NATIONAL URBAN HEALTH MISSION

FRAMEWORK FOR IMPLEMENTATION

MINISTRY OF HEALTH AND FAMILY WELFARE

GOVERNMENT OF INDIA

JUNE 2010

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I - EXECUTIVE SUMMARY

1. As per Census 2001, 28.6 crore people live in urban areas. The urban population is estimated to increase to 35.7 crore in 2011 and to 43.2 crore in 2021. 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 was expected to reach 6.25 crore by 2008, 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.

2. 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. .

3. 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.

4. 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 National Rural Health Mission and the National Urban Health Mission will be two major sub Missions of a larger National Health Mission. The Mission Steering Group of the NRHM will become the National Health Mission. Every Municipal Corporation, Municiplaity, 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 NRHM. The District Plan will now be called the integrated District Health Action Plan covering the urban and the rural population. The Municipal Corporations will have a separate plan of action as per broad norms for urban areas. The National programme Coordination Committee of NRHM will now become the NPCC for the National Health Mission. The Additional Secreatry and Mission Director of NRHM will become the Mission Director National Health Mission, under whom both the sub Missions will work.

5. 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 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

urbnan 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 intent is to develop a 'communitized' model (neither public nor private) of health care where community organizations have the resources to buy services that they need. This will involve intensive capacity building of community organizations on public health issues. 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.

Thus during the Mission period all 640 cities would be covered. This will be in partnership with the NRHM's efforts so far to ensure that there is no duplication of services. The NUHM would have high focus on:

- Urban Poor Population living in listed and unlisted slums
- 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.

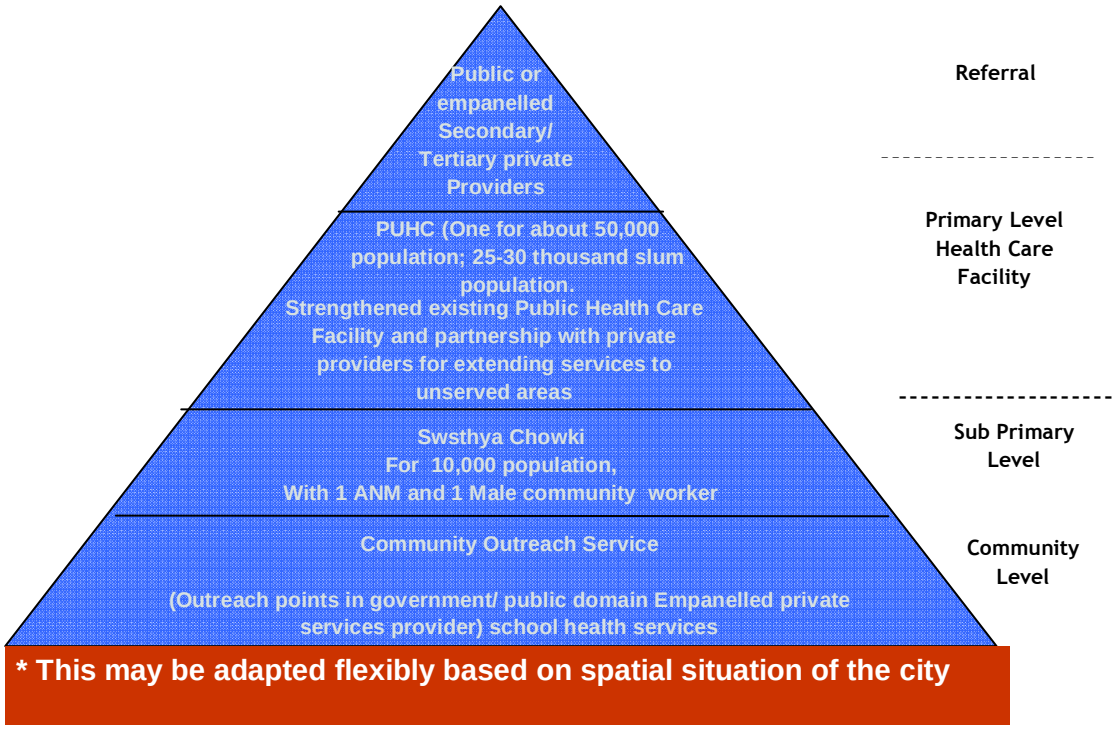
The National Urban Health Mission therefore aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. This 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 as a matter of right. 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 communitization process will

draw heavily on the existing community organizations and self – help groups developed thorugh other initiatives.

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, ICDS to optimize the outcomes.

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. The states will be free to choose from Non Governmental partnerships for public health goals, Public Private Partnership (PPP), strengthening the extant primary public health systems, an optimal mix of these or to propose other innovative models best suitable to their state needs. Selection of models will be service guarantee based and patient welfare oriented. 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 (Urban Social Health Activist-USHA) 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.). All the services delivered under the urban health delivery system will be targeted to the target groups (slum dweller and other vulnerable groups). The entire health delivery system will work under community ownership and as per community led action plans. The intent is to ensure that no compromise is made with service guarantee at reasonable cost and as per agreed protocol.

Diagram: Urban Health Care Delivery Model

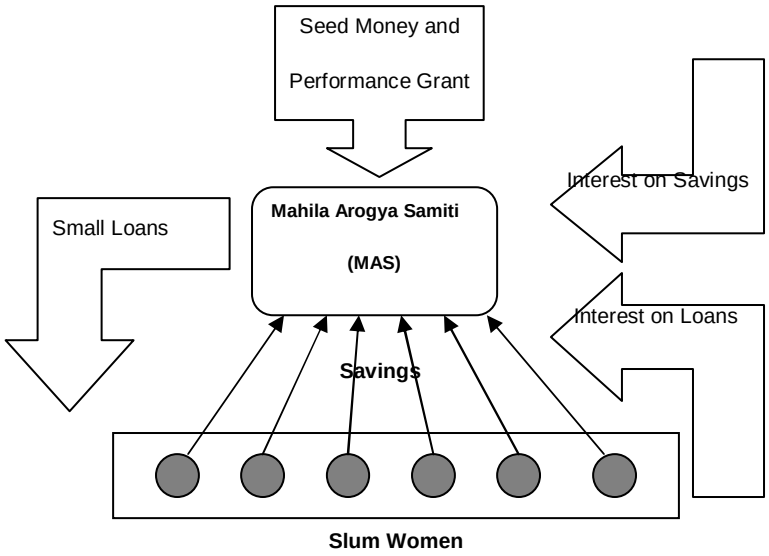


The NUHM would encourage the participation of the community in planning and management of health care services. It would promote an Urban Social Health Activist (USHA) in urban poor settlements (one USHA for 1000-2500 urban poor population covering about 200 to 500 households); ensure the participation by creation of community based institutions like Mahila Arogya Samiti (20-100 HOUSEHOLDS) and Rogi Kalyan Samitis. It would proactively reach out to urban poor settlements by way of regular outreach sessions and monthly health and nutrition day. It mandates special attention for reaching out to other vulnerable sections like construction workers, rag pickers, sex workers, brick kiln workers, rickshaw pullers. This could be done through the public healthcare systems or through PPP or other innovative models deemed suitable by the states.

The NUHM would promote Community health risk pooling as measure for fulfilling the immediate cash requirement at the time of emergency. To promote community risk pooling mechanism slum women would be organized into Mahila Arogya Samiti. The members of the MAS would be encouraged to save money on monthly basis for meeting health emergencies. The group members themselves would decide the lending norms and rate of interest. The NUHM would provide seed money of Rs. 2500 to the

MAS (@ Rs 20/- per household per month amounting to approximately Rs. 5000 by the MAS). The NUHM also proposes incentives to the group on the basis of the targets achieved for strengthening the savings. The USHA will also promote enrolment of the urban poor in schemes like Rashtrya Swastha Bima Yojana (RSBY) for improved access to referral health care services.

Community Risk Pooling under NUHM



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. In addition to the above, at the City level the States may preferably decide to constitute separate City Urban Health Missions/ City Urban Health Societies in view of the 74th Constitutional Amendment, or use the existing structure of the District Health Society / Mission under NRHM with additional stakeholder members. Municipal Corporations will have separate Urban Health Missions.

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.

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 utilisation of the system through the convergence mechanism, through provision of a common platform and availability of all services at one point (PUHC) 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 PUHC level. Appropriate convergences and mechanisms for co-locations and strengthening would be sought with the existing systems of AYUSH at the time of operationalisation.

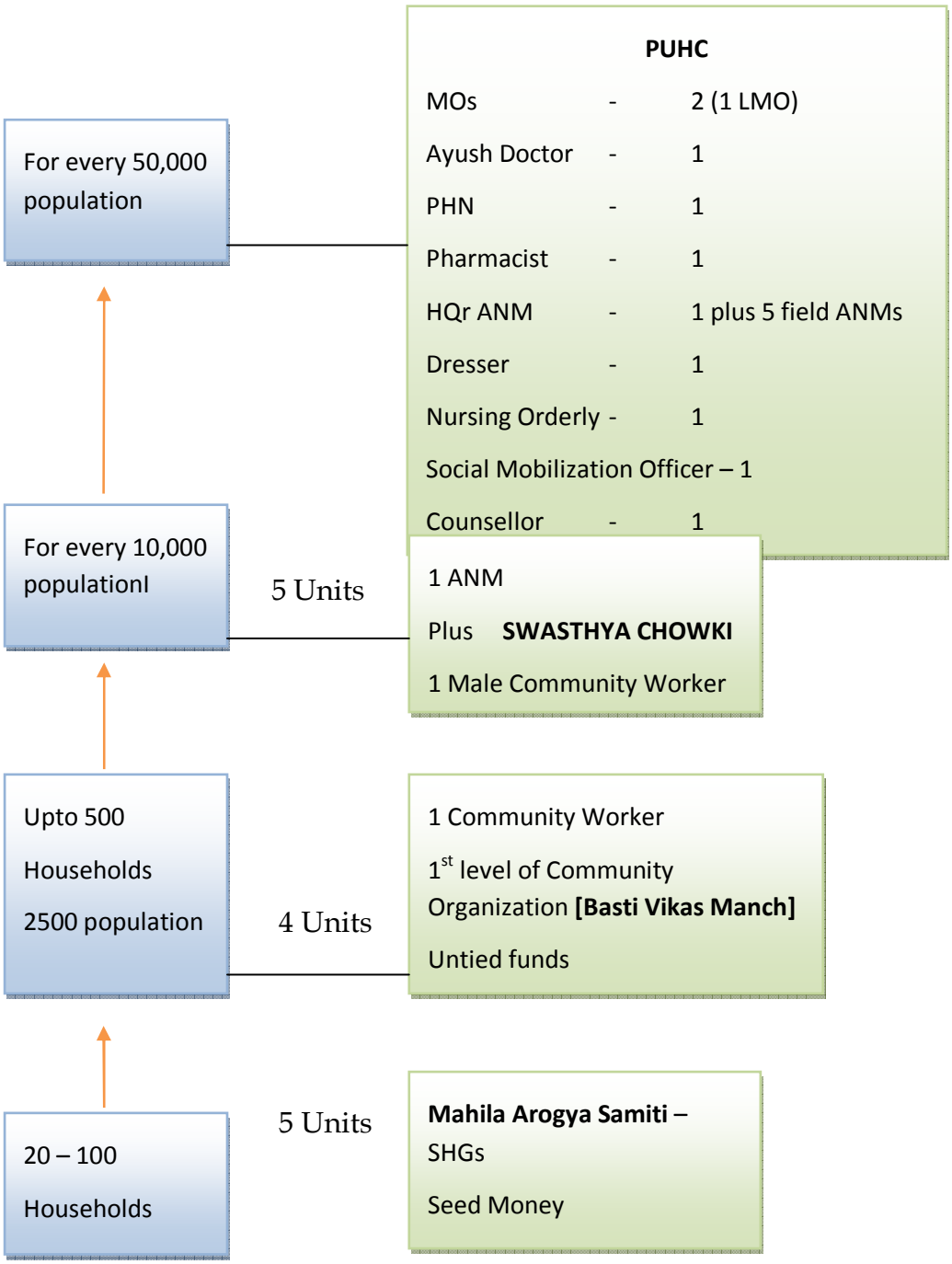
The effective implementation of the above strategies would require skilled manpower and technical support at all levels. Hence the National Urban Health Mission would ensure additional managerial and financial resources at all levels.

