,697,360	1,866,797	9.9	14.7
7	Haryana	22	6,115,304	4,296,670	1,420,407	23.2	33.1
8	Jammu & Kashmir	5	2,516,638	1,446,148	268,513	10.7	18.6
9	Jharkhand	11	5,993,741	2,422,943	301,569	5	12.4
10	Karnataka	35	17,961,529	11,023,376	1,402,971	7.8	12.7
11	Kerala	13	8,266,925	3,196,622	64,556	0.8	2
12	Madhya Pradesh	43	15,967,145	9,599,007	2,417,091	15.5	25.2
13	Maharashtra	61	41,100,980	33,635,219	11,202,762	27.3	33.3
14	Meghalaya	1	454,111	132,867	86,304	19	65
15	Orissa	15	5,517,238	2,838,014	629,999	11.4	22.2
16	Punjab	27	8,262,511	5,660,268	1,159,561	14	20.5
17	Rajasthan	26	13,214,375	7,668,508	1,294,106	9.8	16.9
18	Tamil Nadu	63	27,483,998	14,337,225	2,866,893	10.4	20
19	Tripura	1	545,750	189,998	29,949	5.5	15.8
20	Uttar Pradesh	69	34,539,582	21,256,870	4,395,276	12.7	20.7

21	Uttarakhand	6	2,179,074	1,010,188	195,470	9	19.3
22	West Bengal	59	22,427,251	15,184,596	4,115,980	18.4	27.1
23	A&N Island	1	116,198	99,984	16,244	14	16.2
24	Chandigarh	1	808,515	808,515	107,125	13.2	13.2
25	Delhi	16	12,905,780	11,277,586	2,029,755	15.7	18
26	Pondicherry	3	648,619	513,010	73,169	11.3	14.3

2 - THE URBAN HEALTH CONTEXT – A SITUATION ANALYSIS

Table 2.1: THE URBAN CONTEXT

Census 2001	**28.6 Crore in urban areas** **4.26 Crore people in slums**	**430 towns with 1,00,000 and more population**
Projected figures	**35.7 Crore urban population in 2011** **43.2 Crore urban population in 2021** **7.66 Crore urban slum population in 2011**	**46% population will be urban by 2030** **Growth of urban population is double of rural population**

Table 2.2: ANNUAL POPULATION GROWTH RATE

ALL INDIA	**2%**
URBAN INDIA	**3%**
MEGA CITIES	**4%**
SLUM POPULATION	**5-6%**

Table 2.3: URBAN AREAS COVERED UNDER N.U.H.M

TOWN PANCHAYATS
NOTIFIED AREA COMMITTEES
MUNICIPALITIES
MUNICIPAL CORPORATIONS

Table 2.4: CITIES COVERED UNDER N.U.H.M

MEGA CITIES	**7 – GREATER MUMBAI, KOLKATA, DELHI, CHENNAI, BENGALURU, HYDERABAD, AHMEDABAD**
MILLION PLUS CITIES	**40**
CITIES WITH POPULATION BETWEEN 1-10 LAKHS	**552**
CITIES WITH POPULATION BETWEEN 50,000 TO 1 LAKH	**604**

* The number of cities has been estimated based upon projections using the Census 2001 data.

Box 2.1: HEALTH CONDITION OF THE URBAN POOR

- U5MR of 72.7 against urban average of 51.9
- 46% under- weight children among urban poor – urban average – 32.8%
- 46.8% women with no education; urban average 19.3%
- 44.4% institutional deliveries; urban average – 67.5%
- 71.4% anaemic among urban poor; urban average – 62.9%
- 18.5% urban poor have access to piped water supply; urban average – 50%
- 60% miss total immunization before completing one year.
- Poor environmental condition with high population density – lung diseases, TB, etc.
- Poor access to safe water and sanitation – water-borne diseases, diarrhoea, dysentery
- High incidence of vector borne diseases among urban poor

Table 2.5: Cause of Death in Rural & Urban Areas

Rank	Cause of Death	Male	Female	Pers
	Rural Area			
1	Cardiovascular diseases	18.2	15.1	16
2	COPD, asthma, other respiratory diseases	9.5	8.3	9
3	Diarrheal diseases	7.3	10.7	8
4	Perinatal conditions	6.9	6.7	6
5	Respiratory infections	6.0	7.6	6
6	Tuberculosis	7.3	4.7	6
7	Malignant and other neoplasms	5.0	5.6	5
8	Senility	4.1	6.3	5
9	Unintentional injuries: Other	5.4	4.5	5
10	Symptoms signs and ill-defined conditions	4.7	5.1	4
	Urban Area			
1	Cardiovascular diseases	30.3	26.3	28
2	Malignant and other neoplasms	7.5	8.5	7
3	COPD, asthma, other respiratory diseases	8.1	6.7	7
4	Tuberculosis	5.9	4.5	5
5	Senility	3.4	7.4	5
6	Diarrheal diseases	3.9	6.1	4
7	Unintentional injuries: Other	4.1	4.7	4
8	Symptoms signs and ill-defined conditions	4.0	4.6	4
9	Digestive diseases	5.0	2.5	3
10	Respiratory infections	3.0	4.5	3

Source: Report on Causes of Deaths in India (2001-2003), based on SRS, RGI, India

Table 2.6: Age-wise causes of Death (%), Urban India

	0-4 years	5-14 years	15-24 years	25-69 years	70+ years
Cardiovascular Diseases	---	---	7.6	32.8	34.7
Malignant and other neoplasms	---	3.8	5.3	11.3	5.6
COPD, Asthma and other respiratory diseases	---	---	---	7.7	10.6
Tuberculosis	---	---	8.1	7.7	2.9
Senility	---	---	---	---	14.3
Diarrheal diseases	13.2	17.4	---	---	5
Unintentional injuries: Other	3.1	14.7	11.2	3.6	4.5
Symptoms signs and ill-defined conditions	3.6	5.9	8.4	4.3	3.8
Digestive diseases		3.5		5.8	---
Respiratory infections	19.5	8.3	---	---	---

Perinatal Conditions	**35.7**	**---**	**---**	**---**	**---**
Other infectious and parasitic diseases	**8.8**	**12.4**	**4.3**	**---**	**---**
Congenital anomalies	**5.2**	**---**	**---**	**---**	**---**
Nutritional deficiencies	**3.1**	**---**	**---**	**---**	**---**
Malaria	**1.2**	**5.9**	**3.5**	**---**	**---**
Fever of Unknown origin	**1.2**	**---**	**---**	**---**	**---**
Motor Vehicle Accidents	**---**	**4.4**	**11.8**	**3.7**	**---**
Intentional self harm	**---**	**3.2**	**13.1**	**---**	**---**
Maternal Conditions	**---**	**---**	**3.7**	**---**	**---**
Genito-Urinary diseases	**---**	**---**	**---**	**3.3**	**2.8**
Diabetes Mellitus	**---**	**---**	**---**	**2.8**	**3.4**

Source: Report on Causes of Deaths in India (2001-2003), based on SRS, RGI, India

Table 2.7: STATES WITH HIGHEST AND LOWEST RATES OF URBAN POVERTY

HIGHEST RATES OF URBAN POVERTY	LOWEST RATES OF URBAN POVERTY
BIHAR – 43.7%	NAGALAND – 4.3%
ORISSA – 37.6%	HIMACHAL PRADESH- 4.6%
MADHYA PRDESH-35.1%	MIZORAM – 7.9%
UTTAR PRADESH- 34.1%	PUDUCHERRY – 9.9%

*Source; Expert group – Planning Commission- 2009.

Box 2.2: Findings of some studies regarding urban areas

- The estimated prevalence of coronary heart disease is around 3-4% in rural areas and 8-10% in urban areas among adults older than 20 years, representing a twofold rise in rural areas and a six fold rise in urban areas over the past four decades. [Responding to the threat of chronic diseases in India: K. Srinath Reddy, Bela Shah, Cherian Varghese, Ambumani Ramadoss, The Lancet, October 2005];

- The age adjusted incidence rates in men vary from 44 per 100000 in rural Maharashtra to 121 per 100,000 in Delhi [National Cancer Registry Programme of ICMR];

- Prevalence of diabetes in adults estimated to be 3.8% in rural areas and 11.8% in urban areas [ICMR – Recent surveys];

- Prevalence of hypertension has been reported to range between 20-40% in urban adults and 12-17% among rural adults [Lancet 2005; Global burden of hypertension – Analysis of world wide data];

- 66.6 lakh cases of Asthma in urban areas in India in 2011 – to rise to 73.2 lakhs cases to 2016;

- Dental caries more prevalent in urban areas;

- Higher rates of traffic accidents in urban areas;

- Higher rates of domestic violence in cities;

- High incidence of mental health cases [Reddy and Chandra Shekhar 1998];

- Drugs, Tobacco and alcohol abuse in urban areas

Box 2.3: Current status of the private sector in India

The private sector consists largely of sole practitioners or small nursing homes having 1-20 beds, serving an urban and semi-urban clientele and focused on curative care.

A survey of the qualified provider markets in eight middle-ranging districts: Khammam (AP), Nadia (WB), Jalna (MH), Kozhikode (Kerala), Ujjain (MP), Udaipur (RJ), Vaishali (BH) and Varanasi (UP) showed (National Commission on Macro Economics and Health; 2005):

1. A highly skewed distribution of resources — 88% of towns have a facility compared to 24% in rural areas, with 90% of the facilities manned by sole practitioners.

2. The private sector has 75% of specialists and 85% of technology in their facilities.

3. The private sector account for 49% beds and an occupancy ratio of 44% whereas the occupancy rate is 62% in the public sector.

4. 75% of service delivery for dental health, mental health, orthopedics, vascular and cancer diseases and about 40% of communicable diseases and deliveries are provided by the private sector.

An overview of the private sector:

1. Serious supply gaps and distributional inequities;

2. Need for uniform standards and treatment protocols;

3. Need for cost controls and quality assurance mechanisms;

4. Regulations to protect consumer interests and enforcement systems;

5. Supporting the NGO/charitable or the third sector, which has the capability to provide reasonable quality care at affordable rates and the potential to serve the poor in under-served areas if appropriately incentivized and supported.

2.1 Expenditure on Health Care

2.1.1 As per consumer expenditure data, households spend 5-6% of their total expenditure and 11% of non-food consumption expenditure on health. Data also show an increasing growth rate of 14% per annum in household health spending. It may be noted that almost half the spending was just on outpatient care.

2.1.2 There are wide variations in household spending across states. While Kerala spends an average of Rs. 2548 (2004-05 current prices) per capita per annum, households in Bihar, one of the poorest and most backward state spent Rs. 1021 per capita per annum accounting for 90% of the total health expenditure in the state during the year 2004-05.

2.1.3 A survey of households conducted by the IIHMR, Jaipur (IIHMR 2000) showed that a married woman in the age group of 15-49 years spent an average of Rs 400 for RCH services (amounting to 10 days wage), with urban households spending Rs 604 and rural households about Rs 292. The study also showed that the reluctance of women for institutional deliveries and the persistently high proportion of domiciliary deliveries is driven by cost factors : delivery in a public hospital costs an average of Rs 601, private hospital about Rs 3593, while home only Rs 93. The major item of expenditure was also found to be drugs, which constituted 62%.

2.1.4 Drugs are one of the three cost drivers of the health care system. On the demand side, drugs and medicines form a substantial portion of the out-of-pocket (OOP) spending on health by households in India. Estimates from the

National Sample Survey (NSS) for the year 1999-2000 suggest that about half of the total OOP expenditure is on drugs. In rural India, the share of drugs in the total OOP is estimated to account for nearly 83%, while in urban India, it is 77%. The share of drugs in the total inpatient treatment in rural and urban India is around 56% and 47%, respectively for the same period.

2.2 The Urban Poor and the Private Health Sector

2.2.1 The burgeoning 80 million urban poor in India struggle for basic services like housing, water and sanitation. The links between these contextual forces and health outcomes is manifest not only in the striking differentials in health among urban poor and non-poor groups but in health indicators of the urban poor which are comparable to, and in many cases, worse off than, the poor living in rural areas of the country. Despite the presence of a vast public health network, in the absence of urban primary health care services, the private sector assumes prominence in the health seeking behaviour of this sub-population. One of the largest private healthcare sectors in the world, it encompasses a wide range of players.

2.2.2. The private sector that the poor access may be thought of consisting of three wings:

2.2.2.1 the fully-organized-and-fully qualified;

2.2.2.2 the fully qualified private providers that operate in less than well to do neighbourhoods where the slum population too go; and

2.2.2.3 the 'less-than-fully-qualified' practitioners in the slum.

2.2.3 The last group comprises practitioners who are either untrained or

minimally trained in any system of medicine or trained in one system and practice another. It is estimated that these untrained, unlicensed practitioners in the country outnumber qualified medical doctors by at least 10:1.

2.2.4 Although a large majority of them operate in rural areas, urban areas too are witnessing increasing numbers of these untrained practitioners as we see in the report. [Health of the Urban Poor and Role of Private Practitioners: The Case of a Slum in Delhi – Nupur Barua, Jens Seeberg, Chandrakant S. Pandav, Centre for Community Medicine, AIIMS in collaboration with ICCIDD, New Delhi, 2009]

2.3 Public Sector Provisioning for health care in urban areas

2.3.1 While the Constitution mandates the role of urban local bodies in the management of primary health care, there are a variety of models in the country today. Teams from the Ministry were sent to a diversity of States and urban situations to understand the management of health care in urban areas at present. The Table below captures the key findings.