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.

Primary Urban Health Centre & Below

Norm for every 50,000 population

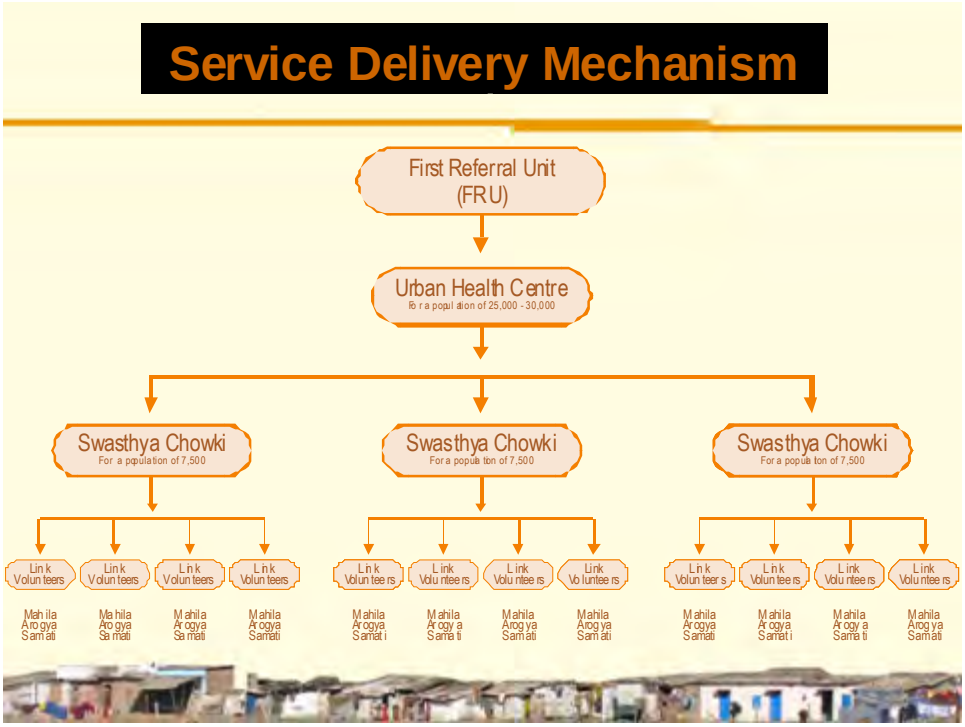
Note: HR norm to be provided by Govt./NGO/Partners at Government cost



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



II - THE URBAN HEALTH CONTEXT – A SITUATION ANALYSIS

1. Growing urbanization: According to the Census 2001, out of total population of 1028.6 million in India about 286 millions lived in urban areas. The percentage of people living in urban areas in the country increased from 11 in 1901 to 28 in 2001. Around 28 out of every 100 persons in the country resided in cities and towns in 2001. It is estimated that the urban population of country will increase to 357.8 million in 2011 to 432.6 million in 2021. **Table 1** provides data on the number of urban agglomerations/ towns, total population, urban population and urban population as a percentage of total population for census years of 1991 to 2001.

Table 1
India: Number and Population (in Million) of Urban Agglomerations (UAs) and Towns (1991-2001)

Census Year	Number of UAs/ Towns	Total Population	Urban Population	Urban Population as % of Total Population
1991	3,769	846,387,888	217,551,812	25.7
2001	4,378	1,028,610,328	286,119,689	27.8

2. The decadal growth rate of urban population in India increased at a fast pace from 1921-1931 until 1951. Subsequently it registered a sharp decline during 1951-1961. This drop was largely due to declassification of a very large number of towns during 1951-1961. The decades1961-1971 and 1971-1981 witnessed a significant escalation in urban growth rate which thereafter steadily dropped to the present level of about 31.2 per cent for decadal growth and 2.7 per cent for annual average exponential growth. As against the average annual growth rate of urban population of 3.27 per cent during 1961-71 and 3.86 per cent during 1971-81, the urban population growth rate was 3.13 per cent for 1981-91 and 3.12 percent for 1991-2001 (see Table 2)

Table 2: Growth in Population of Urban Agglomerations/ Towns: 1991-2001

Census Decade	Percentage Decadal Growth in Population of UAs/ Towns			Average Annual Exponential Growth in Population of UAs/ Towns		
	Total	Rural	Urban	Total	Rural	Urban
1991-2001	21.3	17.9	31.2	1.9	1.7	2.7

3. The number of towns/ cities in the country increased from 4615 in 1991 to 5161 in 2001 (see **Table 3**). Out of this 441 towns constitute the Class I towns (having a population of

100,000 and above) and 496 are Class II towns (having a population of 50,000 to 99,999). The share of population of these Class I and Class II town in 2001 in the total urban population is 62.3% and 12.1 % respectively. Thus it is clear that 74.4% of the urban population of the country is concentrated in large towns/ cities only. **Table 4** shows the growth of population by size class of towns.

Table 3
Growth of Urban Agglomerations & Towns by Size Class/ Category during 1991-2001 (In Numbers)

Year	Class/ Category of Cities/ Towns						
	All Classes	Class-I	Class-II	Class-III	Class-IV	Class-V	Class-VI
1991	4615	322	421	1161	1451	973	287
2001	5161	441	496	1388	1561	1041	234

Table 4
Growth of Population of Cities/ Towns by Class/ Category during 1991-2001

Year	Class/ Category of Cities/ Towns						
	All Classes	Class-I	Class-II	Class-III	Class-IV	Class-V	Class-VI
1991	215.8	122.3	28.8	35.3	21.1	7.4	1.0
2001	286.1	178.2	34.5	42.1	22.6	7.9	0.8

Calcutta was the only million-plus city in the country in 1901. The number of million-plus cities increased to 5 in 1951, 12 in 1981, 23 in 1991 and 35 in 2001. The 35 million-plus cities together had a population of about 108 million as per Census 2001, accounting for about 39 per cent of urban population of the country. **Table 5** shows the steady growth in the number and percentage of urban population living in million-plus cities from 1931 onwards. While 32.5 per cent of the urban population lived in metropolitan urban agglomeration/ towns in 1991, by 2001 the figure went up to 39.6 per cent.

Table 5
Number and Percentage of Urban Population in Million-plus Cities in India 1991-2001

Census Year	Number	Population (in Million)	Population per Million Plus City (in million)	% to Urban Population
1991	23	70.66	3.07	32.54
2001	35	107.88	3.08	38.60

4. **Growth of Slums :** Census of India 2001 has made an attempt for the first

time in the country to collect detailed data about slum areas of the country particularly in cities/ towns having 50,000 populations or more in 1991. All the inhabitants of the areas, which have been notified as slums by the state governments under any legal provisions or even recognized by them, have been accordingly considered as slum population for this purpose. Besides areas in cities/ towns, which satisfy the usual criteria for declaring an area as slum have also been included. For the purpose of Census of India, 2001, the slum areas broadly constitute of:-

(i) All specified areas notified as 'Slum' by State/ Local Government and UT Administration under any Act;

(ii) All areas recognized as 'Slum' by State/ Local Government and UT Administration which may have not been formally notified as slum under any Act;

(iii) A compact area of at least 300 populations or about 60-70 households of poorly built congested tenements, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities.

However, as there are large number of slums which are not notified, as found by the NSSO Report No. 486: Conditions of Urban Slums, 2002: Salient Features NSSO-58; approximately 50% of slums are not notified. There is no data on slum population comparable to that provided by Census 2001 as no such census was conducted earlier. However, the Town and Country Planning Organisation (TCPO) estimated the slum population on the basis 1991 Census of India at 46.26 million. As per TCPO estimates, the slum population in 2001 stood at 61.82 million. As per the 2001 slum census conducted by the Registrar General, slum population identified in 640 towns/ cities having population of 50,000 or more spread over 26 Stat/ Union Territories all over the country was 42.6 million. This figure represents 23.1% of the total population of these towns estimated at about 184 million (as against the total urban population of the country of 286 million). Although there are criticisms as to the method adopted for enumerating slum population under the 2001 census in states like Bihar, Uttar Pradesh and Madhya Pradesh, the data reveals that about one-fourth in the population in metropolitan cities in 2001 lived in slums. Mumbai topped the list with a figure of 54.1% followed by Faridabad at 46.5% and Meerut at 43.5%.

Some highlights of data from first slum census of India in 2001 are as follows:

- 640 cities/ towns in 26 States/UTs in 2001 have reported slum population.
- Andhra Pradesh has the largest number of Towns (77) reporting slums followed by Uttar Pradesh (69), Tamil Nadu (63) and Maharashtra (61).
- 7.4 (17.4%) million of total slum population belong to the Scheduled Castes and one million (2.4%) to Scheduled Tribes.

- 17.7 million Slum population has been reported in the 27 cities with million plus population in 2001. Greater Mumbai Municipal Corporation with 6.5 million slum dwellers has the highest slum population among all the cities followed by Delhi Municipal Corporation (1.9 million), Kolkata (1.5 million) and Chennai (0.8 million)
- Sex Ratio of the total slum population is 876 which is lower than 905 for the corresponding non-slum population.
- Child Sex Ratio of the age group 0-6 is 919 in the slum population which is higher than 904 for non- slum population
- Literacy rate in slum areas stands at 73.1 with 80.7% and 64.4% female literacy against overall non slum urban literacy rates of 81.0% for total, 87.2% for males and 74.2% for females in the states reporting slums.
- 32.9% slum population has been returned as workers. Male work participation rate is 51.3 and female work participation rate is 11.9% in 2001.

Out of 35 metropolitan cities having population of 1 million and above in the country in 2001, 27 metropolitan cities have reported slums. As per Census of India, 2001, 17.7 million populations live in slums in the cities with million plus population which comes out to be 41.6% of the total identified slum population in these 27 large cities.

5. Public sector provisioning for health care in urban areas

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'[1].

6. Urban Family Welfare Centers: 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[2]. An amount of Rs. 520.40 crore has been proposed in the XIth Plan for sustaining the already ongoing activities and payments for heads like salary.

[1]Planning Commission, Government of India ; Tenth Plan Document (2002-2007, Volume II)
[2] MOHFW, GOI : Annual Report on Special Schemes, 1999-2000,

Table 6: 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

7. Urban Health Posts: 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 UTs3, functioning not very satisfactorily. An amount of Rs. 438.44 crore as been proposed in the XIth Plan for sustaining the already ongoing activities and payments for heads like salary.

Table 7: 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

3 MOHFW, GOI Annual Report on Special Schemes 1999-2000

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: IIPS evaluation of the UFWC and UHP scheme: Key findings[4]

- 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

8. Urban towns with population less than 100,000 are being taken up under the National Rural Health Mission (NRHM). However, norms for the urban slums in these townships have not been defined for support. The District/ Taluka Hospitals which usually are in the urban areas are also being strengthened under NRHM. As part of the urban component of RCH-II, there is provision for strengthening delivery of RCH services in cities with population between 1-10 lakh. The programme thus provides for support to the urban poor but restricts it to reproductive and child health services. However, the limited kitty of the flexible fund and lack of interest on part of the states under this scheme has relegated this component to the background of the scheme. Some of the National Diseases Control programmes also have an urban component, though not very well defined.

9. 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.

10. India Population Project (IPP) V and VIII : 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

4 Indian Institute of Population Studies 2005; National Report on Evaluation of functioning of UHPs/UFWCs in India

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.

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 initiative5.

11. Key characteristics of existing public health care in urban areas 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.

Table 7 : City wise description of health care system

Group	Cities	Health care System	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	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.

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Group	Cities	Health care System	Gaps and Constraints
		private providers /NGOs and Charitable trusts	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, Ahemdabad	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, Bhuwaneshwar 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

On the basis of the above field assessment of the cities the following points emerged

12. The Diversity of the Urban Situation: 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: 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% vacancy 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 MoH&FW

13. Weak Capacity of Urban Local Bodies to manage primary health care 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.

14. Though bigger corporations demonstrate improved capacity to manage their health 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.

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.

Issues	Mega City	Million Plus	Less than 10 lakh
Strengthening the delivery of health care services.	**Existing situation :** ▪ The existing health care system consists of three tier structure Primary, Secondary and Tertiary. ▪ The cities have a historical advantage of investments in the health sector through Central government funded schemes of UFWC and UHPs. They also have the advantage of the World Bank Supported IPP projects. ▪ The primary facilities in the city have been developed as a response to projects, not need based. Hence there are many areas which have surplus facilities while there are areas which do not have any facility. ▪ The service guarantee for each tier of facility has not been defined, resulting in a situation whereby different facilities have diverse service mandates. ▪ The referral mechanism is not clearly defined.	**Existing situation :** ▪ The health care service delivery differs for each state. Surat a million plus city has been able to develop an excellent functional health care service delivery system. City like Agra is managing the delivery of health care services though sub optimally functioning UHP and UFWC. In cities like Agra and Allahabad large chunk of the areas do not have a health facility at all. ▪ The primary facilities in the city have been developed as a response to projects, not need based. Hence there are many areas which have surplus facilities while there are areas which do not have any facility. ▪ The service guarantee for each tier of facility has not been defined, resulting in a situation whereby different facilities have diverse service mandates.	**Existing situation :** ▪ There are very few health care facilities and even if they are available the functioning is sub optimal. ▪ The service guarantee for each tier of facility has not been defined, resulting in a situation whereby different facilities have diverse service mandates.
City specific need based planning	In none of the cities visited there exists a clear cut process for planning of health care facilities. Even if the annual plans are developed there appears to be a **skewed priority for the secondary and tertiary health care** in the ULBs even though they are constitutionally mandated for primary health care. The following needs to be		

	addressed 1. **Instituionlise the process of planning** 2. **Mapping of slums and health facilities** 3. **Develop mechanisms for identification of the urban poor** Many states have passed the resolution for constituting of the District Planning Committee and Metropolitan Planning committee, however, they are not functional and effective.		
Strengthening the role of Urban Local Bodies	The Municipal corporations of Mega cities like Mumbai and Bangalore are more effective. Lack of a single point elected authority does not exist. As in all the place leaving aside Kolkatta, the Mayors are elected for one or two years. The urban local bodies have the mandate to plan and manage the health care facilities There is shortage of Manpower and not so effective system of Human resource management and policy exists. The availability of funds is there but the mechanism for its effective utilization does not exist	The urban local bodies are not responsible for managing the health care facilities. The public health responsibility of ULB is limited to birth registration and conservancy. The funding situation is weak There is shortage of manpower	
Communitisation of health care service delivery	The situation is different for each city as in Bangalore there is a Board of Visitor (community based body) for managing the health care facility in Mumbai and Hyderabad	No structures for community participation exists	

	no such mechanism for community structure is there. Link volunteer as part o the IPP V and VIII are present.		
Partnership with private sector for expanding services	Each city has entered into partnership with private providers for expanding the health care services. However, there is lack of effective models except in West Bengal which has utilized the services of the private doctors for outreach services	No experience of partnership exisits	
Role of NGOs	Bangalore has effectively utilized the NGOs for improving the delivery of services. Hyderabad also used the NGOs for expanding and improving health care services. However in none of the cities effective policy or guidelines exists for involving the NGOs	Few Cities like Indore, Agra Gauwahati have used the NGOs for strengthening the delivery of services as part of some donor funded projects. However in none of the cities effective policy or guidelines exists for involving the NGOs	
Human Resource	All the ULBs have dedicated manpower for managing the health care services. However, the city lacks the availability of experts like PPP	Manpower is very limited and lot of support is required	Manpower is very limited and lot of support is required
Funding	Funds are adequate	Very limited funds.	Very limited funds
Capacity Building	No systemic efforts have been made to develop the capacity of the member so the urban local body. However, due to programmatic interventions the	The capacity to plan and manage the health care facility is weak due to limited involvement	

	workforce is better equipped to implement health programme		

Health Facilities in Brihan Mumbai Municipal Corporation (Mega City)

1	Primary	Health Posts	168
		Dispensaries	163
		Post Partum Centres	23
2	Secondary	Municipal Maternity Homes	26
		Municipal Peripheral Hospitals	16
3	Tertiary	Municipal Medical Colleges	3

List of Health Facilities, Patna Million Plus City	
Dispensaries	**7**
Urban Family Welfare Centres	**2**
Referral Hospitals	**5**
Specialized Hospitals	**3**

Health Care Facility in Sharanpur (Below 10 lakh Population)

- UFWC 02 Govt,Rented
- UHP-C Type 06 No Building
- UHP-D Type 03 No Building
- PPC 01 DW Hospital
- Ayurvedic Disp.(Ayur) 01 Rented

15. Data inadequacy: Urban population, unlike the rural population, is highly heterogeneous. Most published data does not capture the heterogeneity as it is often not disaggregated by the Standard of Living Index. 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 reflecting 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.

16. Multiplicity of service providers and dysfunctional referral systems: 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.

17. Weak community capacity to demand and access health care: 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 neighbouring states/countries to the large metropolitan cities, made planning and implementation of social mobilization activities very challenging.

18. Strengthening community capacity increases utilization of services: 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, Basti 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.

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.

Honorary Health Worker (HHW) Scheme : West Bengal

The HHW initiative by KMC, he mentioned that the initiative was floated with the objective of bringing about an overall improvement in the urban health scenario by reducing the CBR, CDR, MMR, IMR, enhancement of CPR and provide primary health care service delivery to the urban population with focus on the RCH outcomes, especially of the BPL population. The initiative strives to implement National Health Programmes to the population of the Urban Local Bodies and ensure maximum utilization of Govt.

The key strategy of this approach was to reach out to the most underserved by strengthening service delivery through a uniform 3-tier service delivery model. HHW were appointed for enhanced community outreach, each of them covering a population of 1000/a ward; Women (ward residents educated to class VIII, with aptitude for social work and between the age group of 25-35 years) were selected as HHWs. Women from the neighbourhood groups and belonging to the BPL families were given preference to ensure that they reached out more effectively among a familiar community. After selection the HHWs were trained for 45 days and engaged on part-time (12 noon to 4 pm) basis with honorariums at Rs. 2,000/- per month and an added Rs. 2000.00 from KMC. This honorarium acted as an incentive.

The HHW conducts fortnightly home visits – their job includes motivation, collection of MCH data, assistance in public health services and registration of pregnant women. Programme strategy also included strengthening inter-departmental convergence, HMIS and IEC activities. In the modified scheme, the HHWs in addition to RCH messages, will promote health messages of all communicable diseases, nutritional deficiency disorders, adolescent health care, participation of males in family health; and identification of all types of cases for early detection and management. The HHWs and their supervisory tiers works in tandem with the offices of the DHFW in district/municipality level for providing comprehensive primary health care, referral services and act as depot holders and provide preventive and authorized curative services.

19. Focus on RCH services and inadequate attention to public health : 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 Control 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.

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.

20. Lack of comprehensive strategy to ensure equitable access to the most vulnerable sections: 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.

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 ragpickers, had any operational strategy for the highly vulnerable section.

21. Private Sector in urban areas: 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.

Box 2 : 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, orthopaedics, 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.

22. The Urban Poor and the Private Health Sector: 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. The private sector that the poor access may be thought of consisting of three wings: (i) the fully-organized-and-fully qualified; (ii) the fully qualified private providers that operate in less than well to do neighbourhoods where the slum population too go; and (iii) the 'less-than-fully-qualified' practitioners in the slum. 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. 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]

23. Expenditure on Health Care: 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.

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.

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%.

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.

24. Morbidity profile in urban areas :

Poor water and sanitary conditions lead to adverse health outcomes in the households living in the slums (Duggal and Sucheta 1989, Nandraj et al 1998, Karn, Shikura and Harada 2003).

Prevalence Rate of Illness and Hospitalization Cases Per 1000 Population in Delhi and Chennai by Type of Settlement

	Prevalence Rate of Acute Illness*	Prevalence Rate of Chronic Illness*	Prevalence Rate of all Illness	Hospitalisation Cases**	Total No of Persons (N)
Delhi					
Slum	62	47	109	21	19626
Resettlement	49	37	86	12	5386
All	59	45	104	19	25012
Chennai					
Slum	65	21	86	21	18452
Resettlement	49	22	71	15	5031
All	62	21	83	19	23483
Delhi & Chennai					
Slum	64	34	98	21	38078
Resettlement	49	30	79	13	10417
All	61	33	94	19	48495

** in the one month reference period , ** in the last one year*
Source: Sundar and Sharma (2002)

Sundar and Sharma (Table above) found higher rates of acute illnesses, chronic illnesses as well as hospitalization in the slums of Delhi and Chennai.

Godbole and Talwalkar (2000) found that in the slum areas of urban Maharashtra, only 34% women reported a birth interval of more than three years. The corresponding number in non-slum areas was 51%.

With regard to women's' health, a survey undertaken by Institute of Medical Health, Pune in 1998 of 27 slums in Pune revealed that 44 percent of women did not take treatment for reproductive tract infections. 28% of slum respondents reported violence against women.

Godbole and Talwalkar (2000) found that the state of child health in urban slums was in some cases worse than that in rural areas. In the context of immunization they find that oral polio vaccine coverage is 92 per cent in rural areas as against 79 per cent in urban slums. They also find that coverage levels of Vitamin A (first dose) in slums are 48 percent as against 80 percent in rural areas. They also find that 48 percent of slum children in the age group 0-23 months were underweight as against 41 percent in rural areas.

Health seeking behaviour is lower in the slums compared to non-slum urban areas. It might be misleading to compare health seeking behaviour across the slums and rural areas without controlling for availability of health infrastructure.

The incidence of the following diseases seems to be larger among the migrant households:

- Viral fever
- Dysentery
- Malaria

Viral fever is very common among the slum dwellers and is linked to contaminated water. Being poor and to economise on fuel almost all households do not boil the drinking water.

Dysentery, a water–borne disease, was largely found among slum households. About 65% of the households have suffered from dysentery. Majority of the respondents (or their family members) have been attacked by viral fever (60%). Malaria was found among 30% of the migrant households in slums. The other ailments suffered by the migrant households are:

- Dengue fever
- Tuberculosis
- Cancer
- Hepatitis
- Skin diseases
- Asthma

In the Tamil Nadu survey, dengue fever was found among 8% of the migrant households, especially at Chennai slums. Migrant households suffered skin diseases particularly during the monsoon when the sewerage overflows.