2.4 City wise description of health care system

Group	Cities	Type of Health care System of the ULBs	Gaps and Constraints

A	IPP CITIES Mumbai, Bengaluru, Hyderabad Delhi, Kolkatta, Chennai	Three tier structure comprising of UHP/ UFWC and Dispensary/ Maternity Homes/ and Tertiary / Super-speciality Hospitals. Community level volunteers. Presence of vast network of private providers /NGOs and Charitable trusts	Inequitable spatial distribution of facilities with multiple service providers Unsuitable timings and distance from urban poor areas, Overload on tertiary institutions and under utilized primary institutions primarily due to weak referral system. Non integrated service delivery with focus mostly on RCH activities, very few lab facilities, shortage of medicines, drugs, equipment, limited capacity of health care professionals and demotivation. Skewed priority to the tertiary sector by the ULBs, High turnover of medical professionals, issues of career progression, incentives and salaries, disconnect between doctors on deputation and municipal doctors Limited community linkages and outreach Limited identification of the urban poor for health In many instances the first interface is with non qualified medical practitioners

B	Surat, Thane, Ahmedabad	UHP/UFWCs, Dispensary / Maternity Homes / Tertiary Hospitals.	The Health care delivery infrastructure is better planned and managed due to personal initiative of the ULBs. However the aforesaid constraints remain.
C	Agra Indore Patna Chengelpet Madhyamgram , Bhubaneswar, Udaipur, Jabalpur, Cuttack, Guwahati, Raipur	UHP/UFWC / a few Maternity Homes Presence of private providers Few NGOs and Charitable trusts	Dependent on State support for health activities in the cities Weak fiscal capacity of the ULBs to plan for urban health. Health low on priority of ULBs except in Madhyamgram Poor availability of doctors and staff in facilities. Few found relocated to secondary and tertiary facilities. Poor state of infrastructure in the facilities
D	Ranchi,	UFWC/ UHP Large presence of Charitable and NGOs	Non-existent urban local body Limited State level initiatives

2.5 Central Assistance for primary health care

2.5.1 The process of developing a health care delivery system in urban areas has not as yet received the desired attention. The Tenth Plan Document observes

that 'unlike the rural health services there have been no efforts to provide well-planned and organized primary, secondary and tertiary care services in geographically delineated urban areas. As a result, in many areas primary health facilities are not available; some of the existing institutions are underutilized while there is over-crowding in most of the secondary and tertiary centres'.

- The Government of India in the First Five Year Plan established 126 urban clinics of four types to strengthen the delivery of Family Welfare services in urban areas. In 1976 these were reorganized into three types by the Department with a staffing pattern as indicated in the table below; at present there are 1083 centres functioning in various states and UTs. An amount of Rs. 520.40 crores has been proposed in the XIth Plan for sustaining the already ongoing activities and payments for heads like salary.

Table 2.8: Types of Urban Family Welfare Centres (UFWC)

Category	Number	Popn. Covered (in '000)	UFWC Staffing Pattern
Type I	326	10-25	ANM (1) / FP Field Worker Male (1)
Type II	125	25-50	FP Ext. Edu./LHV (1) in addition to the above
Type III	632	Above 50	MO – Preferable Female (1), ANM and Store Keeper cum Clerk (1)
TOTAL	1083		

Source: MOHFW, GOI: Annual Report on Special Schemes, 2000

- On the recommendations of the Krishnan Committee, under the Revamping scheme in 1983, the Government established four types of Urban Health Posts (UHP) in 10 States and Union Territories with a precondition of locating them in

slums or in the vicinity of slums. The main functions of the UHPs are to provide outreach, primary health care, and family welfare and MCH services. The table below details the manpower along with the population coverage of health posts. At present there are 871 health posts in various states and UTs, functioning not very satisfactorily. An amount of Rs. 438.44 crore has been proposed in the XIth Plan for sustaining the already ongoing activities and payments for heads like salary.

Table 2.9: Types of Urban Health Posts (UHP)

Category	Number	Population covered	Staffing Pattern
Type A	65	Less than 5000	ANM (1)
Type B	76	5,000 – 10,000	ANM (1), Multiple Worker – Male (1)
Type C	165	10,000 – 20,000	ANM (2), Multiple Worker – Male (2)
Type D	565	25,000 – 50,000	Lady MO (1), PHN (1), ANM (3-4) Multiple Worker – Male (3-4), Class-IV Women (1)
TOTAL	871		

Source: MOHFW, GOI: Annual Report on Special Schemes, 2000

2.5.4 The Indian Institute of Population Studies (IIPS) undertook an evaluation of the functioning of UHP and UFWCs and came out with the following findings, as shown in box below:

Box 2.4: IIPS evaluation of the UFWC and UHP scheme: Key findings

- In terms of functioning, 497 (30%) UHPs and UFWCs were ranked good, 540 (35%) were average and 492(32%) as below average or poor.
- Weak Referral Mechanism
- Provision of only RCH services
- Inadequate trained staff
- In 30% of the facilities the sanctioned post of Medical Officer is vacant/ others mostly relocated.
- Lack of equipments, medicines and other related supplies
- Unequal distribution of facilities among states e.g. in Bihar one centre covers 1, 10,000 urban poor while in Rajasthan average population coverage is 5535.
- Irregular and insufficient outreach activities by health workers

2.5.5 The implementation mechanism of most of the programmes except for the UFWC and UHP schemes of GOI is through the district institutional and planning mechanism. Therefore resources get disaggregated in terms of districts and not cities. Implementation in cities thus appears to be fragmented and patchy. As such the

absence of institutional/ planning mechanisms in cities therefore restricts institutionalized access of the urban poor to the programmes.

2.6 The India Population Project (IPP) V and VIII

2.6.1 Due to rapid growth of urban population, efforts were made in the metropolitan cities of Chennai, Bengaluru, Kolkata, Hyderabad, Delhi and Mumbai for improving the health care delivery in the urban areas through World Bank supported India Population Projects (IPP). Under the program 479 Urban Health Posts , 85 Maternity Homes and 244 Sub Centers were created, in Mumbai & Chennai as part of IPP V and in Delhi, Bengaluru, Hyderabad and Kolkata as part of IPP VIII.

2.6.2 These, to a limited extent, resulted in enhanced service delivery and also

better capacity of urban local bodies to plan and manage the urban health programmes in these cities. They are presently however, facing shortage of manpower and resources. An examination of extended IPP VIII project in Khammam town of Andhra Pradesh has also identified management issues like lack of financial flexibility/ long term financial sustainability, and lack of need based management models as constraints which need to be redressed in any urban health initiative.

2.7 Key characteristics of the extant situation

2.7.1 THE DIVERSITY OF THE URBAN SITUATION

2.7.1.1 The urban health situation in the cities is characterized by marked diversities in the organization of health delivery system in terms of provisioning of health care services, management, availability of private providers, finances etc. In cities like Mumbai, Kolkata, Chennai, Bengaluru, Ahmedabad, etc, it is primarily the urban local bodies (ULBs) in line with the mandate of the 74th Amendment, which are managing the primary health care services. However in many cities like Delhi, along with the urban local body i.e. the Municipal Corporation of Delhi (MCD), New Delhi Municipal Corporation (NDMC), Delhi Cantonment Board and other parastatal agencies along with the State Government jointly provide primary health care services. In cities like Patna, Ranchi, Agra, Bhopal, Meerut, Indore, Guwahati despite the presence of ULBs, the provision of primary health services still vests with the State Government through its district structures.

Box 2.5: STUDY IN CONTRAST: BRIHAN MUMBAI MUNICIPAL CORPORATION AND MIRA BYANDAR MUNICIPAL CORPORATION IN MAHARASHTRA*

The Brihan Mumbai Municipal Corporation (BMC), with a population of 1.19 crore (2001) and a slum population of about 60 lakh, is the largest Municipal Corporation in India, and a major provider of public health-care services at Mumbai. It has a network of teaching hospitals, Municipal General Hospitals and Maternity Homes across Mumbai. Apart from these there are Municipal Dispensaries and Health Posts to provide outpatient care services and promote public health activities in the city. However, Mira Byandar Corporation at the outskirts of Mumbai city and growing at a decadal growth rate of 196% from 1991-2001(from 1.75lakh to 5.20 lakh) with 40% slum population has only first tier structures, namely 7 Urban Health Posts and 2 PHCs(to be shortly transferred from the Zilla Parishad) , in the government system. However as informed there are approximately 1000 beds in the private sector in this city.

On the one hand there is a BMC with a 900 crore health budget (9% of total BMC Budget of which 300 crore is on medical education), many times the health budget of a some of the smaller states, and on the other, there is another Corporation still struggling to emerge from the rural - urban continuum. While ADC heading the health division of BMC is a very senior civil servant, the Chief Health Officer of Mira Byandar Corporation is a recently regularized doctor with around three years experience in the Corporation.

For the ADC of BMC, major health areas requiring policy attention apart from financial assistance from the Centre relate to guidelines for system improvement for health delivery esp. vis a vis issues of Town Planning, land ownership, governance, recruitment structures, reservation policies, migrants, instability of slums, high turnover of workforce in Corporations which often come in the way of providing health care to the poor along with the challenge of getting skilled human resources, which despite repeated advertisements still remain vacant in BMC. There are 8-9% vacancies in the municipal cadres of ANM.

The chief concern of the Mira Byandar Corporation on the other hand is to construct a 200 bedded Hospital, as a Municipal Hospital offers high visibility and also because the poor find it difficult to access the private facility due to high cost of services and therefore are referred to Mumbai which is 40 km away.

** Observations on field visit to cities in September 2007 for stakeholder consultation by officials of MoHFW*

2.7.2 WEAK CAPACITY OF URBAN LOCAL BODIES TO MANAGE PRIMARY HEALTH CARE

2.7.2.1 Two models of service delivery are seen to be prevalent in urban areas. In states like Uttar Pradesh, Bihar and Madhya Pradesh health care programmes are being planned and managed by the State government; the involvement of the urban local bodies is limited to the provisioning of public health initiatives like sanitation, conservancy, provision of potable water and fogging for malaria. In other states like Karnataka, West Bengal, Tamil Nadu and Gujarat the health care programmes are being primarily planned and managed by the urban local bodies. In some of the bigger Municipal bodies like Ahmedabad, Chennai, Surat, Delhi and Mumbai the Medical/Health officers are employed by the local body whereas in smaller bodies, health officers are mostly on deputation from the State health department. Though bigger corporations demonstrate higher capacity to manage their health programmes, there is still scope to further build their capacity. During consultations, officers of even large corporations like Mumbai mentioned that large numbers of urban poor remain underserved by health care. The situation in most cities also revealed that there was a lack of effective coordination among the departments that lead to inadequate focus on critical aspects of public health such as access to clean drinking water, environmental sanitation and nutrition.

2.7.2.2 Though bigger corporations demonstrate improved capacity to manage their heatlh programmes, there is still a need to build their capacity. The IPP VIII Project Completion Report (IPPCR) has also emphasized the capacity and commitment of political leadership as one of the critical factors for the efficacy of the health system. In Kolkata, strong political ownership by elected representatives has played a positive role in the smooth implementation of the project and sustainability of the reforms introduced. On the other hand, in Delhi, despite efforts by the project team, effective coordination between different agencies and levels could not develop a common understanding on improving service delivery and promoting initiatives crucial for sustainability. The experiences in

Hyderabad and Bengaluru were mixed, but mostly driven by a few committed individuals.

2.7.2.3 The situation in most cities also revealed that there was a lack of effective coordination among the departments that lead to inadequate focus on critical aspects of public health such as access to clean drinking water, environmental sanitation and nutrition.

2.7.3 DATA INADEQUACY IN PLANNING

2.7.3.1 Urban population, unlike the rural population, is highly heterogeneous. Most published data does not capture the heterogeneity, as the Standard of Living Index does often not disaggregate it. It therefore masks the health condition of the urban poor. The informal or often illegal status of low income urban clusters results in public authorities not having any mandate to collect data on urban poor population. This often reflects in health planning not being based on community needs. It was seen that mental health, which was an observable problem of the urban slums, was not getting reflected in the city data profile. Most cities visited were found lacking in city-specific epidemiological data, inadequate information on the urban poor and illegal clusters, in-adequate information on existing health facilities esp. in the private sector. Data collection at the local /city level is therefore necessary to correctly comprehend the status of urban health and to assess the urban community needs for health care services.

2.7.4 MULTIPLICITY OF SERVICE PROVIDERS AND DYSFUNCTIONAL REFERRAL SYSTEMS

2.7.4.1 The multiplicity of service providers in the urban areas, with the ULBs and State Governments jointly provisioning even primary health care, has led to a dysfunctional referral system and a consequent overload on tertiary hospitals and underutilized primary health facilities. Even in states where ULBs manage primary health care with secondary and tertiary levels in the State domain, there are problems in referral management. Similar observations have also been made in IPP VIII

completion report which states that *multiplicity of agencies providing*

health services posed management and implementation problems in all project cities: In Delhi, there were coordination problems for health service among different agencies, such as Municipal Corporation of Delhi (MCD), New Delhi Municipal Corporation (NDMC), Delhi Cantonment Board, Delhi Jal Board (DJB), Delhi Government, and Employees State Insurance (ESI) Corporation. Similarly, in Hyderabad, coordination of the project with secondary and tertiary facilities under different managements constrained effective referral linkages. Bengaluru and Kolkata had fully dedicated maternity homes in adequate numbers that facilitated better follow-up care. However, even in these two places, linkages with district and tertiary hospitals, not under the control of the municipalities, remained weak.

2.7.5 WEAK COMMUNITY CAPACITY TO DEMAND AND ACCESS HEALTH CARE

2.7.5.1 Heterogeneity among slum dwellers due to in-migration from different areas, instability of slums, varied cultures, fewer extended family connections, and more women engaged in work, has led to lesser willingness and fewer occasions to build urban slum community as a strong collective unit, which is seen as one of the major public health challenges in improving access. Even the migratory nature of the population poses a problem in delivery of services. Similar concerns have also been raised in the IPP VIII completion report which states lack of homogeneity among slum residents, coming from neighboring states/countries to the large metropolitan cities, made planning and implementation of social mobilization activities very challenging.

2.7.6 STRENGTHENING COMMUNITY CAPACITY INCREASES UTILIZATION OF SERVICES

2.7.6.1 The Urban Health programmes in Indore and Agra have demonstrated that the process of strengthening community capacity either through Link worker or a Community Based Organization (CBO) helps in improving the utilization of services. The IPP VIII project has also

demonstrated that the use of female voluntary health workers viz. Link workers, B*asti Sewikas* etc. selected from the local community played an important role in extending outreach services to the door steps of the slums which helped in creating a demand base and ensuring people's satisfaction. It was also observed that the collective community efforts played an important role in improving access to drinking water, sanitation, nutrition services and livelihood.

2.7.6.2 During the field visits there was consensus during all discussions that some form of community linkage mechanism and collective community effort was an important strategy for improving health of the urban poor. However, this strategy also had to be area specific as it would succeed in stable slums and not where slums were temporary structures under constant threat of demolition.

2.7.7 LARGE PRESENCE OF FOR PROFIT AND NOT FOR PROFIT PRIVATE PROVIDERS

2.7.7.1 The urban areas are characterized by presence of large number of for profit/not for profit private providers. These providers are frequently visited by the urban poor for meeting their health needs. The first interface for OPD services for the urban poor in many cities visited was the private sector, chiefly due to inadequacy of infrastructure of the public system and inconvenient working hours of the facilities. Partnership with private/charitable/NGOs can help in expanding services as was evident in Agra where NGO managed health care facilities were reaching out to large un-served areas. Even in Bengaluru, the management of health facilities had been handed over to NGOs. In several IPP VIII cities partnerships with profit/not for profit providers has helped in expanding the services. Kolkata had the distinction of implementing the programme through establishment of an effective partnership with private medical officer and specialists on a part time basis, fees sharing basis in different health facilities resulting in ensuring community participation and enhancing the scope of fund generation. Andhra Pradesh has completely outsourced service delivery in the newly created 191 Urban Health Posts in 73 towns to NGOs. The experimentation, it appears, has been quite

satisfactory with reduced cost.