The common causes of death i.e., diarrhoea, pneumonia and fevers are the most prevalent diseases identified among slum children besides nutritional deficiencies.

Common Childhood Morbidity from Urban Slums of India

	Age	Morbidity prevalence (%)
S. Rao, Pune 1992-95(15)	<5 years	Diarrheas + Fever + Respiratory infections = 57.5*
Awasthi and Pande, Lucknow, 1998(9)	1.5 – 3.5 years	Respiratory illness = 17.2%, Diarrheas = 4.5%, Dysentery = 1.8%, Skin disorder = 4.5%, Fever = 2%, Others = 1.3%

Prevalence of the common infections as reported by Awasthi and Pande in Table above indicates that more slum children are affected compared with the National Family Health Survey (NFHS) figure of 19% children under three suffering from diarrhoea and respiratory infections. Thus averages mask the underlying inequity in health status.

Nutritional Profile of Children of Urban Slums of India

		Nutritional deficiency and profile
S. Rao, Pune, 1992-5(15)	<5 years	Underweight for age=40% Stunted = 55% Vitamin D deficiency = 23%
		Vitamin A deficiency
	0-2 years	= 5.3 - 5.6%
	2-5 years	= 16.3 - 19.6%
		Anemia = 30%
Kapur, Delhi, 1977(16)	9-36 months	Underweight for age = 90% Anemia = 64%
Awasthi & Pande, 1997(17)	1.5 - 3.5 years	Underweight = 67.6% Stunted = 62.8%, Wasted = 26.5%
Swami, 1999(18)	1-5 years	Vitamin A deficiency = 24.6%

Determinants of childhood mortality and morbidity in Urban Slums

Low birth weight (LBW)

At the national level LBW constitutes about 30% of all live births[6]. A multi-centric study done by Indian Council of Medical Research (ICMR) in three urban slums of Delhi, Calcutta and Madras and in same number of rural areas revealed that 41.4% live births were LBW as compared to 38.1% rural children[7]. The risk of perinatal and infant mortality rates are greater among the LBW infants with higher morbidity and long term developmental problems among those babies who survived[8].

[6] Bhargava S K. Perspectives in child health in India. Indian Pediatr 1991; 28: 1403-1410.

[7] Bhargava S K, Singh K K, Saxena B N. ICMR Task Force National Collaborative Study of Identification of High Risk Families, Mothers and outcome of their off-springs with particular reference to the problem of maternal nutrition, low birth weight, perinatal and infant morbidity and mortality in rural and urban slum communities. Indian Pediatr 1991; 28: 1473-1480.

[8] Gopalan C. Low birth weight: Significance and implications. *In:* Sachdev HPS, Choudhury P, eds. Nutrition in Children Developing Country Concern. 1st edn, New Delhi; Department of Pediatrics, Maulana Azad Medical College, 1995; 1-33.

Maternal age

Marriage at a younger age puts adolescent girls at a greater risk of giving births to a still born child or one who is premature or has low birth weight[9]. ICMR Task Force National Collaborative study revealed that mean age at marriage of slum women is 13.8 years and age at consummation of marriage is 16 years (Bhargava SK et al, 1991).

Environmental Pollution

Children living in the urban slums are exposed to ambient as well as indoor pollutants. This is due to excess use of biomass fuel for cooking, parental smoking, poor housing and improper disposal of garbage and biomedical wastes. Exposure to parental smoking is related to increased episodes of acute respiratory infections and asthma in children10. In a study from urban slums of Lucknow, use of bio-mass fuel was associated with an increased risk of respiratory illness and longer duration of episodes[11].

Hygiene and Sanitation

Practices like Faeces disposal: A case control study12 examined the impact of several environmental sanitation conditions and hygiene practices on diarrhoea occurrence among children under-5 years of age living in an urban area. Cases were identified as children with diarrhoea and controls were randomly selected among children under-5 years of age. The following variables were found to be significantly associated with diarrhoea: washing and purifying fruit and vegetables presence of waste water in the street refuse storage, collection and disposal domestic water reservoir conditions faeces disposal from swaddles presence of vectors in the house, and Flooding in the lot.

Access to sanitation facilities

Access to a flush or pit toilet is a very important determinant of infant and child mortality in developing countries. Factors found to be significantly associated with an increased risk of death from diarrhoea include the non availability of piped water and the absence of a flush toilet[13].

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[9] Friedman HL. The Health of adolescents and youth: A global overview. World Health Stat Q 1985; 38: 256-262.

[10] Were JH. Passive smoking gas cooking and respiratory health of children living in six cities. Am Rev Respir Dis 1984; 129: 366-374.

[11] Awasthi S, Glick AH, Fletcher RH. Effect of cooking fuels on Respiratory Diseases in Pre-school children in Lucknow, India. Am J Trop Med Hyg 1996; 55: 48-51.

[12] Heller L, Colosimo EA, Antunes CM. Environmental sanitation conditions and health impact: A case control study. Rev Soc Bras Med Trop 2003; 36: 41-50

[13] Victora C, Smith P, Vaughan J, Nobre L, Lombardi C, Teixeira A *et al*. Water supply, sanitation and housing in relation to the risk of infant mortality from diarrhea. Int J Epidemiol 1988; 17: 651-654.

The unadjusted figures for neonatal, infant and childhood mortality is higher for children in households that do not have access to a flush or pit toilet, both in India as a whole and in all states[14].

Relationship of access to toilet and neonatal, infant and child mortality rate

State	Has access to own, shared or public flush or pit toilet											
	Neonatal Mortality				Infant mortality				Child mortality			
	Unadjusted		Adjusted		Unadjusted		Adjusted		Unadjusted		Adjusted	
	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
India	63	34	57	44	104	55	93	75	44	19	36	34
UP	82	42	76	59	135	74	123	109	59	29	52	48
Kerala	31	21	26	22	46	28	39	30	16	8	12	9

Zaheer et al[15] showed that the introduction of treated and piped water in 14 towns of Uttar Pradesh was associated with a 43% reduction in the diarrhoea mortality rate at all ages in the 5 years following the improvements compared to the previous five years.

Most women respondents of younger age were anaemic and stated that they suffered from frequent headaches, and nausea caused by the foul smell from the ditches, garbage dumping places, and dirty water canal beds etc. Rapid urbanization has adversely damaged the urban environment through air, water, solid waste and noise pollution. Slum dwellers are the worst victims of urban environment degradation.

A recent WHO study on air pollution in 8 Indian cities reports that every year 30,000 children are affected by asthma and the incidence of asthma is larger among children living on roadsides than those living in less congested streets, because the former inhale emissions of the motor vehicles.

Solid waste is the most visible form of pollution. Most of the methods of disposing them pose serious threat to environment and human health, particularly to those living in slums.

In the absence of regular collection of wastes by Municipalities/ Corporations, the accumulated piles of garbage promotes the multiplication of flies, which results in the spread of fly borne diseases such as typhoid, amoebic dysentery, diarrhoea and cholera.

[14] National Family Health Survey (NFHS-I) India 1992-1993. Key Findings. Morbidity and Mortality. International Institute of Population Sciences, Bombay, 1995: 201-226.

[15] Zaheer M, Prasad BG, Govil KK, Bhadury T. A note on urban water supplies in Uttar Pradesh. Indian Med Assoc 1962; 38: 177-182.

Further in the absence of adequate sewerage and drainage systems in the slums, the stagnant waste water become breeding grounds for various kinds of pests and insects particularly mosquitoes, which transmit diseases such as malaria, and other vector borne diseases to human beings.

Rank	Cause of Death	Male	Female	Person
	Rural Area			
1	Cardiovascular diseases	18.2	15.1	16.8
2	COPD, asthma, other respiratory diseases	9.5	8.3	9.0
3	Diarrheal diseases	7.3	10.7	8.8
4	Perinatal conditions	6.9	6.7	6.8
5	Respiratory infections	6.0	7.6	6.7
6	Tuberculosis	7.3	4.7	6.1
7	Malignant and other neoplasms	5.0	5.6	5.2
8	Senility	4.1	6.3	5.1
9	Unintentional injuries: Other	5.4	4.5	5.0
10	Symptoms signs and ill-defined conditions	4.7	5.1	4.9
	Urban Area			
1	Cardiovascular diseases	30.3	26.3	28.6
2	Malignant and other neoplasms	7.5	8.5	7.9
3	COPD, asthma, other respiratory diseases	8.1	6.7	7.5
4	Tuberculosis	5.9	4.5	5.3
5	Senility	3.4	7.4	5.1
6	Diarrheal diseases	3.9	6.1	4.8
7	Unintentional injuries: Other	4.1	4.7	4.4
8	Symptoms signs and ill-defined conditions	4.0	4.6	4.3
9	Digestive diseases	5.0	2.5	3.9
10	Respiratory infections	3.0	4.5	3.7

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

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 chromic 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

III. KEY PUBLIC HEALTH CHALLENGES IN URBAN AREAS

"We suspect that if there were a stronger information base about who has access to those forms of infrastructure and services that are critical determinants of health (e.g. provision for water, sanitation, health care, emergency services) and a stronger information base related to health outcomes (for instance, infant and child mortality rates, life expectancies, nutritional status), we would find that the urban populations in small and intermediate urban centres would generally be worse off than the urban average" - Satterthwaite and Tacoli (2003)

25. Health status is a key indicator of human well being. The health of people does not depend only on the number of doctors and hospitals, but also on a clean and safe environment. Environment affects human health in many ways and contributes to a wide variety of diseases. World Summit on Sustainable Development (Sept 2002) identified health as an integral component of sustainable development, and called for a more efficient, equitable, accessible and appropriate health care system for the population that rely on them. Poor are the agents and victims of environmental degradation (Report, World Bank, 1992).

While the Indian government has been active in initiating improvements in the living conditions in some slums, unsatisfactory living conditions continue to prevail in the bulk of slums. The poorer health outcomes can partially be traced to the inadequate services, in particular water supply and sanitation, available in the slums.

26. Environmental condition in slums16 : 29% of non-notified and 16% of notified slums do not have access to tap water. 51 percent of non-notified slums do not have a latrine. 44 percent of non-notified slums do not have drainage facilities. The differences are stark when compared to the notified where only 17 percent and 15 percent of them do not have latrine or drainage respectively.

[16] Growth of Slums, Availability of Infrastructure and Demographic Outcomes in Slums: Evidence from India; S. Chandrasekhar, 2005

Table 2: Percent of Rural, Urban Households and Slums Having Access to Infrastructure

	Rural India	Urban India*	Non-notified Slums	Notified Slums
Water Source				
Tap	24.3	68.7	71	84.0
Tubewell	5.7	5.1	22	10.0
Well	22.2	7.7	2	2
Others	47.7	18.5	5	4.0
No Electricity	57	12.4	16.0	1
No Latrine	78.1	26.3	51	17
No Drainage	65.8	22.1	44	15

** Includes Slums Source: Census 2001, NSSO 2003*

27. **Water Supply** : Inadequate water supply facilities and poor sanitary conditions can have a deleterious impact on household outcomes. If the local supply of water is inadequate, women and female children spend a considerable amount of time in fetching water. This affects the decision of the girl child to go to school and also reduces the likelihood of women participating in other economic activities.

In 84% of the notified and 71% of non-notified slums the main water source is the tap. But these numbers mask differences across the states of India. In the states of Bihar none of the slums get water via the tap. In Chhattisgarh, Gujarat and Uttar Pradesh less than 35 percent of slums get tap water. Also, there has not been any significant improvement since 1993. In 1993, 83 per cent of notified slums and 70 per cent for non-notified slums drew their drinking water from tap.