2.7.8 FOCUS ON RCH SERVICES AND INADEQUATE ATTENTION TO PUBLIC HEALTH

2.7.8.1 The existing health care service delivery mechanism is mostly focused on reproductive and child health services, while the recent outbreaks of Dengue and Chikungunya in urban areas and the poor health status of urban poor clearly articulate the need for a broad based public health programme focused on the urban poor. It stresses upon the need to effectively infuse public health focus along with curative services. The urban health programmes in Surat and Ahmedabad have been able to effectively integrate the two aspects. There is also need to integrate the implementation of the National programmes like National Vector Borne Disease Control Programme (NVBDCP), Revised National Tuberculosis Control Programme(RNTCP), Integrated Disease Surveillance Project (IDSP), National Leprosy Elimination Programme (NLEP) , National Mental Health Programme (NMHP), National Deafness Control Programme (NDCP) , National Tobacco Control Programme (NTCP)and other Communicable and Non communicable diseases for providing an effective urban health platform for the urban poor. The urban poor suffer an equally high burden of 'life style" associated diseases due to high intake of tobacco (both smoking and chewing) and alcohol. The limited income coupled with very high out-of-pocket expenditure on substance abuse creates a vicious cycle of poverty and disease. There is also the added burden of domestic violence and stress. Studies also indicate the need for early detection of hypertension in the urban poor, as it is a common cause of stroke and other cardio- neurological disorders.

2.7.8.2 The high incidence of communicable diseases emphasizes the need for strengthening the preventive and promotive aspects for improved health of urban poor. It also becomes critical that the outreach of services, which have an important bearing on health like safe drinking water, environmental sanitation, protection from pollutants, and nutrition services is improved.

2.7.9 LACK OF COMPREHENSIVE STRATEGY TO ENSURE EQUITABLE ACCESS TO THE MOST VULNERABLE SECTIONS

2.7.9.1 Though the urban health programmes have a mandate to provide outreach services as envisaged by the Krishnan Committee, at present very limited outreach activities were being undertaken by the ULBs. It is only the IPP cities, which were conducting some outreach activities as community Link workers were employed to strengthen demand and access. Limited outreach activities through provision of link volunteers under RCH were visible in Indore, Agra, Ahmedabad and Surat.

2.7.9.2 Another challenge facing the urban health programmes is inadequate methodology for identification of the most marginalized poor. None of the cities, except Thane, which had a scheme for rag pickers, had any operational strategy for the highly vulnerable section.

3 - KEY PUBLIC HEALTH CHALLENGES IN URBAN AREAS

3.1 A list of key public health challenges in urban areas and possible responses from the National Urban Health Mission is listed below:

Table 3.1: Public Health Challenges & Possible Responses

	KEY PUBLIC HEALTH CHALLENGES IN URBAN AREAS	**POSSIBLE RESPONSES UNDER THE NATIONAL URBAN HEALTH MISSION**

1.	Poor households not knowing where to go to meet health need	The biggest challenge is to connect every household to health facilities. The role of the slum level Community Worker (like the Honorary Health Worker in Kolkata slums) is a possible intervention. The Community Worker becomes the first point of contact for any health need. She has the authority to connect households to health facilities. A health facility or health personnel is responsible for a certain number of households.
2.	Weak and dysfunctional public system of outreach	A detailed review of the existing arrangements to identify the causes for dysfunctional/functional systems. The investments under NUHM could be to provide a responsive public system – service guarantees well defined and well recognized by all.

3.	Contaminated water, poor sanitation.	Work towards a possible public health bill that sets standards for provision of basic entitlements like water and sanitation facilities. Provide resources to communities to ensure action at their end to prevent contamination/ maintain cleanliness. Work with urban local bodies to increase access to functional toilets.
4.	Poor environmental health, poor housing	Work with urban local bodies to set standards for environmental sanitation, set up systems of waste disposal, basic housing systems, etc. Work towards a rights and entitlement based approach though a public health bill.
5.	Unregistered practitioners first point of contact – use of irrational and unethical medical practice	Develop systems of accrediting private not fully qualified practitioners if they do basic specially designed courses for them, which gives them some level of acceptable competence. Make them work under the supervision of government doctors. Special thrust on rational drug use and ethical practice. Making local practitioners do more of preventive and promotive health.

6.	Community organizations helpless in health matters	Establish vibrant community organizations at slum level, under the umbrella of the urban local body, wherever feasible. Co-opt community leaders like members of Self Help Groups, women's groups, etc. Provide untied grants to local community organizations to carry out community led action for public health. JNURM is providing the hardware but in the absence of effective community action, the hardware will be of little sustainable use. Community led action for public health encompassing all the wider determinants of health, is needed. (nutrition, water, sanitation, education, housing, women's empowerment, skill development, etc.).
7.	Weak public health planning capacity in urban local bodies	Re-orient existing staff of urban local bodies to understand public health challenges better.

8.	Large private sector but poor cannot access them	Develop systems of accrediting private practitioners for public health goals. These could be for a range of services. Need for transparency in developing protocols, and costs. Community organizations to exercise key role in roll-out of such partnerships. Non Governmental Organizations to build capacity in community organizations to handle such partnerships.
9.	Problems of targeting the poor on the basis of BPL card	Many urban poor households do not have BPL card. How to reach every poor household and provide special entitlements at public costs to them for secondary and tertiary care. It will not be possible to provide free cancer treatment for all. Naturally there is a need for identifying the poor. NUHM to develop criteria for such identification on the basis of a wider understanding of poverty as not only income or nutritional poverty.

10.	No convergence among wider determinants of health	Creating common institutional arrangements to ensure that the same community organization, under the umbrella of urban local body, is responsible for all the wider determinants – water, sanitation, nutrition, health care, education, skill development, housing, etc.
11.	No system of counseling and care for adolescents	Adolescents face multiple problems in urban areas. Need to mobilize local youth for community led public health action. Need to attend to special needs of adolescent girls to make them cope with physiological changes.
12.	Over congested secondary and tertiary facilities and under underutilized primary care facilities.	Need to generate awareness through MAS and community workers in every slum so that people know clearly where the house hold has to be sent. Need based referrals are the only way of decongesting.
13.	Problem of drug abuse and alcoholism	Urban life is demanding and leads to living with stress of all kinds. Problems of drugs and alcoholism, tobacco use, etc. need strong public health interventions.

14.	Many slums not having primary health care facility	Creating new public health infrastructure using community buildings, mobile medical units based on fixed schedules where infrastructure cannot be created.
15.	High incidence of domestic violence	Need for Counselors in Bastis to help in many behavior change and gender relation issues.
16.	Multiplicity of urban local bodies, State government, etc. management of health needs of urban people	Need for clarity of responsibilities for urban health. Setting up of an over-arching urban local body level health mission for convergent action.
17.	No norms for urban health facilities.	Need to develop clear norms for primary health care service guarantees for urban areas.
18.	No concerted campaigns for behavior change	Need for concerted campaigns for behavior change to enforce public health thrust. Problem of malaria, dengue, Chikanguniya in urban areas. Counseling services for well-being of households.
19.	Problems of unauthorized settlements	Developing health care facilities in the framework of law for such areas.

4 – DEFINING THE POOR IN URBAN AREAS

4.1 Targeting is a difficult process in informal economies. Income data is unreliable. Mere targeting by slum residence is also faulty as there are many slums that are not even notified. Targeting is needed, especially for secondary and tertiary care to all. It can be provided free only to those who cannot afford it otherwise. Primary health care through Urban PHCs will be universally available to all citizens residing in urban areas. Outreach services will be provided on a targeted basis for the slum and other vulnerable population.

4.2 How to define the urban poor? Considering that urban areas have a constant stream of migration, the process of issuing BPL cards does not keep pace with the migration of poor people from rural to urban areas, in search of a livelihood. As a consequence, many poor households are also not necessarily in slums. This means that mere spatial targeting will also not suffice.

4.3 This calls for a household survey through community organizations/ NGOs under the supervision of urban local bodies, to define the urban poor. This necessarily has to be through a communitized process and must also take note the vulnerability of the households in terms of the assets that it possesses. There will be a need to get away from mere income poverty or mere calorie based poverty line. The urban poor will have to be defined and selected based on a household survey through community validation and transparency. It has to take note of vulnerability in the context of urban life. It will also have to take note of assets possessed and state of access to basic public services.

4.4 The NUHM will make use of surveys of urban poor done under various government programmes. However, it will subject all such listings to a household survey and a public disclosure of names of households before the Mahila Arogya Samiti (MAS) or Ward level ULB unit.

5 - NUHM – GOALS, OBJECTIVES, STRATEGIES, OUTCOMES

5.1 GOAL

The National Urban Health Mission would aim to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies.

5.2 CORE STRATEGIES

The exigencies of the situation as detailed in the aforesaid chapters merit the consideration of the strategies given below. These strategies may be implemented mainly by strengthening the existing public health systems. In some big cities where credible private sector or other public sector exists, partnerships may be developed with them through (i) public private partnerships i.e. with private service providers or with NGOs/faith based organizations, and (ii) through public-public partnerships, i.e. partnership with Railways hospitals, ESIC, Public sector companies hospitals etc. An optimal mix of these strategies can be included in the existing planning and implementation framework of the state to augment the urban health care system. The decision as to which is the best mix for the state may be taken by the state in the best interests of the urban poor. In case of partnerships, clear guidelines as defined later should be in place with monitoring by the state.

- **Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing existing government primary urban health structure and designated referral facilities**

  5.2.1.1 The situational analysis has clearly revealed that most of the existing primary health facilities, namely, the Urban Health Posts (UHPs) /Urban Family Welfare Centres (UFWC)/ Dispensaries are functioning

sub- optimally due to problems of infrastructure, human resources, referrals, diagnostics, case load, spatial distribution, and inconvenient working hours. The NUHM therefore proposes to strengthen and revamp the existing facilities into an "Urban Primary Health Centre" with outreach and referral facilities, to be functional for every 50,000 population on an average. However, depending on the spatial distribution of the slum population, the population covered by a U-PHC may vary from 50000 for cities with sparse slum population to 75,000 for highly concentrated slums. The U-PHC may cater to a slum population between 25000-30000, providing preventive, promotive and non-domiciliary curative care (including consultation, basic lab diagnosis and dispensing). State/UT Governments will specify clearly the coverage of NUHM in terms of towns and cities based on 2011 census. The areas (including notified towns) not covered by NUHM, which would be covered by the NRHM may be clearly specified. The phasing of coverage across States and within States may be clearly indicated.

5.2.1.2 The NUHM would improve the efficiency of the existing system by making provision for a need based contractual human resource, equipments and drugs. Provision of Rogi Kalyan Samiti is also being made for promoting local action. To further strengthen the delivery of specialised OPD care, the cities, if need arises, can utilize the services of specialist on weekly basis. The provision of health care delivery with the help of outreach sessions in the slums would also strengthen the delivery of health care services. On the basis of the GIS map the referrals would also be clearly defined and communicated to the community thus facilitating their easy access.

5.2.1.3 The eligibility criterion for resource support under the Mission however would be rationalization of the existing public health care facilities and human resources in addition to mapping of unlisted slums and clusters.

5.2.1.4 The existing UHP/ UFWCs are already being supported through planned grant. With the launching of NUHM, all of these existing programmes/schemes will automatically cease to exist. Hence all the existing staff in this scheme (Urban Health Posts, Urban Family Welfare

Centers) should be rationalized.

5.2.1.5 Based on GIS mapping, the cities would identify existing public sector health facilities to act as referral points for different types of healthcare services like maternal health, child health, diabetes, trauma care, orthopaedic complications, dental surgeries, mental health, critical illness, deafness control, cancer management, tobacco counseling / cessation, critical illness, surgical cases etc. NUHM would provide strengthening support as per the city PIP subject to approval at appropriate levels.

- **Promotion of access to improved health care at household level through community based groups : Mahila Arogya Samitis**

  5.2.2.1 The 'Mahila Bachat Gat' scheme in Maharashtra and urban health initiatives in Indore and Agra have demonstrated the efficacy of women led thrift/self help groups in meeting urgent cash needs in times of health emergency and also empowering them to demand improved health services.

  5.2.2.2 In view of the visible usefulness of such women led community/ self help groups; it is proposed to promote such community based groups for enhanced community participation and empowerment in conjunction with the community structures created under the Swarna Jayanti Shahari Rojgar Yojana (SJSRY), a scheme of the Ministry of Urban Development which seeks to provide employment to the urban poor. Under the Urban Self Employment Programme (USEP) of the scheme there are provisions for Development of Women and Children in Urban Areas (DWCUA) groups of at least 10 urban poor women and Thrift Credit Groups (TCG), which may be set up by groups of women. There is also provision for informal association of women living in mohalla, slums etc to form Neighbourhood Groups (NHGs) under SJSRY who may later federate towards a more formal Neighbourhood Committee (NHC). Such existing structures under SJSRY may also federate into *Mahila Arogya Samiti*, (MAS) a community based federated group of around 50-100 households, depending upon the size and concentration of the slum population, with

flexibility for state level adjustments, and be responsible for health and hygiene behavior change promotion and facilitating community risk pooling mechanism in their coverage area. The Accredited Social Health Activist (ASHA) , detailed in the following pages, may provide the leadership to the Mahila Arogya Samiti. Each of the MAS may have a committee of 5-20 members with an elected Chairperson/ Secretary and other elected representative like Treasurer. The mobilization of the MAS may also be facilitated by a contracted agency/NGO, working along with the ASHA responsible for the area.

- **Strengthening public health through innovative preventive and promotive action**

  5.2.3.1 Urban Poor face greater environmental health risks due to poor sanitation, lack of safe drinking water, poor drainage, high density of population etc. There is a significant correlation between morbidity due to diarrhea, acute respiratory infections and household hygiene behavior, environmental sanitation, and safe water availability. Thus strengthening preventive and promotive action for improved health and nutrition and prevention of diseases will be a major focus of the Mission. The Mission would also provide a framework for pro-active partnership with NGOs/civil society groups for strengthening the preventive and promotive actions at the community level. The ASHA, in coordination with the members of the MAS would promote proactive community action in partnership with the urban local bodies for improved water and environmental sanitation, nutrition and other aspects having a bearing on health.

  5.2.3.2 The urban areas, due to presence of multiple health service providers, presence and access to technology and relatively higher awareness and demand of health services in the community, provide with

opportunities to develop innovative strategies. Hence NUHM provides for some untied funds at all levels for developing need based innovative strategies for improved service delivery and public health action.

- **Increased access to health care through creation of revolving fund**

5.2.4.1 As substantiated by various studies *(" Morbidity and Treatment of Ailments" NSS Report Number- 441(52/25.0/1) based on 52nd round*) the urban poor incur high out-of- pocket expenditure often leading to indebtedness and impoverishment. To mitigate this risk, it is proposed to encourage *Mahila Arogya Samitis* to "save for a rainy day" for meeting urgent health needs.

5.2.5 **IT enabled services (ITES) and e- governance for improving access improved surveillance and monitoring**

5.2.5.1 Various studies (*Conditions of Urban Slums, 2002, NSSO Report Number 486(58/0.21/1) based on 58th round*) have shown that the informal status and migratory nature of majority of the urban poor, compromises their entitlement and access to health services. It also poses a challenge in tracking and provisioning for their health care.

5.2.5.2 Studies have also highlighted that the private providers, which the majority of the urban poor access for OPD services, remain outside the public disease surveillance network. This leads to compromised reporting of diseases and outbreaks in urban slums thereby adversely affecting timely intervention by the public authorities.

5.2.5.3 The availability of ITES in the urban areas makes it a useful tool for effective tracking, monitoring and timely intervention for the urban poor. The NUHM would provide software and hardware support for developing web based HMIS for quick transfer of data and required action. Mobile telephony will be used for data gathering and follow ups.

5.2.5.4 The States would also be encouraged to develop strategies for affecting an urban disease surveillance system and a plan for rapid

response in times of disasters and outbreaks. It is envisioned that the GIS system envisioned would be integrated into a disease surveillance and reporting system on a regular basis. This system would also be synchronized with the IDSP surveillance system.

5.2.6 Capacity building of stakeholders

5.2.6.1 It was observed that except for a few, provisioning of primary health care was low on priority for most of the urban local bodies with many Counselors showing a clear proclivity for development of tertiary facilities. This skewed prioritization appears to have clearly affected the primary health delivery system in the urban local bodies, also adversely affecting skill sets of the workforce and limiting technical and managerial capacities to manage health. NUHM thus proposes to build managerial, technical and public health competencies among ULBs/ Medical and Paramedical staff/ Private Providers/ Community level structures and functionaries of other related departments.

5.2.7 Prioritizing the most vulnerable amongst the poor

- It is seen that a fraction of the urban poor who normally do not reside in slum, but in temporary settlements or are homeless, comprise the most disadvantaged section. Under the NUHM special emphasis would be on improving the reach of health care services to these vulnerable groups among the urban poor, falling in the category of destitute, beggars, street children, construction workers, coolies,

  rickshaw pullers, sex workers, street vendors and other such migrant workers. Outreach services would target these segments consciously, irrespective of their formal status of resident ship etc.

5.2.8 Ensuring quality health care services

5.2.8.1 NUHM would aim to ensure quality health services by a) defining

Indian Public Health Standards suitably modified for urban areas wherever required b) defining parameters for empanelment/regulation/accreditation of non-government providers, c) developing capacity of public and private providers for providing quality health care, d) encouraging the acceptance and enforcement of local public health acts d) ensuring citizen charters in facilities e) encouraging development of standard treatment protocols.

5.3 OUTCOMES

The NUHM would strive to put in place a sustainable urban health delivery system for addressing the health concerns of the urban poor. The NUHM proposes to measure results at different levels with a long term as well as intermediate term view.

5.3.1 Process/ Throughput level indicators:

5.3.1.1 Number cities/population where Mission has been initiated

5.3.1.2 Number of City specific urban health plans developed and operationalised

5.3.1.3 Number of U-PHCs with outreach made operational

5.3.1.4 Number of Cities/population with all slums and facilities mapped

5.3.1.5 Number of Slum/ Cluster level Health and Sanitation Day

5.3.1.6 Number of MAS formed

5.3.1.7 Number of U-PHCs with Programme Managers

5.3.1.8 Number of ASHAs trained and functioning

5.3.2 Output level indicators:

5.3.2.1 Increase in OPD attendance

5.3.2.2 Increase in BPL referrals from U-PHCs/ referral availed

5.3.2.3 Increase in institutional deliveries as percentage of total deliveries

5.3.2.4 Increase in complete immunization among children < 12 months

5.3.2.5 Increase in case detection for malaria through blood examination

5.3.2.6 Increase in case detection of TB through identification of chest symptomatic

5.3.2.7 Increase in referral for sputum microscopy examination for TB

5.3.2.8 Increase in number of cases screened and treated for dental ailments

5.3.2.8 Increase in ANC check-up of pregnant women

5.3.2.10 Increased Tetanus toxoid (2nd dose) coverage among pregnant women

5.3.2.11 Strengthened civil registration system to achieve 100% registration of births and deaths

5.3.3 Impact level focus on urban poor:

5.3.3.1 Reduce IMR by 40 % (in urban areas) – National Urban IMR down to 20 per 1000 live births by 2017

5.3.3.1.1 40% reduction in U5MR and IMR

5.3.3.1.2 Achieve universal immunization in all urban areas.

5.3.3.2 Reduce MMR by 50 %

5.3.3.2.1 50% reduction in MMR (among urban population of the state/country)

5.3.3.2.2 100% ANC coverage (in urban areas)

5.3.3.3 Achieve universal access to reproductive health including 100% institutional delivery

5.3.3.4 Achieve replacement level fertility (TFR 2.1)

5.3.3.5 Achieve all targets of Disease Control Programmes

6 – CONVERGENT ACTION IN URBAN AREAS

6.0.1 The NRHM provides scope for innovations at the district level. These have resulted in development of need based innovative strategies resulting in expansion of services and greater access of those services especially by the poorest communities.

6.0.2 Some of the innovations coming out under NRHM are very encouraging and paving way for many more similar initiatives. The use of radio technology for capacity building of ASHAs (in Assam), promotion of high end diagnostic services in medical colleges and establishment of regional diagnostic centers through public private partnerships (PPP) and promoting easy availability of

generic drugs in shops through PPPs are some of such innovations.

6.0.3 The urban areas, due to presence of multiple health service providers, access to technology and relatively higher awareness and demand of health services in the community, provide the opportunities to develop innovative strategies. Hence NUHM provides for some untied funds at all levels for carrying out these activities. Some of the areas of innovation are listed below. This list is illustrative and not exhaustive.

6.1 SUGGESTED SLUM LEVEL INNOVATIONS

6.1.1 Community monitoring

6.1.2 Creating mentoring groups/support structures for MAS/ASHA through NGO/CBOs

6.1.3 "Healthy Mother", "Healthy Infant" competitions

6.2 SUGGESTED U-PHC LEVEL INNOVATIONS

6.2.1 Involving private practitioners for special drives on immunization, diabetes, etc.

6.2.2 Involving schools for public health action like "slum cleaning (*safai abhiyan)*", health promotion, etc.

6.2.3 Special programs for adolescent health

6.3 SUGGESTED CITY LEVEL INNOVATIONS

6.3.1 Innovations with ICT (Information and Communication Technology) like 'sms' based health promotion, touch screen kiosks, PDAs for outreach workers.

6.3.2 "Help-lines" for general health advise / medical emergencies

6.3.3 Review/monitoring of quality, regularity of services through NGOs

6.3.4 Identification and management/rehabilitation of malnourished children (with special focus on girl child) and Nutrition Resource Centres

6.3.5 Special Strategies for addressing anaemia among women and girls

6.3.6 Special strategies for addressing anemia, malnutrition and neonatal mortality

6.4 SUGGESTED STATE LEVEL INNOVATIONS

6.4.1 Operations/Action research/special studies

6.4.2 Resource Centres/Units at State or city levels for urban health data, program lessons, and other information

6.4.2 Empanelment of hospitals/doctors for defined specialised services

6.4.3 Innovations for addressing adverse sex ratio

6.5 SUGGESTED NATIONAL LEVEL INNOVATIONS

6.5.1 Human Resource development, training, capacity building, Resource Centres/Units for urban health data, program lessons, & other

information and additional support to national health programmes at all levels e.g.

6.5.1.1 Maternal/infant death audit

6.5.1.2 Disease outbreaks in case of natural disasters like floods

6.5.1.3 Mass injury/trauma cases because of fire in slums, riots, etc.

6.5.1.4 Epidemiological surveys/research

6.6 IMPROVING SANITATION AND WATER SERVICES

6.6.1 It is important to focus on infra-structural facilities in terms of access to safe and adequate water supplies and sanitation facilities for combating various infectious diseases in children residing in urban slums.

6.6.2 Studies have shown that non-availability of piped water and absence of flush toilets are associated with increased incidence of infant deaths from diarrhea. Hence, it is vital to expand availability of water and sanitation facilities to the urban population to effectively address mortality and morbidity associated with diarrhea.

6.7 ADDRESSING COMMUNITY BEHAVIOURS PERTINENT TO THE CAUSATION OF CHILDHOOD ILLNESSES IN URBAN SLUMS

6.7.1 Appropriate hygiene behaviors can play a critical role in minimizing the frequency of infectious diseases, and can possibly reduce the risk of malnutrition in children. In India and in developing regions it is recognized that if community water supply and sanitation programs are undertaken in isolation, without action to integrate these with promotion and education on hygiene and sanitation within the community (particularly the home and its immediate surroundings), the health benefits from these programs will not commensurate

with the investment made. Evidence shows hand washing could prevent more than one million deaths a year from diarrheal diseases. Therefore, improvement of water supplies needs to be integrated with other interventions, such as sanitation and health education, which focus on better environmental hygiene and personal cleanliness.

6.7.2 **Health seeking behaviour**: Behaviour promotion strategies addressing community beliefs focusing on environment-related issues such as hand washing, feeding practices, health seeking and appropriate prenatal and new born care are paramount.

6.8 COMMUNITY PARTICIPATION IN PREVENTION AND TREATMENT OF CHILDHOOD ILLNESSES

6.8.1 There is an urgent need to empower communities to take control of their health by strengthening their participation in identifying their own maternal and child health needs and identifying measures to address them.

6.8.2 This can be achieved by training basti level women groups which could serve as a platform for counseling and behavior promotion focusing on health education about environment-related issues. These women groups could also strengthen linkage with service providers, thereby increasing utilization of services, coverage of left outs and dropouts and improved referrals.

6.9 FOCUS ON ALL ASPECTS OF PUBLIC HEALTH

6.9.1 The existing health care service delivery mechanism is mostly focused on reproductive and child health (RCH) services, while the recent outbreaks of Dengue and Chikungunya in urban areas and the poor health status of urban poor clearly articulate the need for a broad based public health programme focused on the urban poor. It stresses upon the need to effectively infuse public health focus along with curative services.

6.9.2 The situation in most cities also reveals that there is a lack of effective coordination among the departments that leads to inadequate focus on critical aspects of public health such as access to clean drinking water, environmental

sanitation and nutrition.

6.10 INTER AND INTRA SECTORAL COORDINATION

NUHM will promote both inter sectoral as well as intra sectoral convergence to avoid duplication of resources and efforts. The convergent actions can be grouped as:-

- Convergence with the National Disease Control Programmes
- Convergence with other departments of Ministry of Health and Family Welfare
- Convergence with other Ministries

6.10.1 CONVERGENCE WITH NATIONAL DISEASE CONTROL PROGRAMMES

6.10.1.1 NUHM would aim to provide a system for convergence of all **communicable and non communicable disease programmes** at the city level through integrated planning - both annual and prospective, sharing of funds and human resources and joint monitoring and evaluation.

6.10.1.2 NUHM would bring all the disease control programs like RNTCP, IDSP, NVBDCP, NPCB etc. under the umbrella of City Health Plan so that preventive, promotive and curative aspects are well integrated at all levels.

6.10.1.3 The objective of convergence would be optimal utilization of resources and ensuring availability of all services at one point (U-PHC) thereby, enhancing their utilization by the urban population. The existing IDSP structure would be leveraged for improved surveillance.

6.10.2 CONVERGENCE WITH OTHER DEPARTMENTS OF MOHFW

6.10.2.1 DEPARTMENT OF AYUSH

6.10.2.1.1 NUHM would also strive to revitalize local health traditions and mainstream AYUSH to strengthen the Public Health System at all levels. The following areas for convergence with the **Department of AYUSH** have been identified:-

- Co-location of an existing AYUSH dispensary in Urban PHCs/CHCs, wherever feasible, so as to provide clear choices to people to avail services under one system or other.
- AYUSH drugs to be regularly supplied by the state government.
- AYUSH doctor posted would essentially practice his own system. However he may additionally provide basic emergency services in absence of allopathic doctor and participate in national health programmes.
- Specialized AYUSH treatment facilities like Panchkarma, Ksharsutra to be made available by AYUSH department in Urban PHCs/CHCs.
- Department of AYUSH to support Govt. AYUSH hospitals and dispensaries at the district /sub district level.
- Life style clinics of AYUSH for preventive and promotive health care to be established at the District Hospitals.
- AYUSH doctors engaged at the Urban PHCs/CHCs would be given adequate training on current diagnostic techniques, emergency medicine, IUCD insertions and treatment approaches on a regular basis.

6.10.2.1.2 However, no provision of funds will be made separately for mainstreaming of AYUSH activities under NUHM. Funds and manpower available with the AYUSH departments of the Central/ State Govt. will be utilized.

6.10.2.2 DEPARTMENT OF AIDS CONTROL:

6.10.2.2.1 Convergence between NUHM and NACP will help in early detection, effective surveillance and timely intervention by means of:

- Universal HIV screening will be made an integral part of ANC check-up. The health and nutrition days would be utilized for rapid blood tests and positive cases would be referred to ICTCs for confirmation.
- Counsellors, ANMs and ASHA/Link workers at the U-PHC would be trained for counselling on RTI, PPTCT, ANC, nutrition and spacing between births. The training for RTI and PPTCT counselling will be provided by the respective State AIDS Control Society.
- Testing kits to be made available at the Urban PHCs/CHCs by NACO.
- Distribution of condoms and IEC materials for promoting safe sexual practices will be done at the Urban PHCs.
- All HIV positive patients will be tested for T.B. and vice-versa.