28. Sanitation: Poor sanitary conditions and poor water quality lead to sickness, cause diarrhoea and other water borne diseases among children and adults and also affect life expectancy. According to a case study, water and sanitation diseases are responsible for 60 per cent of the environmental health burden and over 11 per cent of total burden of disease in Andhra Pradesh.

Among water borne diseases, diarrhoea disproportionately affects children under the age of five. Poor health among children adversely affects the attendance rate at schools.

"Water-borne diseases are caused by contamination of water with viruses (viral hepatitis, poliomyelitis), bacteria (cholera, typhoid fever, bacillary, dysentery, etc.), parasites (amoebiasis, giardiasis, worm infestation, guinea worm, etc.), or chemicals. India still loses about 0.4 to 0.5 million children under age five each year due to diarrhoea. Community studies from two urban communities have revealed that the incidence (of viral hepatitis) may be around 100 per 100,000 populations." (Planning Commission, 2002, pp. 45-46).

In a survey conducted in slums of Coimbatore, Chennai and Tirupur in Tamil Nadu17, only 5% of the total migrant households had underground sewerage system, which means that 95% of the households lacked this facility. Even in a metropolitan city like Chennai, no sewerage facility was available to more than 95% of the migrant households. The main problem is that during monsoon, the sewerage flows into the huts of the households.

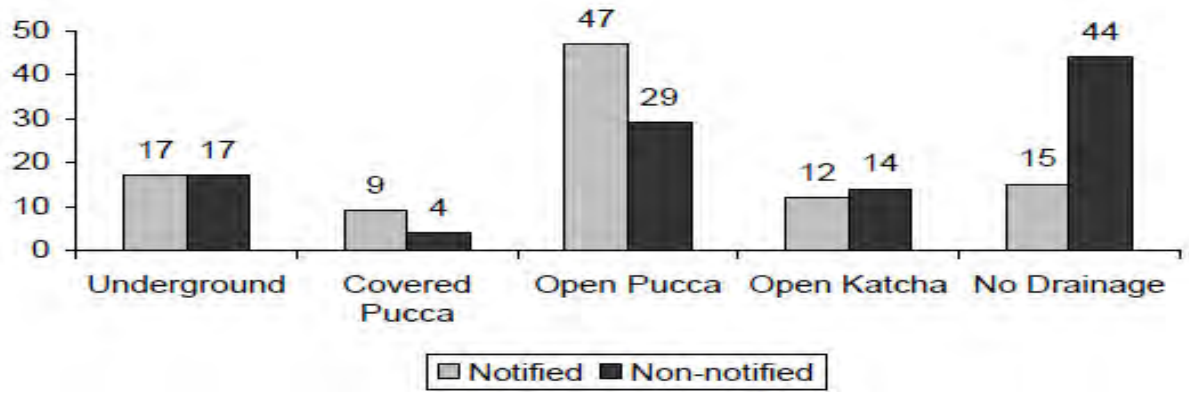
Distribution of Migrant Households in Slums on the Basis of Sewerage System

Sl.No	Areas	Type of sewerage system		
1.	Coimbatore slum	Open	Underground	Total
		192 (24)	18 (46)	210
2.	Tirupur slum	171 (22)	4 (10)	175
3.	Chennai slum	418 (54)	17 (44)	435
	Total (%)	781 (100) (95.25)	39 (100) (4.75)	820 (100)

Source: Primary Survey
Figures in parenthesis are percentage to the total.

Nearly 44 percent the non-notified slums do not have a drainage system of any type. In contrast only 15 percent of notified slums do not have a drainage system.

Distribution of Slums According to Drainage Facility



In Tamil Nadu survey, it was observed that drainage systems were totally absent in about 92% of slum households, whereas around 4% had an open katcha drainage system. Open pucca

[17] **Sundari**, S. "Quality Of Life Of Migrant Households In Urban Slums" in Martin J. Bunch, V. Madha Suresh and T. Vasantha Kumaran, eds., *Proceedings of the Third International Conference on Environment and Health, Chennai, India, 15-17 December, 2003*. Chennai: Department of Geography, University of Madras and Faculty of Environmental Studies, York University. Pages 537 – 552

drainage was available to less than 2% of sample households. Only 1% of the migrant households in slums had covered pucca drainage system. Underground covered pucca system of drainage was totally absent in the households covered by this survey.

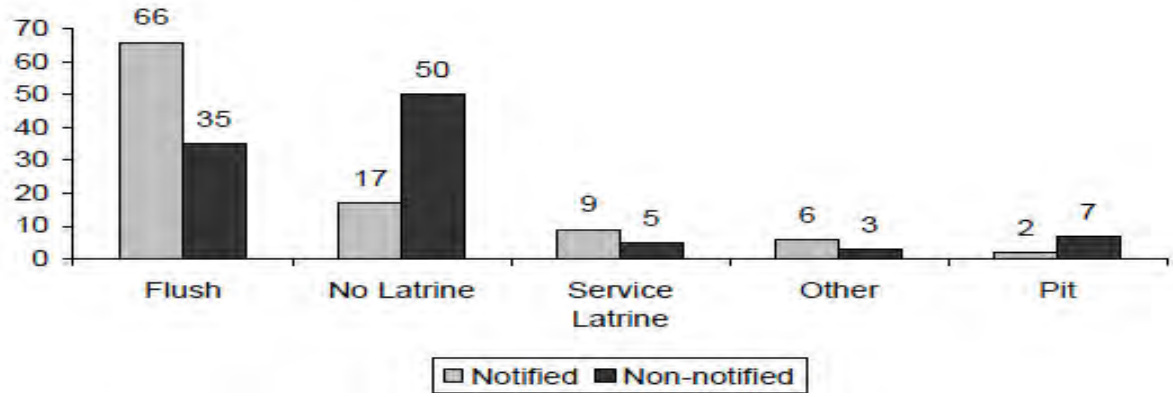
Distribution of Migrant Households on the basis of type of Drainage System

Area	Type of drainage system					Total
	No drainage	Open		Covered pucca	Underground	
		Katcha	Pucca			
Coimbatore slum	189 (25)	17	-	4	-	210
Tirupur slum	146 (19)	15	14	-	-	175
Chennai slum	422 (56)	4	2	7	-	435
Total	757 (100) (92.32)	36 (100) (4.39)	16 (100) (1.95)	11(100) (1.34)	-	820 (100)

Source: Primary Survey
Figures in brackets are percentage to the total

A similar picture emerges in the case of latrines. Nearly half the non-notified slums do not have a latrine of any type. In contrast only 17 percent of notified slums do not have a latrine.

Distribution of Slums According to Latrine Type



In the Tamil Nadu survey, it was found that no latrine facility of any kind was available for about 79% of migrant households and they had to use the open fields. The incidence of non-existence of latrines was higher among the migrant households of Chennai slums (52%) than other slums of Tirupur (22%) and Coimbatore (26%). Latrines with flush system were available to only about 9% of migrant households.

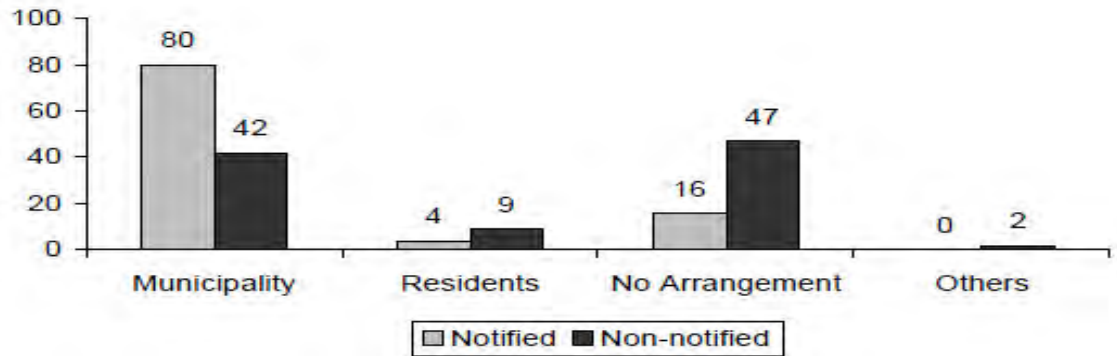
Distribution of Migrant Households in Slums on the Basis of Latrine Facilities

Area	Type of Latrine Facility			
	No latrines	Community latrines	Latrines with flush system	Total
Coimbatore slum	166 (26)	21 (20)	23 (31)	210
Tirupur slum	143 (22)	13 (13)	19 (26)	175
Chennai slum	335 (52)	69 (67)	31 (43)	435
Total	644 (100) (78.54)	103 (100) (12.56)	73 (100) (8.90)	820 (100)

Source: Primary Survey
Figures in parenthesis are percentage to the total.

Figure below shows that the municipality provides garbage clearance services in 80% of the notified slums. Of the non-notified slums, 47 percent of them do not have any garbage clearance.

Distribution of Slums According to Garbage Clearance



In the Tamil Nadu Survey, nearly 67% of the sample migrant households in slums did not have any arrangement made either by public or private services for garbage collection and disposal. These households resorted to open dumping of garbage in streets/ditches etc. Thus risk to human health are compounded in these slums, where garbage collection is nonexistent in most cases and drainage tends to be poor, promoting the growth of insects and other diseases vectors.

While percentage of slums reporting a deterioration of the facilities from 1993 to 2002 is not very high, there is still cause for concern in context of drainage, sewerage and garbage disposal in bother notified and non-notified slums and the condition of roads within the non-notified slums. What is however of concern is that in the 2002 survey over 80 percent of slums report no improvements in garbage disposal in the notified slums.

Distribution (%) of Slums by Change in Condition of Slums

	Notified			Non-notified		
	Improved	No Change	Deteriorated	Improved	No Change	Deteriorated
Road Within Slum	52.7	44.8	2.5	21.1	65.7	13.2
Approach Road to the Slum	51.1	46.3	2.6	40.1	56.7	3.3
Water Supply	47.9	48.1	4	31.6	62.5	5.9
Electricity	34.5	64.4	0.1	27.1	70.4	2.5
Street Light	39.4	59.8	0.8	22.7	77.4	2.8
Latrine	49.6	47.8	2.7	33.1	62.4	4.5
Drainage	46.6	50.1	3.3	22.5	66.3	11.2
Sewerage	23.8	71.3	4.9	41.4	54.7	4
Garbage Disposal	5.7	88	6.4	15.4	76.6	7.5

Source: NSSO 2003

In 2002, 36 per cent of the notified slums and 54 per cent of non-notified slums experienced water logging during monsoon. Water logging is one of the main problems of slums during monsoon. According to a survey results, nearly 95% of the migrant households experienced water logging in their areas during monsoon. The incidence seems to be greater (54%) among the migrant households of Chennai slums, because nearly 45% of them are pavement dwellers and further, most slums are found below the street level / under the bridges.