6.10.2.3 DEPARTMENT OF HEALTH RESEARCH:

6.10.2.3.1 Convergence of NUHM with the Department of Health Research (DHR) will help to bring modern health technology to people by:

- Encouraging innovations related to diagnostics, treatment methods and vaccines;
- Translating the innovations into products/ processes by facilitating evaluation/ testing in synergy with other departments of MOHFW and
- Introducing these innovations into public health service

6.10.2.3.2 For promoting innovations some funds will be provided to the states every year under a separate budget head.

6.10.3 CONVERGENCE WITH SCHEMES OF OTHER MINISTRIES

6.10.3.1 MINISTRY OF URBAN DEVELOPMENT AND MINISTRY OF HOUSING AND URBAN POVERTY ALLEVIATION

6.10.3.1.1 Convergence with Jawaharlal Nehru National Urban Renewal Mission (JnNURM):

6.10.3.1.1.1 Basic Services to the Urban Poor (BSUP), which is a sub mission of JnNURM mandates the provision of health services to the urban poor via a seven point charter, namely security of land tenure, affordable shelter, water, sanitation, education, health and social security.

6.10.3.1.1.2 Under the Sub- Mission on Basic Services to the Urban Poor (BSUP), convergence would be sought through the following:

- City will be the unit of planning for health and allied activities.

- The City Health plan would also be shared for prioritization of actions at the City level. Similarly the City Development Plans (CDPs) of JnNURM cities (Basic Services component) would also be taken into account for avoiding duplication of efforts and resources.

- Under JnNURM at the city level as part of the City development plans GIS based physical mapping of the slums is being undertaken. The City level planning process would also leverage the GIS based mapping wherever completed.

- The community level institutions such as MAS may also be utilized by the implementation mechanism of JnNURM.

6.10.3.1.1.3 The guidelines for the Integrated Housing and Slum Development Programmes (IHSDP) include the following under the admissible components:

- The community centers being created under IHSDP will be used as sites for conducting fixed outreach session.

- Under the admissible components of IHSDP Community primary health care center buildings can be provided. This mechanism can be used for establishing new urban primary health centres for un-served urban poor population.

6.10.3.1.1.4 Under the BSUP and IHSDP mandatory reforms at the urban local body level are proposed. The same can be reinforced by NUHM also for strengthening the role of urban local bodies in cities where the BSUP and IHSDP are being implemented. Identification of slums and updating of the lists can also be made part of the mandatory reforms.

6.10.3.1.2 Convergence with Rajiv Awas Yojana (RAY):

6.10.3.1.2.1 Rajiv Awas Yojana aims at creating a slum free India by bringing existing slums within the formal system and enabling them to avail the same level of basic amenities as the rest of the town.

6.10.3.1.2.2 Convergence of RAY and NUHM would be sought through the following:

- The City Health Plans under NUHM can be incorporated into the slum free city and state plans of action under RAY.

- GIS based physical mapping of the slums and the spatial

representation of the socio-economic profile of slums (Slum MIS) is

being undertaken under RAY. This will also be useful for development of city health plans.

6.10.3.1.3 Convergence with Swarn Jayanti Shahri Rozgar Yojana (SJSRY):

The community level structures being proposed under NUHM can be strengthened by effectively aligning them with the SJSRY structures.

- Community organizer for about 2000 identified families under SJSRY can be co-opted as ASHA.
- Neighborhood Groups which are informal associations of woman living in mohalla or slum or neighborhood representing 10 to 40 urban poor or slum families and Development of Women and Children in Urban Areas (DWCUA) Groups under SJSRY may be federated into Mahila Arogya Samitis (MAS).
- Neighborhood Committee (NHC) is a more formal association of women from the above neighborhood groups. Representatives from other sectoral programmes in the community like ICDS supervisor, school teacher, ANM etc. are also its members. These may be coterminous with the MAS. Alternatively, State/District can choose to make them function as MAS.
- Project officer in-charge of the project responsible for managing community level structures may be involved in planning and identification of urban poor.

6.10.3.1.4 Convergence with North Eastern Region Urban Development Programme (NERUDP):

6.10.3.1.4.1 Ministry of Housing & Urban Poverty Alleviation has project proposals for the North Eastern States in the following identified areas:

- Housing projects (predominantly for the urban poor)
- Poverty alleviation projects
- Slum improvement/up gradation projects

Funds under this provision are non-lapsable and unspent balances under this provision in a financial year are pooled up in the non-lapsable central fund meant for these States, and are governed by the Department of Development of North Eastern Region (DoNER). Hence, in the north eastern states, NUHM can develop synergy and mobilize funds from this programme.

6.10.3.2 MINISTRY OF WOMEN AND CHILD DEVELOPMENT

- MAS/ASHA in coordination with the ANM to organize Community Health and Nutrition day in close coordination with the Anganwadi worker (AWW) on lines of NRHM.

- MAS/ ASHA to support AWW/ANM in updating the cluster/ slum level health register.

- Outreach session also to be organized in the Anganwadi centers located in slums or nearby.

- Organization level health education activities at the AW Centre.

- AWW and MAS to work as a team for promoting health and nutrition related activities.

6.10.3.3 MINISTRY OF HUMAN RESOURCE DEVELOPMENT

6.10.3.3.1 Convergence with School Health Programme:

6.10.3.3.1.1 School Health Programme helps in advocating healthy behavioral

practices and imparting awareness about preventive and curative health measures to the school going children. This awareness further percolates to households and families of the students. Therefore School Health Programme in cities can help the National Urban Health Mission to achieve its goals and objectives by reaching out to a large section of the community in a cost effective manner.

6.10.3.3.1.2 In urban areas, the scheme would cover Government or private schools located in slums (U-PHC catchment) or government schools near slums which slum children attend. The major components of School Health Programme are:

- Health Education (H.E.) Activities, creating awareness about hygiene, prevention of Vector Borne Disease Nutrition/Balanced Diet, Oral Rehydration etc.

- Medical examination of primary school children for eye ailment, nutrition, and others

- Treatment of minor ailments such as de-worming, anaemia, skin diseases at school itself

- Special In-patient care at identified hospitals and referral services

- Control of communicable diseases through Immunization

- Training of teachers for early identification of symptoms

- To advise children and school health authorities regarding importance of safe drinking water and good environmental sanitation etc.

6.10.3.3.2 Convergence with Adolescent Reproductive and Sexual Health (ARSH):

6.10.3.3.2.1 Under ARSH, once a week adolescent clinic will be organized at the Urban PHC. During this teen clinic health education and counseling will be provided to the adolescent girls for promoting menstrual hygiene, prevention of anaemia, prevention of RTIs/STIs, counseling for sexual problems etc.

6.10.3.4 MINISTRY OF MINORITY AFFAIRS

6.10.3.4.1 Convergence with Multi Sectoral Development Programme (MsDP):

6.10.3.4.1.1 Under this scheme, 90 minority districts have been identified throughout the country which are relatively backward and are falling behind the national average in terms of socio-economic and basic amenities indicators. The programme aims at improving the socio-economic parameters of basic amenities for improving the quality of life of the people residing in rural and semi-urban areas.

6.10.3.4.1.2 District specific plans are prepared for provision of better infrastructure for school and secondary education, sanitation, pucca housing, drinking water and electricity supply, besides beneficiary oriented schemes for creating income generating activities. In addition, creation of basic health infrastructure and ICDS centres is also eligible for inclusion in the plan.

6.10.3.4.1.3 So, in the towns covered under MsDP, NUHM can leverage the health infrastructure and Anganwadi centres created under this programme for provision of health care services to the urban poor population.

6.10.3.5 OTHER AREAS OF SYNERGY

6.10.3.5.1 MEMBER OF PARLIAMENT LOCAL AREA DEVELOPMENT SCHEME (MPLADS):

All members of parliament (MPs), members of legislative assemblies (MLAs) and municipal councillors (MCs) receive area development fund which can be mobilized for creation of health facilities in underserved urban areas and also for procurement of equipments, Mobile Medical Units and ambulances etc.

6.10.3.5.2 CORPORATE SOCIAL RESPONSIBILITY (CSR):

Around 2 percent of the total profit of all corporate sector companies is earmarked for social development under CSR. This fund can also be mobilized for health sector through efforts of MOHFW and the State Govts. Department of Public Enterprise (DPE) for public sector and Ministry of Corporate Affairs for the private sector can emerge as important players.

7 - INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

7.1 The National Urban Health Mission would leverage the institutional structures of the NRHM at the National, State and District level for operationalisation of the NUHM. However in order to provide dedicated focus to issues relating to Urban Health the institutional mechanism under the NRHM at various levels would be strengthened for NUHM implementation.

7.2 At the central level, the Mission Steering Group under the Union Health Minister, the Empowered Programme Committee under the Secretary (H&FW), and the National Programme Coordination Committee under the Mission Director will be responsible for providing overall guidance and taking important decisions.

7.3 For effective implementation and monitoring of NUHM, a National Programme Management Unit (NPMU) will be set up at the central level. The

NPMU will also be expected to provide technical assistance to the Urban Health Division of the Ministry.

7.4 At the state level, for improving the Program Management under NUHM, a State Program Management Unit (SPMU) will be set up, which would essentially be an extension of the NRHM SPMU, with a separate Urban Health Cell, reporting to the State Mission Director. The staff at the SPMU- Urban Health Cell may be as proposed below:

- State Urban Health Program Manager
- State Urban Health MIS Manager
- State Urban Health Finance Manager
- State Urban Health Consultant (M&E and Community Participation)

7.5 In addition to the above, at the City level the States may either decide to constitute a separate City Urban Health Missions/ City Urban Health Societies or use the existing structure of the District Health Society / Mission under NRHM with additional stakeholder members.

7.6 At the city level, the management of NUHM activities may be coordinated by a City level Urban Health Committee headed by the District Magistrate/ Additional District Magistrate/Sub Division Magistrate based on whether the city is a district headquarters or a sub-division headquarter. This would help ensure better coordination with municipal departments like sanitation, water, waste management, especially in times of response to disease outbreaks/epidemics in the city.

7.7 Further for enhancing the Program Management, a City Program Management Unit (CPMU) may be established. The staff at the City PMU level may be as proposed below:

- Urban Health Data Manager.
- Urban Health Accounts Manager
- Consultant (Epidemiologist)

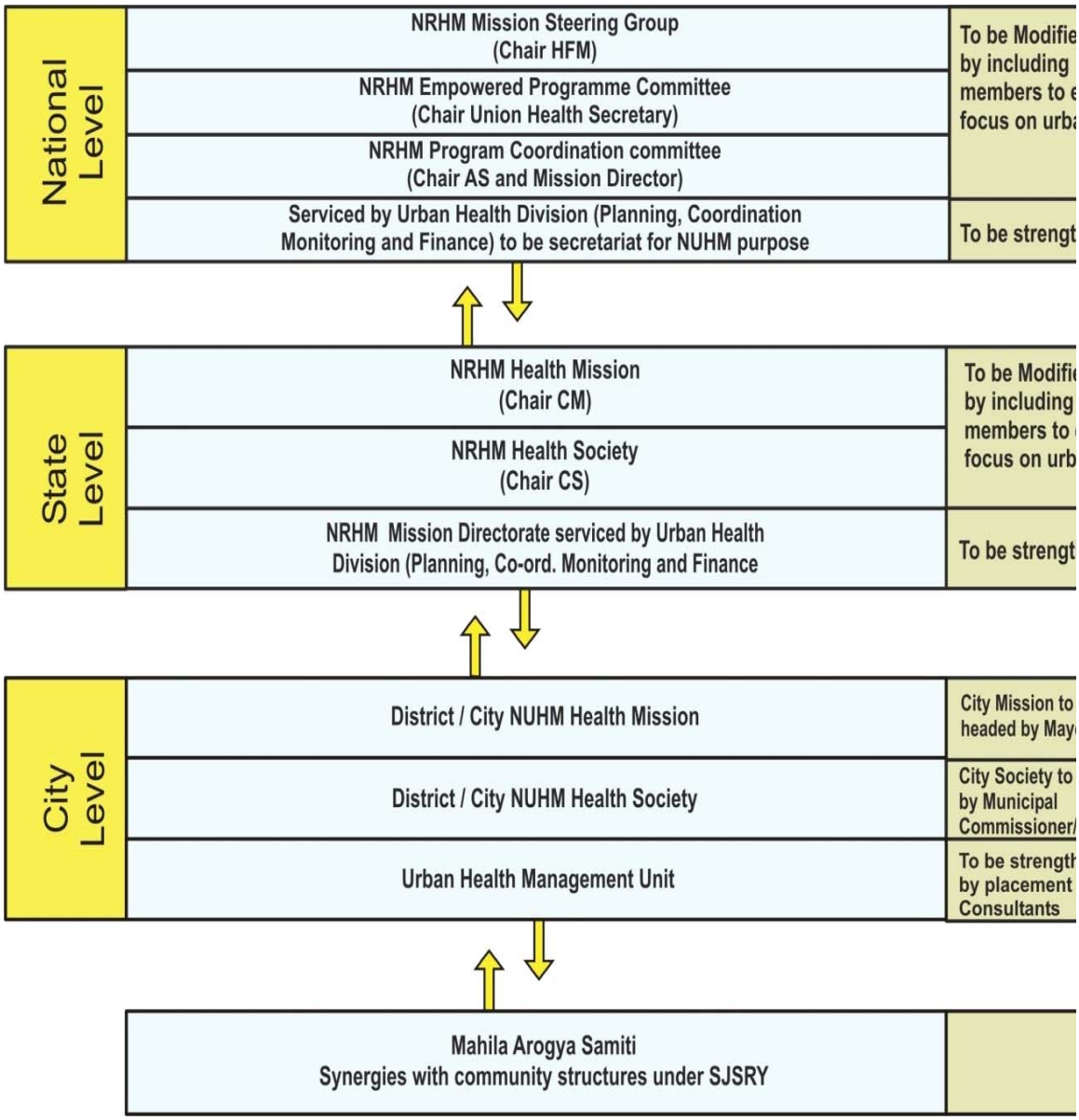
7.8 The National Urban Health Mission would promote participation of the

urban local bodies in the planning and management of the urban health programmes.

7.9 For the seven mega cities, namely Delhi, Mumbai, Kolkata, Chennai, Bengaluru, Hyderabad and Ahmedabad, the NUHM may be implemented through the respective ULBs. For the remaining cities, health department would be the primary implementation agency for NUHM. However, for cities/towns where capacity exists with the ULBs, the states may decide to hand over the management of the NUHM to them.

7.10 A generic institutional model for a National / State/District/City level Urban Health Mission and Society is illustrated, notwithstanding the flexibilities provided to the states.

FIGURE 7.1 DIAGRAM: INSTITUTIONAL MODEL



7.11 The National Urban Health service delivery model would make a concerted effort to rationalize and strengthen the existing public health care system in urban areas and promote effective engagement with the non-

governmental sector (profit/not for profit) for expanding reach to urban poor, along with strengthening the participation of the community in planning and management of the health care service delivery.