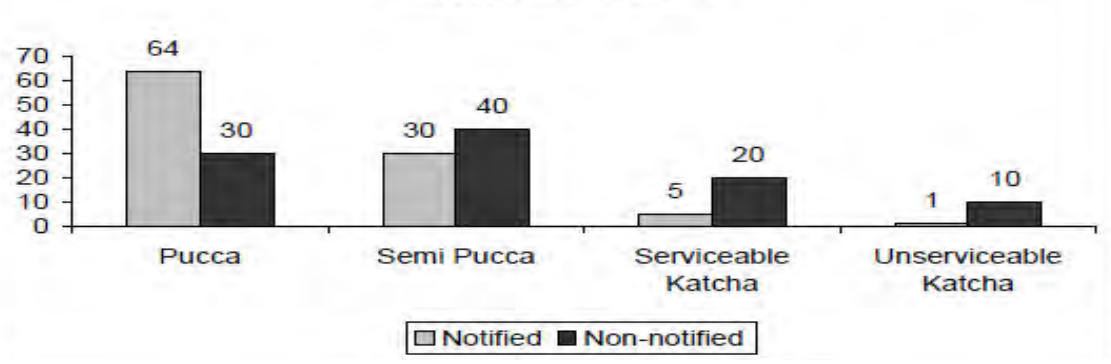
Housing Condition in the Slum Areas

In terms of density, the notified slums are denser in terms of households (205 per slum) as compared to the non-notified slums (112 per slum). A large number of houses are not pucca in nature. The problem is more acute in the non-notified slums.

The per capita floor area available was 4.6 sq.m in the urban slums, 7.5 sq. m. in the rural areas and in the non-slum urban areas it was 8.5 sq.m.

In terms of roads within the slum, 71 percent of the notified slums have a pucca road while only 37 percent of non-notified roads have a pucca road within the slum. In terms of access road to the slums, 86 (27) percent of notified (non-notified) slums have a pucca approach road to the slum.

Distribution of Slums According to Type of Houses in the Slum



The moneylenders are relatively more active in the urban slums than in the rural or non-slum urban areas. In the urban slum areas, the moneylenders funded 15 per cent of general expenses and 21 per cent of the expenses related to major repairs.

The problem of poor service provision in the urban slums is not a phenomenon peculiar to India only. The study undertaken by the Panel on Urban Population Dynamics states, "The spatially concentrated poor – such as those living in slums – may face additional health penalties that erase the urban health advantage." (Montgomery et.al 2003).

Living condition in many urban slums is worse than those in the poorest rural areas of the country (World Bank, 1993). This can be attributed partly to the slums exceptionally unhealthy environment. Many of the most serious diseases in cities are 'environmental' because they are transmitted through air, water, soil and food or through insect or animal vectors. The concentration of people in areas where the provision of water, sanitation, garbage collection and health care is inadequate creates the conditions where infectious and parasitic diseases thrive and spread. Around half the urban population in developing countries is suffering from one or more of the diseases associated with inadequate provision of water and sanitation (DFID, 2001:20).

Based on a study in Delhi, the book ' Health of the Urban Poor and Role of Private Practitioners – The Case of a Slum in Delhi' by, Nupur Barua, Jens Seeberg, Chandrakant S. Pandav, Centre for Community Medicine, AIIMS in collaboration with ICCIDD, New Delhi, 2009, makes some useful recommendations to meet the key public health challenges in urban areas. They are -

Recommendations

Ensure basic services in slums, in particular, water, sanitation, drainage, and housing;

Mapping: Slum specific interventions should begin by taking each region in a city and collecting data and analysing the health status as baseline information; all health-related services (all private practitioners, types and kinds of practice) need to be mapped and in-depth information on client satisfaction needs to be collected;

Set up responsive facilities: Unless health facilities are responsive to the requirements of the urban poor, there will not be optimal utilization of its services and the existing ambivalence towards government institutions will continue. This could be achieved by allocation of qualified doctors in all under-served areas, perhaps through a compulsory student roster like out-patient wards in hospitals, and regular mobile clinics in slums. Medicines should be readily available;

Train less-than-fully qualified practitioners to provide basic primary care and to recognize and refer complicated cases to government facilities. Clear definition of parameters for enrolment, standard treatment guidelines and care protocols need to be framed to define the exact nature of their functions;

Evolve referral protocols and service delivery linkages at all levels of care for all kinds of ailments. This will prevent overcrowding of public hospitals for conditions that can be treated at urban health centre level;

Evolve a monthly surveillance system to monitor the practices of the private practitioners that they are not providing healthcare outside their training as well as to monitor the quality of services provided in the public health facilities;

Evolve micro-planning strategies and enable community participation. A consultative approach involving all stakeholders – NGOs, self-help groups, local private practitioners – will determine what is best in a specific context. Slum level committees (with representations from both males and females and adolescent groups) should be formed to plan, take ownership of, and monitor programmes. Community collectives will also ensure access at the household level;

Public awareness campaigns should focus on educating consumers about inappropriate treatment protocols like re-use of disposable syringes and to provide feedback to public authorities;

Integrate programme that deal with communicable diseases with urban health programmes; integrate coordination between various service providers such as the state health department, Urban Local Bodies, Integrated Child Development Scheme, the Swarana Jayanti Shahri Rozgar Yojna scheme for construction workers, and NGOs;

Create community based insurance schemes. A separate health insurance scheme for the urban poor under the National Urban Health Mission will ensure that health care payments do not exceed their ability to pay.

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

	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. He has the authority to connect households to health facilities. A health facility or a 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. Make them work under the supervision of government doctors. Special thrust on rationa 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 urbal local body local level elected systems. 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	Provide additional human resources to urban local bodies for meeting public health challenges. Re-orient existing staff 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. What possible criteria can be used. 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 risk pooling or community insurance system	Need to see health care costs not as episodes of illness. System of savings by households to create funds for health care needs. Developing a thrust for preventive and promotive care and for life cycle approach to saving for health care needs.
11.	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. Creating Basti Vikas Samitis that have wider than medicalized care focus.
12.	No system of counselling 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.
13.	Over congested secondary and tertiary facilities and under underutilized primary care facilities.	Need to create community workers in every slum who know clearly where the household has to be sent. Need based referrals are the only way of decongesting.
14.	Problem of drug abuse and alcoholism	Urban life is demanding and lead to living with stress of all kinds. Problems of drugs and alcoholism, tobacco use, etc. need strong public health interventions.
15.	Many slums not having	Creating new public health infrastructure using community

	primary health care facility	buildings, mobile medical units based on fixed schedules where infrastructure cannot be created.
16.	High incidence of domestic violence	Need for Counsellors in Bastis to help in many behaviour change and gender relation issues.
17.	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.
18.	No norms for urban health facilities.	Need to develop clear norms for primary health care service guarantees for urban areas.
19.	No concerted campaigns for behaviour change	Need for concerted campaigns for behaviour change to enforce public health thrust. Problem of malaria, dengue, chikanguniya in urban areas. Counselling services for well-being of households.
20.	Problems of unauthorized settlements	Developing health care facilities in the framework of law for such areas.

IV – DEFINING THE POOR IN URBAN AREAS

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 will be freely available to all citizens residing in urban areas.

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

This calls for a household survey thorugh 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 frommere 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.

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 Basti Vikas Manch. The whole process will be undertaken in close collaboration with the JNNURM PMU and Slum free city cell.

Identification and mapping of slums: Rajeev Awas Yojana

The Ministry of Urban development has launched an ambitious program Rajiv Awas Yojan with an objective of ' Slum free India'. The Slum-free City Cell in Urban Local Body headed by the Municipal Commissioner /Executive Officer will be primarily responsible for the preparation of Slum-free City Plans. The methodology involves following steps. (a) survey of all slums – notified and non-notified; (b) mapping of slums using the state-of-art technology; (c) integration of geo-spatial and socio-economic data; and (d) identification of development model proposed for each slum.

Identification and engagement of Lead NGO/CBO to guide and anchor community mobilization for the purpose of slum survey, (May be more than one NGO/CBO in different slum zones) of the city. These Lead NGOs/CBOs should also be associated in slum survey operations and dialogues for preparation of slum level redevelopment plans;

V - NUHM – GOALS, OBJECTIVES, STRATEGIES, OUTCOMES

Goal

The National Urban Health Mission would aim to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based risk pooling mechanism with the active involvement of the urban local bodies. The strategy will take into cognizance the existing diversity of urban areas and adopt a differential approach in terms of funding and capacity building. Substantial public health investments would be required for Tier 2 and 3 cities while the Mega cities the need may be more for development of regulatory frameworks, guidelines, models of PPP. The response would reflect the need and prioritization done by the city and articulated through City Urban Health Plans for developing effective public health systems. The following would be the core strategies

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 by either strengthening the existing public health systems, through public private partnerships with other private service providers or through NGOs, through an optimal mix of these strategies or through other innovative strategies proposed by the cities/ states depending on the healthcare needs, existing planning and implementation capacities of the state etc. The decision on 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

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 a "Primary Urban 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 PUHC may vary from 5000 for cities with sparse slum

population to 75,000 for highly concentrated slums. The PUHC may cater to a slum population between 20000-30000, with provision for evening OPD, providing preventive, promotive and non-domiciliary curative care (including consultation, basic lab diagnosis and dispensing).

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 utilise 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.

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.

The existing UHP/ UFWCs are already being supported through planned grant. Hence all the existing staff in this scheme (Urban Health Posts, Urban Family Welfare Centers) should be rationalized, however as is being currently done under NRHM, the funds can flow through treasury route but the monitoring may be brought under the purview of the NUHM. The strengthening of UHP/UFWC will be to complement the already existing support and in no case duplication would be allowed.

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 counselling / 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

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.

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 Samittee, (MAS) a community based federated group of around 20 to 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 behaviour change promotion and facilitating community risk pooling mechanism in their coverage area. The Urban Social Health Activist (USHA) an ASHA like activist, detailed in the following pages, may provide the leadership and promote the Mahila Aorgya Samitee. The USHA may be preferably co-located with the Anganwadi Centres located in the slums for optimisation of health outcomes. Each of the MAS may have 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 USHA responsible for the area.

Strengthening public health through innovative preventive and promotive action

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 diarrhoea, acute respiratory infections and household hygiene behaviour, 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 USHA, 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.

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 provides the ULBs 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 community risk pooling models

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.

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

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.

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.

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.

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.

As per the current status, the IDSP is already at an advanced stage of implementing urban surveillance in 4 mega cities of the country by combining the existing Urban Health Posts with newly established epidemiology analysis units at intermediate and apex levels in these cities. There is a plan to upscale this model to include 23 more, million- plus cities, by the middle of calendar year 2008. Also a surveillance reporting network of 8 major infectious diseases hospitals located across the length and breadth of the country is being established that would act as state of the art surveillance centres for epidemics. It is envisioned that as the NUHM becomes operational there would be natural synergies with the IDSP urban surveillance set up.

Capacity building of stakeholders

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 Counsellors 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. In order to effectively build the capacity the NUHM would leverage the Network Resource Institutions currently being supported under JNNURM. The NUHM would provide support to the resource institutes for strengthening their public health capacity and function as resource centre for the ULBs.

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. Support would be through city specific strategy with a cap of 10% of the city budget.

Ensuring quality health care services

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.

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.

Process/ Output level indicators:

Number cities/population where Mission has been initiated
Number of City specific urban health plans developed and operationalised
Number of PUHCs with outreach made operational
Number of Cities/population with all slums and facilities mapped
Number of Slum/ Cluster level Health and Sanitation Day
Number of USHAs receiving full honorarium
Number of MAS formed
Number of UHCs with Programme Managers

Outcome level indicators:

Increase in OPD attendance

Increase in BPL referrals from UHCs/ referral availed
Increase in institutional deliveries as percentage of total deliveries
Increase in complete immunisation among children < 12 months
Increase in case detection for malaria through blood examination
Increase in case detection of TB through identification of chest symptomatic
Increase in referral for sputum microscopy examination for TB
Increase in number of cases screened and treated for dental ailments
Increase in ANC check-up of pregnant women
Increased Tetanus toxoid (2nd dose) coverage among pregnant women
Impact level focus on urban poor
IMR reduced to 30/1000 live births by 2015 among urban poor.
Maternal Mortality reduced to 100/100,000 live births by 2015 among urban poor .
TFR reduced to 2.1 by 2012.
Malaria Mortality Reduction Rate - 50% up to 2013, additional 10% by 2015.
Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.
Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
Dengue Mortality Reduction Rate - 50% by 2013 and sustaining at that level until 2015.
Cataract operations- all urban poor covered by 2015.
Leprosy Prevalence Rate –reduce from 1.8 per 10,000 in 2005 to less that 1 per 10,000 thereafter.
Tuberculosis DOTS series - maintain 85% cure rate through entire Mission Period and also sustain planned case detection rate.