7.12 The diagram below describes the components of the proposed urban health service delivery model.

Diagram: Urban Health Care Delivery Model

7.13 The urban health delivery model would basically comprise of an Urban Primary Health Centre for provision of primary health care with outreach and referral linkages as elucidated below:

7.14 COMMUNITY LEVEL

7.14.1 Accredited Social Health Activist (ASHA)

7.14.1.1 Each slum/community would have one frontline community worker called ASHAASHA similar to ASHA under NRHM, covering about 1000 - 2,500

beneficiaries, between 200-500 households based on spatial consideration, preferably co-located at the Anganwadi Centre functional at the slum level, for delivery of services at the door steps. She would remain in charge of each area and serve as an effective demand–generating link between the health facility (Urban Primary Health Centre) and the urban slum populations. She would maintain interpersonal communication with the beneficiary families and individuals to promote the desired health seeking behaviour. They will be responsible to the *Mahila Arogya Samitis* (community groups) for which they are designated.

7.14.1.2 Wherever possible the existing community workers under other schemes like JnNURM, SJSRY etc. may be co-opted under NUHM. ASHAASHA

7.14.1.3 The ASHA would be a woman resident of the slum, preferably in the age group of 25 to 45 years. The ASHA should also be literate with formal education up to class tenth, which may be relaxed only if no suitable person with this qualification is available. ASHA would be chosen through a rigorous community driven process involving ULB Counsellors, community groups, self-help groups, Anganwadis, ANMs. A team of five facilitators may be identified in each U-PHC catchment area with the help of an NGO, through a consultative process, for facilitating the selection of the ASHA. The facilitators would preferably be from local NGOs; community based groups, Anganwadi or Civil Society Institutions. In case none of these is available in the area, the officers of other Departments at the slum level/local school teachers may be taken as facilitators. The selection process for ASHA in NRHM may be suitably modified to the urban context as per the local condition and adopted for selection of the ASHAs.

7.14.1.4 The ASHA would help the ANM in delivering outreach services in the vicinity of the doorsteps of the beneficiaries. Preferably some suitable identified place for ASHA may be arranged in the slums which may be AWW centres, clubs, community premises set up under the JnNURM, Sub Health Posts set up in IPP cities, municipal premises etc, or even her own residence.

7.14.1.5 An ASHA mentoring system on the lines of NRHM may be put in place involving dedicated community level volunteers/professionals preferably through the local NGO at the U-PHC level, for supporting and coordinating the activities of the ASHA. The states may also consider the option of 1 Community Organizer for 10 ASHAs for more effective coordination and mentoring, preferably located at the mentoring NGO. The Community organizer along with the ANM may be designated as the mentoring and management team at the slum level for the ASHAs.

7.14.1.6 Essential services to be rendered by the ASHA may be as follows:

- Active promoter of good health practices and enjoying community support.

- Facilitate awareness on essential RCH services, sexuality, gender equality,

age at marriage/pregnancy; motivation on contraception adoption, medical termination of pregnancy, sterilization, spacing methods. Early registration of pregnancies, pregnancy care, clean and safe delivery, nutritional care during pregnancy, identification of danger signs during pregnancy; counseling on immunization, ANC, PNC etc. act as a depot holder for essential provisions like Oral Re-hydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Oral Pills & Condoms, etc.; identification of target beneficiaries and support the ANM in conducting regular monthly outreach sessions and tracking service coverage.

- Facilitate access to health related services available at the Anganwadi/Primary Urban Health Centres/ULBs, and other services being provided by the ULB/State/ Central Government.

- Formation and promotion of *Mahila Arogya Samitis* in her community.

- Arrange escort/accompany pregnant women and children requiring treatment to the nearest Urban Primary Health Centre, secondary/tertiary level health care facility.

- Reinforcement of community action for immunization, prevention of water borne and other communicable diseases like TB (DOTS), Malaria, Chikungunya and Japanese Encephalitis.

- Carrying out preventive and promotive health activities with AWW/ *Mahila Arogya Samiti*.

- Maintenance of necessary information and records about births & deaths, immunization, antenatal services in her assigned locality as also about any unusual health problem or disease outbreak in the slum and share it with the ANM in charge of the area.

7.14.1.7 In return for the services rendered, she would receive a

performance based incentive. For this purpose a revolving fund would be kept with the ANM at the U-PHC (in the PHC account), which would be replenished from time to time, based on Utilisation Certificate/Statement of Expenditure. The following performance based incentive package is suggested subject to modifications by the State.

TABLE 7.4: ASHA INCENTIVE CHART *

	Proposed Activities
1	Organization of outreach sessions
2	Organization of monthly meeting of MAS
3	Attend monthly meeting at U-PHC
4	Organize Health & Nutrition day in collaboration with AWW
5	Organize community meeting for strengthening preventive and promotive aspects
6	Provide support to Baseline survey and filling up of family Health Register
7	Maintain records as per the desired norms like Household Registers, Meeting Minutes, Outreach Camps registers
8	Additional Immunization incentives for achieving complete immunization in among the children in her area of responsibility:
9.	Incentives/compensation in built in national schemes for ASHA under JSY, RNTCP, NVBDCP, Sterilization, Home Based Newborn Care etc. and any other National programme

* This list is indicative but not exhaustive.

7.14.1.8 During the field visits it was observed that provision of a photo identity card to the community volunteers greatly boosts their self-esteem.

The states/cities can also explore the option of providing ASHAs with Photo ID card.

- The Urban Local Body would provide the leadership to the selection process of ASHA. The following process may be adopted:

  - The ASHA will be selected through a community driven process led by the Urban Local Body. To facilitate the selection process the District/ City level Mission would constitute a City Level ASHA Selection Committee headed by the member of the urban local body. The CMO/CDMO; DPO-ICDS; and PO of JnNURM; DUDA; SJSRY would be the members. The District/ City level health mission can also decide to induct more members from the NGO/ Civil society based on the local need. The City Level ASHA Selection Committee would approve the names of the ASHA proposed by the PUHC level facilitation committee. The selection committee would also provide all the guidelines for the selection of ASHA. The City Level ASHA Selection Committee would also be responsible for Constitution of health facility/unit level ASHA selection committees. It will monitor and provide all necessary support to carry out the ASHA selection process including approval of the list of selected ASHAs/LWs.

  - The Catchment area of the U-PHC would form the unit for selection process. At the unit level a ASHA Facilitation Committee for proposing the name of the ASHA to the City level Selection Committee would be constituted. The U-PHC level committee would also monitor the whole process and ensure that the selection process is as per the approved selection process.

  - The Urban Local Body if appropriate may also involve local NGOs working in urban areas in the selection process of the ASHA. As the situation varies from city to city flexibility would be provided for need based adoption of above process.

- **Mahila Arogya Samiti (MAS) –**

7.14.2.1 **MAS** acts as community group, involved in community awareness, interpersonal communication, community based monitoring and linkages with the services and referral. The MAS may cover around 50- 100 households (HHs) with an elected Chairperson and a Treasurer, supported by an ASHA. This group would focus on preventive and promotive health care, facilitating access to identified facilities and management of revolving fund. The following process may be adopted for constitution of the MAS.

7.14.2.2 **Constitution of Mahila Arogya Samiti:**

To expand the base of health promotion efforts at the community level and to build sustainable community processes, each ASHA will promote organized collective efforts through a group of socially committed females from the community itself. Present or past experiences of collective efforts in the slums towards fulfillment of any objective will be explored. Women's/ SHG groups wherever present would be encouraged to expand their scope of work to address health challenges in the community.

7.14.2.3 **Process of promotion of Mahila Arogya Samiti:**

7.14.2.3.1 Constitution of a team at slum level: The ASHA with support of NGO field functionary (if any), AWW and ANM will constitute a team

- Meetings with slum women: The team (ASHA and others) conduct a series of meetings with women from the slum to understand the health conditions and to sensitize the women to work towards improving the health of the men, women and children in the slum It is generally observed that the initial meetings have a large number of slum women attending mainly due to curiosity or with

expectations to get some benefits (monetary).

- Identification of active and committed women: At least a gap of 1-2 weeks is given between women to reflect, discuss with others and determine their commitment to serve their slum community. Generally towards the 3rd or 4th meeting, the numbers of women attending falls and only interested women come for the meeting. Active, interested and committed women will be identified and over a period of time, encouraged to work collectively on community issues to form the base of the Mahila Arogya Samiti. It may be borne in mind that each community responds differently and takes its own time to crystallize, and interventions would have to be designed, keeping in alignment with the community

- Suggested group size: The suggested norm for one group is 10-12 members over 50-100 families. The numbers will vary depending on the size of the slum (e.g. in case of a small slum with 50 families, the Committee will be promoted over 50 families) and also the factors within the slum (e.g. different communities within a small area).

- Promotion of MAS: The active women (10-12) identified then meet and decide to work collectively as a group. They nominate office bearers, formulate rules and regulations for the group and record proceedings of the meetings and start functioning as a group.

7.14.2.4 Desired characteristics of members of Mahila Arogya Samiti:

7.14.2.4.1 Membership in the Women's Health Committee may be guided by the objectives and expected roles of this group. The membership in the group would be a natural process, guided by the team of ASHA and others. Therefore the following should not be seen as eligibility criteria. However the common features emerging in this scene would be –

7.14.2.4.2. Woman with a desire to contribute to 'well-being of the community' and with a sense of social commitment and leadership skills.

7.14.2.4.3 Woman's age is not being kept as a barrier as the role of the woman in the house and the community is either as a target beneficiary or as an influencing force.

7.14.2.4.4 If a group is being formed over a number of pockets of different communities, membership from all such pockets shall be ensured.

7.14.2.4.5 If the slum has a presence or history of collective efforts (as a self help group, DWCUA group, Neighborhood Group under SJSRY, thrift and credit group), women involved in these efforts should be encouraged.

7.14.2.4.6 ASHA may be a member of this group, if the group desires so. She should be conscious of her dual role in this context, and consciously encourage leadership.

- ***Outreach session: ANM***

- Responsible for providing preventive and promotive healthcare services at the household level through regular visits and outreach sessions. (i) Each ANM will organize a minimum of one routine outreach session in her area every month. ii) special outreach sessions (for slum and vulnerable population) – Once in a week the ANMs covering slum/vulnerable populations would organize one special outreach session in partnership with other health professionals (doctors/pharmacist/technicians/nurses – government or private). It will include screening and follow-up, basic lab investigations (using portable /disposable kits), drug dispensing, and counseling.

7.14.2.5.2 For improving the routine outreach services in the field ANMs would be provided with mobility support of Rs. 500 per month. 4-5 ANMs will be posted in each U-PHC depending upon the population.

7.14.2.5.3 Outreach sessions will be planned to reach out to the vulnerable sections like slum population, rag pickers, sex workers, brick kiln workers, street children and rickshaw pullers.

7.14.2.5.4 The outreach sessions (both routine and special outreach) could be organized at designated locations mentioned in the aforesaid paras in coordination with ASHA and MAS members.

7.15 URBAN PRIMARY HEALTH CENTRE

7.15.1 Functional for a population of around approximately 50,000-60,000, the U-PHC may be located preferably within a slum or near a slum within half a kilometer radius, catering to a slum population of approximately 25,000-30,000, with provision for OPD from 12 noon to 8 pm in the evening. The cities, based upon the local situation may establish a U-PHC for 75,000 for areas with very high density and can also establish one for around 5,000-10,000, slum population for isolated slum clusters.

- At the U-PHC level services provided will include OPD (consultation), basic lab diagnosis, drug /contraceptive dispensing, apart from distribution of health education material and counseling for all communicable and non communicable diseases. In order to ensure access to the urban slum population at convenient timings, the U-PHC may provide services from 12 noon to 8 pm in the evening. It will not include in-patient care.

- It will be staffed by two doctors, one regular and one on a part time basis. Apart from that there will be 3 staff nurses, 1 pharmacist, 1 lab technician, 1 LHV and 4-5 ANMs (depending upon the population covered), apart from clerical and

support staff and one Programme Manager for supporting community mobilization, behavior change communication, capacity building efforts and strengthening referrals.

- To further strengthen the delivery of services cities can also engage the services of specialist doctors to provide services periodically at U-PHC based on needs on reimbursement basis. U-PHC can also serve as collection centre for diagnostic tests in partnership with empanelled private diagnostic centres.

- The option of co-locating the AYUSH centre with U-PHC may also be explored, thus enabling the placement of AYUSH doctor and other AYUSH paramedic staff in the U-PHC.

7.15.6 The situation analysis showed that at present there are various types of primary health care facilities (UHP/UFWC/ Dispensary) with different service guarantee and human resource norms. There has been no reorganization/expansion of these schemes for a long period. With the launching of NUHM, all of these existing programmes/schemes will automatically cease to exist. The existing infrastructure available under these schemes would be rationalized and aligned with the new IPHS.

7.15.7 Under NUHM a uniform health care service delivery mechanism with IPHS norms will be developed and the states are encouraged to adopt these norms for U-PHCs.

- Maximum effort would be made to strengthen the already existing public health care infrastructure in urban areas. Existing SDH/CHC etc. would be upgraded and strengthened.

- Where there are no government health facilities, new public health facilities would be established. All the U-PHCs would be set up in Govt. buildings. Partnership with other government facilities like Railways, Army, ESIC and Public Sector Units could also be explored for strengthening the delivery of services.

- The government facilities strengthened as U-PHC will also be provided annual financial support in the form of Rogi Kalyan Samiti/ Hospital Management Committee Fund of Rs. 50,000 per U-PHC per year, with the amount being proportional to the population covered (@ Re.1.00 per head, i.e. a U-PHC covering 40,000 population will get Rs.40, 000 and a U-PHC covering 75,000 population will be getting Rs. 75,000 per year).

7.15.11 The recurrent cost support provided to U-PHCs of Rs.20 lakh per year, would include cost of all contractual staff in the U-PHC.

7.15.12 In addition, ANMs and LHVs are supported separately (and these may be contractual posts.

7.16 REFERRAL UNIT:

- Urban Community Health Centre (U-CHC) may be set up as a satellite hospital for every 4-5 U-PHCs. The U-CHC would cater to a population of 2,50,000. It would provide in patient services and would be a 30-50 bedded facility. U-CHCs would be set up in cities with a population of above 5 lakhs, wherever required. These facilities would be in addition to the existing facilities (SDH/DH) to cater to the urban population in the locality.

- For the metro cities, the U-CHCs may be established for every 5 lakh population with 100 beds.

- For setting up the U-CHCs the Central Govt. would provide only a one time capital cost, and the recurrent costs including the salary of the staff would be borne by the respective state governments.

- The U-CHC would provide medical care, minor surgical facilities and

facilities for institutional delivery.

7.17 REFERRAL LINKAGES:

7.17.1 Existing hospitals, including ULB maternity homes, state government hospitals and medical colleges, apart from private hospitals will be empanelled /accredited to act as referral points for different types of healthcare services like maternal health, child health, diabetes, trauma care, orthopedic complications, dental surgeries, mental health, critical illness, deafness control, cancer management, tobacco counseling / cessation, critical illness, surgical cases etc.

7.17.2 There might be different and multiple facilities for the different healthcare services, depending upon type of hospitals available in the city.

7.17.3 Collaboration with District Hospitals/ Area Hospitals/ Sub District hospitals and local Medical Colleges may be promoted for strengthening the training support and supplement human resource at the U-PHC level.

7.17.4 Public Health laboratories will also be strengthened under NUHM for early detection and management of disease outbreaks in urban concentrations.

7.17.5 Wherever public sector coverage is inadequate, reputed private sector institutions may be considered. The empanelled/accredited facilities would be reimbursed for the services provided as per the pre-decided rates, negotiated with them at the time of empanelling/accrediting them and indicated in the city level urban health PIPs subject to approval at the appropriate level. This will not only ensure flexibility to adapt to different conditions in different cities but also increase the range of options for the beneficiaries.

7.18 SCHOOL HEALTH SERVICES

7.18.1 Schools can serve as nodal points for advocating healthy behavioral practices and imparting awareness about preventive and curative health measures. This awareness percolates to households and families of the students. It also ensures creation of aware students who will be parents in the near future. Therefore School Health Programme in cities can help the National Urban Health

Mission to achieve its goals and objectives by reaching out to a large section of the community in a cost effective manner.

7.18.2 Over one fifth of our population comprises of children, aged 5-14 i.e., the age group covering primary and secondary education. About 80% of these children are enrolled in schools. Of those enrolled 65-85% are regularly attending school, for an average of 200 days in a year. In urban areas, most of children who are attending government run primary and secondary schools are coming from disadvantaged sections of the urban population. Thus the bulk of the school age children are in schools on majority of days in a year and are very easy to reach. There are around 6.25 crore slum population in India (Census 2001). There will be approximately 1 crore urban poor children going to schools from slums.

7.18.3 The school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness, not only of the extended family, but the future generation as well.

7.18.4 In urban areas, the scheme would cover Government or private schools located in slums (U-PHC catchment) or government schools near slums which slum children attend.

7.18.5 School health programmes may consist of three related components; school health services, school environment and health education. It aims at screening of all primary school children for common ailments which include anaemia, worm infections, night blindness, iodine deficiency diseases (goitre), ear discharge, scabies, pyoderma, vision defects and dental problems.

7.18.6 COMPONENTS OF THE SCHOOL HEALTH PROGRAMME

- Health Education (H.E.) Activities, creating awareness about hygiene, prevention of Vector Borne Disease etc

- Medical examination of primary school children for eye ailment, nutrition,

and others

- Treatment of minor ailments such as de-worming, skin diseases at school itself
- Special In-patient care at identified hospitals and referral services
- Control of communicable diseases through Immunization
- Training of teachers for early identification of symptoms

7.18.7 Partnership with NGOs for health education activities, liasioning with other schools and monitoring the referral services could be done. Referral services have to be emphasized because without a good functioning referral system school health services cannot be successful in their objectives. The two way referral system, school-health worker-medical officer at health centre/school health clinic-specialist shall be established and be working. Teachers may be trained and equipped for recognition of sickness/danger signals, for giving first aid/on the spot treatment and for referring the children needing further care. For this purpose training programmes have to be designed, ideally jointly with health functionaries (of appropriate levels) for present teachers and suitable changes made in the training curricula for future teachers.

7.18.8 The states are implementing their existing school health programmes and the scheme can be integrated with the School Health Programme under NUHM. The state can take a lead in streamlining implementation of the programme with appropriate budget allocation.

7.19 IMPROVING ACCESS TO VULNERABLE SECTION OF URBAN POOR

7.19.1 To target special interventions on the vulnerable groups in the cities, mapping of the vulnerable groups (one time) would be undertaken. The vulnerable sections would include the rag pickers, destitute, beggars, street

children, construction workers, coolies, rickshaw pullers, sex workers, street vendors and other such migrant workers. It is also

envisaged that dedicated drug distribution centres be opened for the identified concentration of vulnerable groups, through NGO/CSOs, which will have provisions for emergency OTC drugs and contraceptives. Special attention would be paid to organizing outreach sessions for these vulnerable communities. For targeted IEC/BCC interventions, the details of which will be as per the city PIP, the provision is Rs.5 per capita for the target urban vulnerable population (in line with the provision for IEC/BCC under NRHM). This will also include community mobilization, identification of recently settled urban poor families and support through NGO/CSO. The details of this mobilization strategy will be as per the city PIP.

TABLE 17.1: Indicative Service Norms by levels of Service Delivery *

Services**	**Levels of service delivery**		
	Community (Outreach)	**First point of service delivery (U-PHC)**	**Referral Centre - U- CHC (Specialist services)**
A. Essential Health Services			
A1. Maternal health	Registration, ANC, identification of danger signs, referral for institutional delivery, follow-up Counseling and behavior promotion	ANC, PNC, initial management of complicated delivery cases and referral, management of regular maternal health conditions, referral of complicated cases	Delivery (normal and complicated), management of complicated Gynae/ maternal health condition, hospitalization and surgical interventions, including blood transfusion.

A2. Family welfare	Counseling, distribution of OCP/CC, referral for sterilization, follow-up of contraceptive related complications	Distribution of OCP/CC, IUD insertion, referral for sterilization, management of contraceptive related complications	Sterilization operations, fertility treatment
A3. Child health and nutrition	Immunization, identification of danger signs, referral, follow-up, distribution of ORS, paediatric cotrimoxazole post-natal visits/counseling for newborn care	Diagnosis and treatment of childhood illnesses, referral of acute cases/ chronic illness Identification and referral of neonatal sickness	Management of complicated paediatric/neo-natal cases, hospitalization, surgical interventions, blood transfusion
A4. RTI/STI (including HIV/AIDS)	referral, community level follow-up for ensuring adherence to treatment regime of cases undergoing treatment	Symptomatic Diagnosis and primary treatment and referral of complicated cases	Management of complicated cases, hospitalization (if needed)
A5. Nutrition deficiency disorders	Height/weight measurement, Hb testing, distribution of therapeutic doses of IFA, promotion of iodized salt, nutrition supplements to identified children and pregnant/ lactating women Promotion of breast feeding, complementary feeding for prevention of under-nutrition	Diagnosis and treatment of seriously deficient patients, referral of acute deficiency cases	Management of acute deficiency cases, hospitalization Treatment and rehabilitation of severe under-nutrition

A6. Vector-borne diseases	Slide collection, testing using RDKs, DDT Counseling for practices for vector control and protection	Diagnosis and treatment, referral of terminally ill cases	Management of terminally ill cases, hospitalization
A7. Mental Health		Initial screening and referral	Psychiatric and neurological services, including hospitalization, if needed
A7.1 Oral Health		Diagnosis and referral	Management of complicated cases, hospitalization (if needed)
A7.2 Hearing Impairment/ Deafness			Management of complicated cases, hospitalization (if needed)
A8. Chest infections (TB/ Asthma)	Symptomatic search and referral, ensuring adherence to DOTs, other treatment	Diagnosis and treatment, referral of complicated cases	Management of complicated cases
A9. Cardio-vascular diseases	BP measurement, symptomatic search and referral, follow-up of under-treatment patients	Diagnosis and treatment and referral during specialist visits,	Management of emergency cases, hospitalization and surgical interventions (if needed)
A10. Diabetes	Blood/urine sugar test (using disposable kit), symptomatic search and referral,	Diagnosis and treatment, referral of complicated cases	Management of complicated cases, hospitalization (if needed)

A11. Cancer	Symptomatic search and referral, follow-up of under-treatment patients	Identification and referral, follow-up of under-treatment patients	Diagnosis, treatment, hospitalization (if and when needed)
A12. Trauma care (burns & injuries)	First aid and referral	First aid , emergency resuscitation, documentation for MLC (if applicable) and referral	Case management and hospitalization, physiotherapy and rehabilitation
A13. Other surgical interventions	--- not applicable ---	Identification and referral	Hospitalization and surgical interventions
B. Other support services			
B1. IEC/BCC	IPC, Health Camps/fairs, performing arts, wall/poster writing, events (in schools, women's groups)	Distribution of health education material	Distribution of health education material
B2. Counseling	Individual and group/family counseling –	Patient/attendant counseling	Patient/attendant counseling
B3. Personal & Social Hygiene	IEC on hygiene, community mobilization for cleanliness drives, disinfection of water sources, etc.	--- not applicable ---	--- not applicable ---

*Norms adapted from NCMH Report

** Services based on situational analysis

TABLE 7.2: INDICATIVE NORMS FOR OPERATIONALISATION OF URBAN PHC

- Accessibility

- Preferably located near the slum to be served
- Accessed by slum dwellers

- Services
    - Medical care: OPD services: From 12 noon to 8 pm
    - Services as prescribed under RCH II
    - National Health Programmes
    - Collection and reporting of vital events and IDSP
    - Referral Services
    - Basic Laboratory Services
    - Counseling services
    - Services for Non Communicable Diseases
    - Social Mobilization and Community level activities

- Basic Infrastructure
    - Consultation room, Dressing and treatment room, Medicine room

- Medical equipments and instruments

- Basic Staff

TABLE 7.3: PROPOSED HUMAN RESOURCE AT URBAN PHC

#	Staff Category	Number
1	Medical Officer	2 (1 regular and 1 part time)
2	Staff Nurse	3
3	Pharmacist	1
4	Lab Technician	1
5	Public Health Manager/ Community Mobilisor	1
6	LHV	1
7	ANMs	4-5 * Depending upon the population
8	Secretarial Staff including for account keeping and MIS	2
9	Support staff	1

TABLE 7.4: INDICATIVE NORMS FOR OPERATIONALISATION OF URBAN CHC

As the partnership for the referral unit would be need based, empanelment criteria can be developed based upon the norms prescribed by the IPHS for hospitals. Some of the suggested criteria can be

- Accessibility
    - The Hospital/ Nursing home to be easily accessible for the served population.
    - Willingness to provide services at the rates negotiated

- Facilities :
    - As per IPHS norm for Hospitals locally adapted as per need
    - Round the clock availability of services

- Availability of Specialties services for which the partnership is being entered. Some of them may be:
    - Obstetrics and Gynaecology
    - Paediatrics
    - General Surgery
    - Ophthalmology
    - ENT
    - Orthopaedics

- Dermatology
- CVD
- Endocrinology (Diabetes, Thyroid)
- Mental Health
- General Medicine
- Dental
- Any other based on epidemiological profile of the City

- Diagnostic facilities: As per the requirement. Some of it can be:
    - Fully equipped laboratory for biochemistry, microbiology and hematology
    - X- Ray machine with minimum capacity of 60 MA
    - Ultra-Sonography
    - Any other based on epidemiological profile of the City

8 - BROAD NORMS FOR NUHM INTERVENTIONS

	Activity	Norm

1.	Mapping of all urban health facilities/ poor households	Norms will have to be developed to classify the poor households. GIS Mapping of all health care facilities-public and private and slums-listed and unlisted would be done to study the population distribution and morbidity pattern (GIS maps prepared under various urban schemes would be taken wherever available). Data base to be generated involving the Community Workers, CBOs and NGOs. Cost will vary in mega cities, million plus cities, and other categories of cities and towns.
2.	Preparation of slum/city specific plans Baseline Surveys	Based on the detailed GIS mapping and household surveys and after intensive discussion at all levels, Slum/City level plans to be drawn up. Cost of planning will vary as per the population. Detailed baseline su`rvey at household and facility level to determine the gaps.
3.	Female Health Worker (FHW)	One FHW/ANM will be provided in urban areas for a population of 10-12 thousand. As health sub-centres are not proposed under NUHM, FHWs will be based in U-PHC. They will be provided mobility support for outreach services.
4.	Community Worker/Link Worker for every 200-500 slum/vulnerable households (1000-2500 slum/vulnerable population)	Community Worker/ASHA//LW preferably a woman should be a local resident and at least Class 10 pass. To be paid performance based incentives. Main tasks to be generating awareness in the community, coordinating with community groups/MAS for preventive and promotive actions for health and health determinants, and linking households to health facilities (government or private accredited).

5.	Capacity building, performance based payments, drug kit for Community Worker Training Infrastructure to be synergized with NRHM	Basic training modules for Community Workers to be developed based on the ASHA training modules. 4 weeks induction training followed by 10-15 days refresher training in various aspects of public health and community mobilization. Compensation for training. To ensure economies of scale, training infrastructure created under NRHM would be used for training and orientation of staff for urban health. There should be no duplication of infrastructure between NUHM and NRHM. The saving that will accrue due to the use of common infrastructure may be clearly indicated.
6.	Community Organization (Mahila Arogya Samiti) for 50-100 households in slums/other vulnerable population (250-500 slum/vulnerable population).	Community Organization in homogeneous setting with 10-12 members, will receive grant of Rs. 5000 per year. Major responsibility of community mobilization and awareness/demand generation addressing health and health determinants.
7.	Training and Capacity Building of Mahila Arogya Samitis	Through NGOs. To ensure greater role in management of savings and community mobilization. Quarterly orientation workshops/meetings will be organized for the MAS members.

8.	One Urban Primary Health Centre for every 50,000 population	U-PHC as nodal point. To function under government with well defined service guarantees and provisions for human resources, infrastructure, equipment, etc. Indian Public Health Standards will be developed for U-PHC as per the recommendations of the Shiv Lal Committee. U-PHC to operate preferably from 12 noon to 8 pm.
	Land and building for U-PHC	Land for the Urban Primary Health Centres and other such infrastructure would be given free of cost by the State Government. The cost of land shall not be included in the total project cost for the purpose of calculating the State share.
	Assured package of services	Building for new UPHCs and other additional infrastructure shall be provided by the State Government as per specified parameters. The cost within these parameters can be counted as part of 25% State share. Assured package of services for the primary level care at the U-PHCs would be defined as part of the IPHS.