VI – CONVERGENT ACTION IN URBAN AREAS

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.

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), use of unified telephone numbers for availing ambulance and doctor services (Bihar, Orrisa), promotion of high end diagnostic services in medical colleges and establishment of regional diagnostic centres through public private partnerships (PPP) and promoting easy availability of generic drugs in shops through PPPs are list a few such innovations (Bihar).

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 provides the ULBs with opportunities to develop innovative strategies. Hence NUHM provides for some untied funds at all levels for carrying out the activities. Some of the areas of innovation suggested under component 10 and 11 of NUHM are listed below. The list is illustrative and not exhaustive.

(a) Suggested Slum level innovations

- Community monitoring
- Creating mentoring groups/support structures for MAS/USHA through NGO/CBOs
- "Healthy Mother", "Healthy Infant" competitions

(b) Suggested PUHC level innovations

- Involving private practitioners for special drives on immunisation, diabetes, etc.
- Involving schools for public health action like "slum cleaning (safai abhiyan)", health promotion, etc.
- Special programs for adolescent health

(c) Suggested City level innovations

- Innovations with ICT (Information and Communication Technology) like 'sms' based health promotion, touch screen kiosks, PDAs for outreach workers.
- "Help-lines" for general health advise / medical emergencies
- Review/monitoring of quality, regularity of services through NGOs
- Identification and management/rehabilitation of malnourished children (with special focus on girl child) and Nutrition Resource Centres
- Special Strategies for addressing anaemia among women and girls
- Incentive schemes for service providers for conducting deliveries at night, difficult duties, and special achievements.
- ISO Certifications

- Special strategies for addressing neonatal mortality

(d) Suggested State level innovations

- Operations/Action research/special studies
- Resource Centres/Units at State or city levels for urban health data, program lessons, and other information
- Empanelment of hospitals/doctors for defined specialised services
- Innovations for addressing adverse sex ratio

(e) Suggested National level innovations

- 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.
- Maternal/infant death audit
- Disease outbreaks in case of natural disasters like floods
- Mass injury/trauma cases because of fire in slums, riots, etc.
- Epidemiological surveys/research
- Inter and Intra Sectoral Coordination

NUHM would aim to provide a system for convergence of all communicable and non communicable disease programmes including HIV/AIDS through an integrated planning at the City level. The objective would be to enhance the utility of the system through the convergence mechanism, through provision of a common platform and availability of all services at one point (PUHC) 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 PUHC level.

Appropriate convergences and mechanisms for co-locations at PUHCs would be sought with the existing systems of RNTCP, ICTC, AYUSH, IDSP, NVBDCP etc at the time of operationalisation.

The following suggestions of the Department of AYUSH may be considered for incorporation during the City planning process:

- General AYUSH services should be made available under one roof with allopathic units.
- Specialized AYUSH treatment facilities like Panchkarma, Ksharsutra should be promoted in district and teaching Hospitals.
- Geriatric Care and Women & Child specific AYUSH clinics once or twice a week should be set up at secondary and tertiary health delivery centres.

- Collaborative approach should be promoted to provide integrated treatment to patients, who suffer from such diseases/disease-conditions as are not manageable with pure allopathic medication/intervention.
- Lifestyle-clinics of AYUSH for preventive and promotive health care should be established under Social & Preventive Medicine Department of the hospital.
- AYUSH manpower engaged in allopathic set up should be given adequate training on current diagnostic techniques and treatment approaches on a regular basis.
- Use of medicinal herbs, Yoga and healthy life style should be included in the school curriculum particularly in urban areas due to prevalence of obesity among urban middle class children.

Convergence with Jawahar Lal Nehru National Urban Renewal Mission (JNNURM)

The government has launched multiple programmes like JNNURM, BSUP, RAY, revamped SJSRY, IHSDP with an objective of improving living conditions in cities. NUHM will work very closely with these programs. The following could be the areas of convergence.

Areas of Convergence	**Interventions under JNNURM : Areas of convergence**
Planning	Utilise the GIS based slum map and the data from the socio-economic survey to be doen under RAY. Closely work with the JNNURM PMU/ Slum free City Cell for leveraging the expertise and also ensuring effective convergence
Strengthening Health Care facilities	Utilise the community infrastructure created as part of the BSUP and IHSDP for expanding the reach of health care services. Utilise the expertise available under the JNNURM cell in the area of PPP for developing partnership with private providers.
Communitisation	The NUHM will use the communitisation provisions provisions under the BSUP, Community participation law RAY and SJSRY for strengthening the communitisation efforts
Improved water and sanitation	The provisions under BSUP and RAY will be effectively utilized for improving availability of drinking water and sanitation and environmental sanitation. The hardware for improved water and sanitation will be leveraged from various schemes of MHUPA while the NUHM will provide the software for realizing the health impact.
Monitoring and Implementation	NUHM PMU will work closely with the JNNURM PMU and ensure that the programmes are effectively monitored.
Capacity Building	The JNNURM has made provisions for capacity building of ULBs and has also created a network of resource institutions for supporting the capacity building efforts. NUHM will develop capacity building modules and work closely with the capacity building cell of JNNURM to ensure that public Health component becomes an integral part of the training calendar.
Implementing Public health	JNNURM has introduced d a set of mandatory and optional reforms for ULBs. The same are closely monitored. NUHM will work closely with the JNNURM to

Reform Agenda	introduce reforms to advance the public health agenda. It will also leverage the reforms like communitisation reforms, increased fund allocation for poor, strengthening the devolution of powers, introducing user charges.

Programme wise details are

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

- Prioritisation of cities on the basis of high focus JNNURM cities and the City as the unit of planning for health and allied activities.
- The City Urban 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.

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

The provision for utilization of community centers can also be used as fixed outreach session in the admissible components for strengthening the delivery of health care services to urban poor.

Under the admissible components Community primary health care center buildings can be provided. The same mechanism can be used for making available the buildings for establishing new primary health care facilities for un-served urban poor population.

(iii) 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.

Convergence with Swarn Jayanti Shahri Rozgar Yojana (SJSRY)

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

Table: Proposed areas of synergy with SJSRY

Community Structure under SJSRY	Alignment of Community level structure

	under NUHM
Community organizer for about 2000 identified families.	If eligible the community organizers can be linked to integrated Urban Health Centres as USHA if eligible.
Neighbourhood Group: An informal association of woman living in mohalla or slum or neighborhood group of manageable size (preferably to 10 to 40 to represent urban poor or slum families). Development of Women and Children in Urban Areas (DWCUA) Groups are SHGs under SJSRY	These may federate into the Mahila Arogya Samittee
Neighbourhood Committee (NHC) is a more formal association of women from the above neighbourhood groups. Representatives from other sectoral programmes in the community like ICDS supervisor, school teacher, ANM etc. are also the member. Thrift Credit Groups (TCG) under SJSRY	Maybe coterminous with the Mahila Arogya Samittee
Project Officer in-charge of the project responsible for managing community level structure	May be involved in planning and identification of urban poor. Management of the proposed community level structures under NUHM

Convergence with ICDS

- MAS/USHA in coordination with the ANM can organize Community Health and Nutrition day in close coordination with the Anganwadi worker (AWW) on lines of NRHM.
- MAS/ USHA can support AWW/ANM in updating the cluster/ slum level health register.
- Outreach session can also be organized in the Anganwadi centers located in slums or nearby.
- Organisation level health education activities at the AW Centre.
- AWW and MAS to work as a team for promoting health and nutrition related activities.
- Health education and adolescent discussion forums should be developed as part of the school health programme under NRHM / state programme through convergence with the Education Department.

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BASIC SERVICES TO THE URBAN POOR (BSUP)[1]

Need : The ever increasing number of slum dwellers causes tremendous pressure on urban basic services and infrastructure. In order to cope with massive problems that have emerged as a result of rapid urban growth, it has become imperative to draw up a coherent urbanization policy/strategy to implement projects in select cities on mission mode.

Mission Strategy

Planned urban perspective frameworks for a period of 20-25 years (with 5 yearly updates) indicating policies, programmes and strategies of meeting fund requirements would be prepared by every identified city. This perspective plan would be followed by preparation of Development Plans integrating land use with services, urban transport and environment management for every five year plan period. In this context, a City Development Plan (CDP) would be required before the city can access Mission funds

In respect of the implementation of BSUP the reforms critical to slum improvement are:

- Internal earmarking within Urban Local Body budgets for basic services to the urban poor eventually developing Basic Services the Urban Poor Fund so that adequate resources are available for meeting the needs of the urban poor;
- Provision of basic services to the urban poor including security of tenure at affordable prices, improved housing, water supply, sanitation and ensuring delivery of other already existing universal services of the government for education, health and social security in a time-bound manner; and
- Earmarking at least 20-25% of developed land in all housing projects (both Public and Private Agencies) for EWS/LIG category with a system of cross-subsidization so that land is available for affordable housing for the urban poor.
- Accordingly, release of Central assistance to States/Union Territories under the Sub-Mission on Basic Services to the Urban Poor (BSUP) is linked to the progress of implementation of 3 pro-poor reforms under JNNURM that are critical to slum improvement.

Reform Snapshot: BSUP

- Adoption of clear, affirmative policy of earmarking (allocating) certain quantum (MHUPA recommended norm is 25 %) of municipal budget.
- Constitution of 'Basic Services for Urban Poor Fund' and setting the rules/modalities for contribution to and disbursement from funds.
- Defining clearly who is urban poor?
- Undertake a citywide slum mapping to locate all notified and non notified slums with basic demographic information on a GIS platform.
- Enlist all families through household survey with biometric identification.
- Notification of slums for upgrading and provision of services – Slums, not currently notified, must be enlisted by the local body through a formal process so that these become eligible for provision of basic services.
- Prioritization of slums for investment –The poorest and the most disadvantaged slums must get priority for upgrading/resettlement.
- Setting up of a BSUP Task Force consisting of representatives from neighborhood groups, community based organizations, elected representatives, and civil society agencies.
- Development of Detailed Project Reports (DPRs) with community participation

Community Participation law

As part of the Community Particpation law JNNURM contemplates the creation of another tier of decision-making in the municipality which is below the ward level, called the *Area Sabha*. All the *Area Sabhas* in a ward will be linked to the ward level ward committee through *Area Sabha* representatives, who will be community representatives. There will thus be a minimum of 3 tiers of decision-making in a municipality, namely, the municipality, the ward committee, and the *Area Sabhas*. In addition, states may choose to have an intermediary level for administrative reasons, clustering multiple wards into a regional structure between the ward and the municipality. The CPL is a mandatory reform under the JNNURM and it refers to making appropriate provisions in the state-level municipal statute(s) for the establishment of such a three/four-tiered structure. The JNNURM makes it mandatory for states to either enact a separate CPL or make appropriate amendments to their existing municipal laws. These enactments will need to ensure clear definition of functions, duties and powers of each of these tiers, and provide for appropriate devolution of funds, functions and functionaries to these levels. The Community participation law would ensure involvement of citizens in municipal functions like setting priorities, budgeting provisions, exerting pressure for compliance of existing regulations etc

VII - INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

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.