9.	One Urban Community Health Centre for every 2.5-3 lakhs population (every 5 –6 U-PHCs) in cities above 5 lakh population	U-CHC to function as in-patient and first referral level for the urban population, reducing the workload of sub-district/district or medical college hospital in the city (which take the load of the entire area and only of the city). To function under government with well defined service guarantees and provisions for human resources, infrastructure, equipment, etc. Indian Public Health Standards will be developed for U-CHC. One U-CHC for every 2.5 lakh population (in non-metro cities above 5 lakh population) and for every 5 lakh population in metro cities. The central assistance would provide only for one-time grant of Rs.5 crores in non-metro cities for 30-50 bedded hospital and Rs.9 crores in metros for 100 bedded hospitals. The recurrent cost would be borne by the state. Establishment of U-CHCs to be decided by the concerned State Government on the basis of actual need.
10.	Training and Capacity Development of Ward level Standing Committee on health under Urban Local Body	NGOs to be involved in training and capacity development of Ward level Standing Committees of health.

11.	Untied grants to Rogi Kalyan Samiti	Each U-PHC to get Rs. 2.5 Lakh and each U-CHC to get Rs.5 lakhs as untied grant every year for local public health action and for its maintenance and upkeep. The District Health Society may re-appropriate the overall amount amongst various health institutions by ±25%, depending on need and utilization levels. The resource envelope for each state would be calculated on the basis of the total urban population to be covered, with an appropriate and additional weightage for urban poor / slums in the identified towns of the State being given.
12.	Resources for outreach services as per fixed schedule in urban slums by ANMs Outreach services and health check-ups	Outreach services at slum level will be provided by the ANM. Buildings (community halls etc) constructed under the schemes of the Department of UD, HUPA and other government departments may be utilized as fixed points for providing periodic outreach services. Health check up in the Anganwadi Centres preferably on a monthly basis, coordinated by ANM, with AWW and ASHA. Outreach programmes (like Urban Health and Nutrition Day) may be done in Anganwadi Centres and Primary Schools to ensure convergence of scheme for the target population with no duplication.
13.	Involvement of NGOs in U-PHC area	NGOs will be utilized for community mobilization, capacity building, and other preventive and promotive activities for health and health determinants.
14.	Hiring of NGOs/Private providers for U-PHC services	Services of NGOs and private providers may be hired to bridge the gaps in health care delivery as per actual need. For this the accreditation process and deliverables to be clearly defined.

15.	Enhancing planning capacity in urban local bodies Convergence with existing programmes	Provision for need based additional human resources in public health, management of health system, finance, MIS, planning, etc. Convergence for planning, mapping, coordinated service delivery, addressing gaps in health and health determinants and joint monitoring. This would include convergence with MoWCD, MoHUPA, MoUD, MoHRD and MoLE.
16.	Referral Transport and Mobile Medical Units	MMUs and Referral Transport System provided in the district under NRHM will also be used to cover urban areas.
17.	Setting up of City Level society (in metros and cities that are considered capable of managing the urban health programme by the states)	In the metropolitan cities and other cities where the State government decides to hand over the management of urban health system to municipal corporations, city level health society will be set up. In such cases, an MOU may be signed with the city corporation with clearly defined performance benchmarks.
18.	Behaviour Change Communication	IEC and BCC have a very important role especially in urban areas where the influence of media and advertising needs to be countered effectively, especially against use of junk food, aerated drinks, tobacco and alcohol consumption, etc. Provision of Rs. 5 per capita for IEC/BCC. Interpersonal communication through LWs/ASHAs to play a major role in promoting behaviour change.
19.	MIS for health in urban areas	As per need.
20.	Management cost for programme	Up to 6 percent of the resource envelope for recurrent cost. A capital grant of Rs.5 lakhs per Program Management Unit (PMU) would be provided separately.

21.	Interventions for making surveillance system effective	As per norms of IDSP.
22.	Special interventions for vulnerable groups like sex workers, street children, migrant labor, etc.	As per specific proposals and preferably through NGOs.
23.	Strengthening Secondary and tertiary care hospitals	As per need.
24.	Community Monitoring	As per need.
25.	Urban Areas having less than 50,000 population	Urban Areas having less than 50,000 population will be covered by the health care delivery system supported by the National Rural Health Mission.
26.	Building ownership of Sub Divisional Officer	In the cities/towns other than State/district headquarters, a committee headed by the sub-divisional officer will be constituted by the District Magistrate in consultation with the Chief Medical Officer. This committee will ensure effective coordination and implementation of NUHM activities in the cities/towns in the jurisdiction of the sub-division. Similar arrangement with Additional District Magistrate (ADM)/Sub Divisional Officer may also be put in place for district headquarter towns/cities.

9 - FINANCIAL RESOURCE NEEDS FOR NUHM

9.1 The National Urban Health Mission would initiate planning activities in 2012-13. The Centre-State funding pattern will be 75:25 for all the states except North-Eastern states including Sikkim and other special category states of J&K,

Himachal Pradesh and Uttarakhand for whom the centre-state funding pattern will be 90:10.

TABLE 9.1: POPULATION ASSUMPTIONS UNDERLYING FINANCIAL ESTIMATES FOR NUHM:

	Population	Numbers
•	Urban Population 2001 (Census 2001)	28.61 crores
•	Urban population 2011 (Census 2011)	37.71 crores
•	Urban population residing in cities with a population of above 50 thousand	22.13 crores
•	Projected Urban slum population 2011 (in cities above 50 thousand population – estimated 25% of urban population + 10% additional estimated vulnerable population)	7.75 crores
•	No. of metro cities	7
•	No. of cities with population above 1 million (10 lakh) as per projections (taking into account urban population growth@ 3% p.a)	27
•	Cities with population between 1 - 10 lakh	353
•	Cities with population between 50,000 - 1 lakh	392
•	Total Number of U-PHCs to be strengthened (@ 1 U-PHC for 50,000 population)	4,425
•	Total Number of U-CHCs (@ 1 U-CHC for 5-UPHCs, i.e. 2.5 lakhs population	344
•	Total no. of ANMs required in the U-PHCs (@ 4 ANM per U- PHC)	23,688
•	Total Number of ASHAs /LWs required (@ 1 ASHA for 2000 slum population)	38,720
•	Total Number of Mahila Arogya Samitis (@ 1 MAS for 100 HHs in slum areas)	1,54,882

9.2 ESTIMATED FUNDS REQUIRED FOR NATIONAL URBAN HEALTH MISSION

9.2.1 It is estimated that the proposed NUHM would need a total of Rs.22,507 crores (approximately) from 2012-13 to 2016-17, of which Rs.16,955 crores (approximately) is envisaged to be the central government share. Year wise financial requirement, by central and state share, is shown below.

(in crores)

Year	GOI	States	Total	Remarks
2012-13	2,325.61	762.13	3,087.74	GOI 75%, state 25% in all states except northeastern states where the ratio is GOI 90%, state 10%
2013-14	3,782.74	1,239.42	5,022.17	
2014-15	3,957.74	1,296.35	5,254.09	
2015-16	3,949.20	1,293.20	5,242.40	
2016-17	2,939.77	961.04	3,900.82	
Total	**16,955.07**	**5,552.14**	**22,507.21**	

9.2.2 As per the above table, the financial requirement for the central government in the XII Plan period is estimated to be Rs. 16,955 crores (central share).

9.3 MANAGEMENT COSTS

9.3.1 It is imperative that management capacities be built at each level. To attain the outcomes, the NUHM would provide management costs up to 6% of the total annual plan approved for a State/City (similar to NRHM norms of 6% for management costs). The services of experts and other functionaries may have to be hired on contractual basis to carry out the activities under the Mission. The Mission would also need to be vested with authority to strengthen management structures without creating any new permanent posts.

9.4 NORMS FOR RELEASE OF FUNDS TO THE STATE GOVERNMENTS

9.4.1 In order to ensure that the state specific focus is retained in planning and management of NUHM the urban population and health infrastructure would be given appropriate weight-age for release of the funds to the States. However, actual release would depend upon the actual State Level PIP based on respective city and district level PIPs subject to approval by the NPCC at the Central level.

9.5 SUSTAINABILITY

9.5.1 The NUHM would strive to ensure the sustainability of the Mission through state and ULB contribution, promotion of community structures like the Mahila Arogya Samitis and facility based Rogi Kalyan Samitis on the lines of NRHM.

9.5.2 The Rogi Kalyan Samiti would also be encouraged to pool funds, on the lines of NRHM, from other sources like donations/ MP or MLA/ULB etc contributions for broad-basing the community health fund.

10 - PLANNING PROCESS OF NUHM

10.1 City specific planning is extremely essential as the health structure in cities varied considerably. However in order to optimize the utilization of central, state, municipal, and private health assets and manpower, it was essential that a **City Health and Sanitation Planning Committee** in the urban areas works under the umbrella of the **District Health Mission** and the **District Health Society** whose primary role would be to integrate health service delivery to the urban poor in the urban areas.

10.2 The planning process would involve identification, mapping and vulnerability assessment of slums, assessment and mapping of the existing health care services, stakeholder consultations, mapping of referrals in each area, rationalization of manpower, mapping and accrediting the private sector, ensuring private sector

participation and also ensure effective convergence with departments likes ICDS and JnNURM.

10.3 Household surveys through the Mahila Arogya Samiti and the ASHA/Link Worker are needed to understand the poverty of households and the challenges of public health in urban slums. The Mahila Arogya Samiti will be the basic unit of planning and community action.

11 - APPRAISAL AND APPROVAL PROCESS OF NUHM

11.1 The NRHM has developed a transparent mechanism for appraisal of state PIPs and subsequent release of funds. The NUHM will also follow norms as has been developed under NRHM for programme appraisal and fund release.

- Each City would develop a **CPIP**, which would be consolidated at the State level as State Programme Implementation Plan **(SPIP)** incorporating additionalities at the State level.

- The CPIP would be a reflection of the comprehensive resources available to the City under the various ongoing national health/state/ULB programmes and also other sources of funds including State Health Systems projects, State Partnership Projects, Finance Commission awards, projects / schemes funded

through Global Funds and/or Global Partnerships in the health sector and projects / schemes being (or proposed to be) funded outside the State budget as an illustrative but not an exhaustive list. Clear delineation of funds allocated under RCH, NRHM Flexipool, RNTCP, NVBDCP, IDD, NLEP, NMHP, NPCB, NACP, UFWC, UHP etc would have to be enunciated in the PIP.

- The National Programme Coordination Committee (NRHM) headed by the Mission Director would undertake the appraisal of the proposals received and also recommend for funding.

11.5 With the launching of NUHM, all of these existing programmes/schemes (supporting the various types of primary healthcare facilities like UHP/UFWC/Dispensary) will automatically cease to exist. The existing infrastructure available under these schemes would be rationalized and aligned with the new IPHS.

11.6 The City /State PIP would also clearly articulate the funds required for the urban component of the various National programmes and the funds would be released by the Programme Divisions.

11.7 The NUHM similar to the NRHM would also try to provide a platform for integrating all the programmes for urban areas as is being done under the NRHM. Till the time this process is put in place and institutionalized the fund flow mechanism under the NRHM would be adopted. E-banking systems would be put in place for facilitating this.

11.8 Given the current absorptive capacities in the States as also the structures

for managing accountability at various levels, it is likely that the demand for resources will be less in the initial years. The actual need year to year will depend on the pace at which States push reforms in order to remove the constraints on expenditure and its effective utilization. Efforts would be made to kick-start the Mission with the desired pace by capacity building workshops to increase the absorptive capacity of the states. Annual financial demands would be accordingly made. A flexible pool of resource envelope would be indicated to the states with provision for inter component variability in activity heads/costs in view of extant urban situation/city specific conditions.

12 - ROLE OF THE NON-GOVERNMENTAL SECTOR IN NUHM

12.1 Transparent partnerships with non-governmental providers for health care services

12.1.1 Recognizing that government health facilities do not have adequate reach in urban slums leading to low demand and poor utilization, involving NGOs in outreach and referral in the urban poor settings may be a viable option. Many state governments have also contracted private hospitals to provide outreach activities (using the private partner's facilities and staff) in un-served areas and

also provide referral support. There is a considerable existing capacity among private providers (NGOs, medical practitioners and other agencies), which should be explored, fruitfully exploited and operationalised.

12.1.2 Potential private partners should be identified and tapped optimally to improve the quality and standard of health among the urban poor, by capitalizing on the skills of potential partners, encouraging pooling of resources, and supplementing the investment burden on the Government of India's resources deployed in the health sector. Appropriate mechanisms for partnering (or entering into agreement) with the private sector needs to be considered, including accreditation methods (for ensuring quality), memorandum of understanding, reporting and monitoring systems etc.

12.2 Role of NGOs in strengthening health services for the poor

12.2.1 The presence of active NGOs in several cities presents a unique and powerful opportunity to extend the reach of health services through various ways of outreach and enhancing utilization by raising community demand for the existing services. The support of the NGOs would be encouraged and supported to get suitably involved in the planning and implementation of the urban health projects. They may support in undertaking situational analysis, identification and mapping of slums, identification & capacity building of Link Volunteers and IEC/BCC activities.

13 - ROLE OF REGULATION AND DEFINING STANDARDS

13.1 The IPHS standards for U-PHC and U-CHC will be developed and shared

with the States.

13.2 The Quality Assurance activities would mainly involve formation of an overarching Quality Assurance Committee (QAC) at state and city levels and one or more Quality Assurance Teams (QAT), composed of renowned specialists and senior technicians.

13.3 The Quality Assurance teams would be responsible for recommending accreditation of clinics/ hospitals/ nursing homes/ diagnostic centers and pharmacies for empanelment for outreach services/ U-PHCs/ referral centers.

13.4 These teams would also undertake periodic medical audits of selected/empanelled health facilities, either by themselves, or through external auditors, in consultation with the Quality Assurance Committee.

13.5 For this purpose, it is proposed to allocate a lump sum amount of Rs. 50 lacs per year per metro city, Rs. 20 lacs per city with 10 lac+ population, Rs. 10 lacs per other city with 1 lac+ population, and Rs. 1 lac for cities less than 1 lac population (but above 50,000 population).

13.6 These funds would also include provision for orientation and training of QAC/QAT.

13.7 But these provisions do not include funds for certification of government hospitals.

13.8 In addition a Health Service Charter will be displayed at the facility level. It is envisaged that such public display of information would empower the community for demanding services. The different institutional mechanism like Rogi Kalyan Samiti/ Mahila Arogya Samiti would ensure that the service guarantee at each level is met.

13.9 In order to identify discrepancies and take corrective actions the practice of Concurrent audit may be introduced right from the inception stage. All the funds/ untied grants would be audited on a quarterly basis and report of which would be made public. This process would also facilitate timely submission of utilization certificates and Audit Reports to ensure financial health of the Mission.

13.10 A grievance redressal mechanism would be put in place in which a committee, comprising of members from government and reputed community members would be constituted which will help resolve the problems and complaints.