At the Central level, the Mission Steering Group under the Union Health Minister, the Empowered Programme Committee under the Secretary (H&FW), the National Programme Coordination Committee under the Mission Director would be modified by incorporating additional government and non government and urban stakeholders , professionals and urban health experts (e.g. members from MHUPA). For this purpose Urban Health Division of MOHFW will be the Secretariat. At the State level, the State Health Mission under the Chief Minister, the State Health Society under the Chief Secretary and the State Mission Directorate would also be similarly modified (e.g. Nodal Secretaries/ Officers dealing with JNNURM and SJSRY at state level).

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.

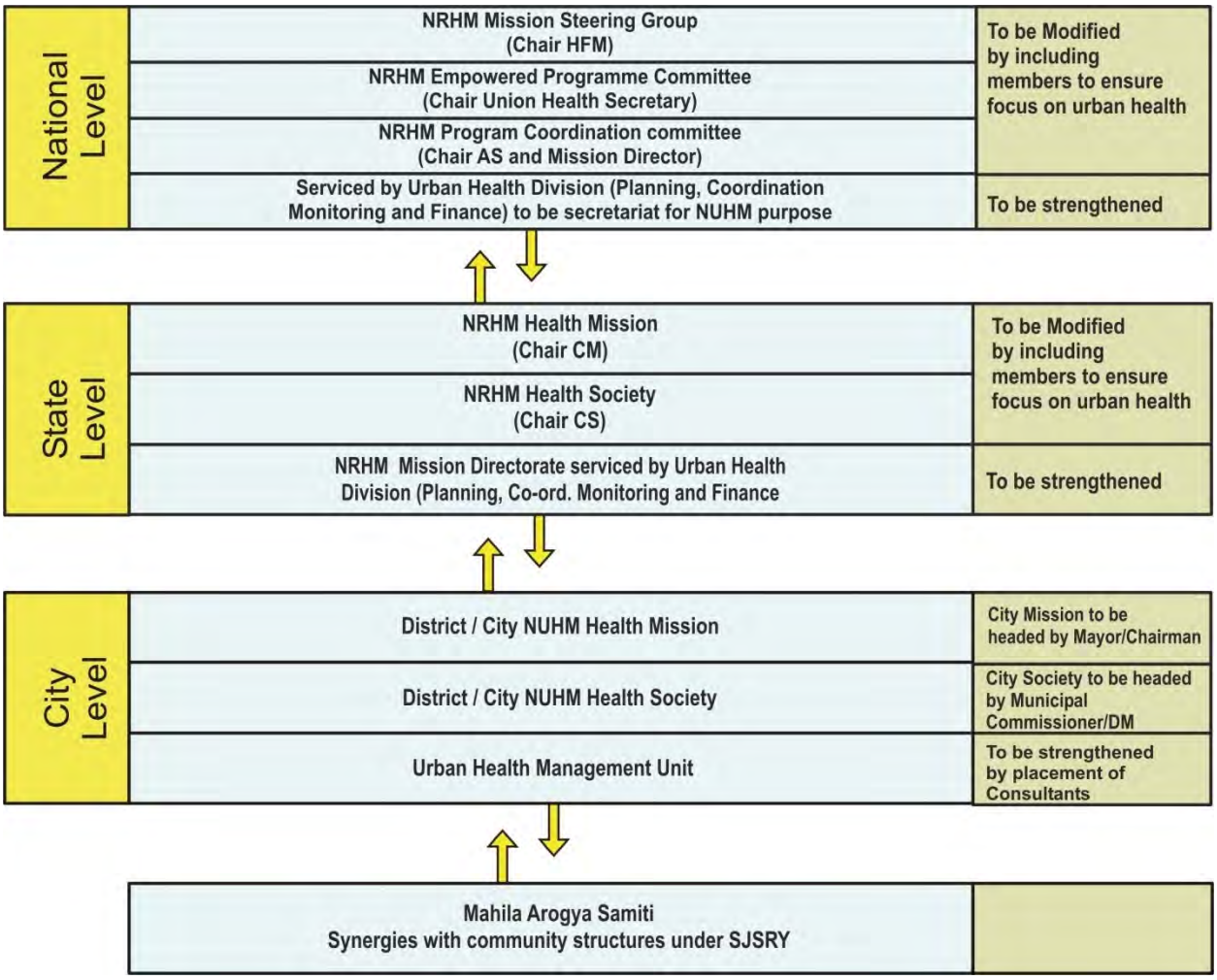
It is proposed that the City structure may be ULB led in metros and in cities with a population 10 lakh and above or where ULBs are actively involved in managing primary health effectively. In such situations a Tripartite MoU instead of a Bipartite MoU would be required. For cities with population below 10 lakh or where ULB structures are weak in managing primary health care, the states may co-locate/amalgamate the Urban Health Mission/Societies with the District Health Mission/Societies under NRHM as an interim measure till the development of independent city structures in the future. In view of the extant urban situation and multiplicity of local bodies in cities like Delhi etc. flexibility would be accorded to the States to decide on the city level institutional mechanism. The states can suitably adapt the by-laws of District Health Mission/Societies as developed under NRHM for the City Health Missions/ Societies.

The institutional framework would be strengthened at each level for providing leadership to the urban health initiatives. At the National level the existing Urban Health Division would be revamped with the Joint Secretary of the Division as the Head, reporting to the Mission Director of NRHM who will also act as the Mission Director for NUHM, with the divisions under DS/ Director rank officers namely Urban Health Division for Planning and Appraisal, the Finance Management Group (FMG), and the Monitoring and Evaluation Division and other programme divisions with enhanced professional /secretarial support engaged through contractual arrangements.

Similarly the NRHM Mission Director at the State level may also be designated as NUHM Mission Director, and be provided with enhanced professional and secretarial support through contractual engagement. Likewise the City/District Societies would be adequately supported with professional support and secretarial staff. Synergies with PMUs formed under JNNURM would also be sought for ensuring effective convergence. As urban health being relatively new area capacity building and technical support would be required at all levels for which need based involvement of specialised agencies/ institutions working in this area are also envisaged.

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

Diagram: Institutional Model

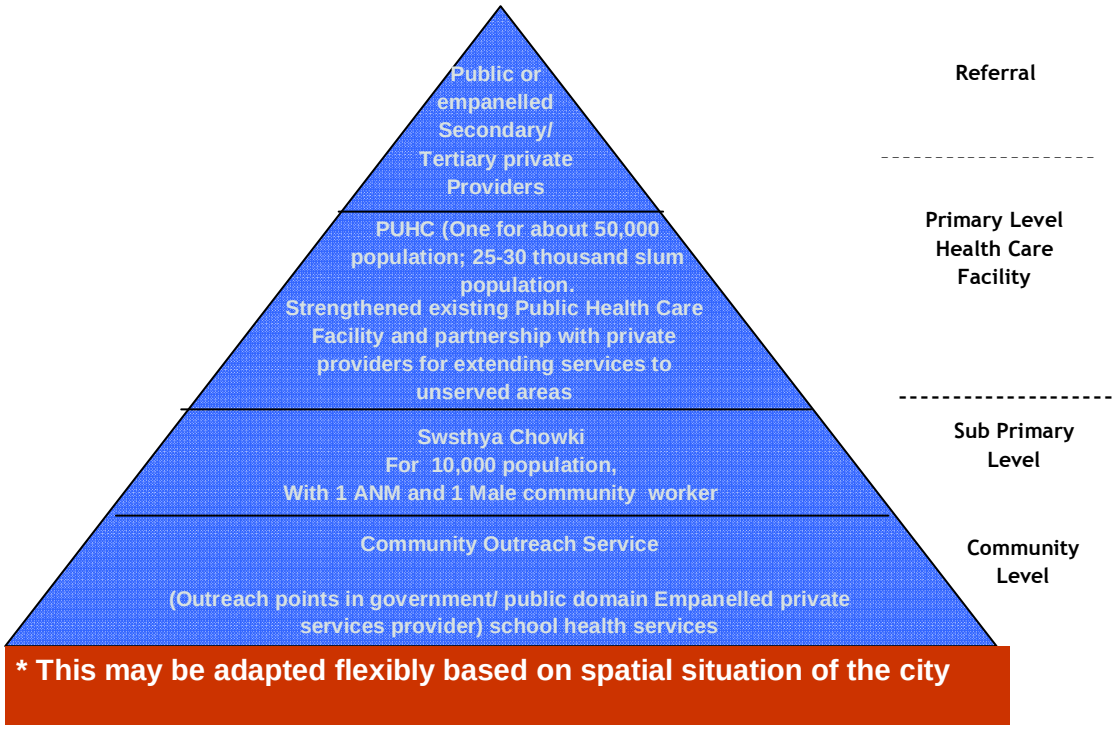


VIII. KEY COMPONENTS OF NUHM

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.

All the services delivered under the urban health delivery system will be focused towards the target groups (slum dweller and other vulnerable groups). The diagram below describes the components of the proposed urban health service delivery model.

Diagram: Urban Health Care Delivery Model



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

(a) Community level

Urban Social Health Activist (USHA)

Each slum/community would have one frontline community worker called USHA on the lines of 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 and demand–generating link between the health facility (Primary Urban Health Centre) and the urban slum populations. She would maintain interpersonal communication with the beneficiary families and the Mahila Arogya Samitis for which they are earmarked.

The USHA on the lines of ASHA, would preferably be a woman resident of the slum–married, preferably in the age group of 25 to 45 years. She should also be a literate woman with formal education up to class eight which may be relaxed only if no suitable person with this qualification is available. She 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 PUHC catchment area with the help of an NGO, through a consultative process, for facilitating the selection of the USHA. The facilitators would preferably be women from local NGOs; community based groups, Anganwadis 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 as per the local condition and adopted for selection of the USHAs.

The USHA would actually be the nerve centres for delivering outreach services in the vicinity of the door steps of the beneficiaries. Preferably some suitable identified place for USHA may be arranged in the slums which may be AWW centres, clubs, community premises set up under the JNNURUM , Sub Health Posts set up in IPP cities ,municipal premises etc, or even her own residence. An USHA 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 PUHC level, for supporting and coordinating the activities of the USHA. The states may also consider the option of 1 Community Organiser for 10 USHAs 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 USHAs.

Essential services to be rendered by the USHA may be as follows:

- Actively promoting good health practices and enjoying community support.
- Facilitate awareness on essential RCH services, sexuality, and gender equality, age at marriage/pregnancy; motivation on contraception adoption, medical termination of pregnancy, sterilization, spacing methods. Distribution of condoms and oral contraceptive Pills; early restriction of pregnancies, pregnancy care, clean and safe delivery, nutritional care during pregnancy, identification of danger signs during pregnancy; counselling on immunisation, 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 Primary Urban 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 .
- Provision for a minimum package of curative care empowered with minimum knowledge for timely referrals equipped with an ASHA like drug kit.
- Promote the enrolment of the urban poor population in the RSBY scheme
- 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 PUHC which would be replenished from time to time. The following performance based incentive package is suggested subject to modifications by the State.

Table: USHA incentive chart

	Activity	**Proposed Incentive per month (Rs)**
1	Organization of outreach sessions	200
2	Organization of monthly meeting of MAS	100
3	Attend monthly meeting at PUHC	200
4	Organize Health & Nutrition day in collaboration with AWW	100
5	Organize community meeting for strengthening preventive and promotive aspects	50 per meeting (200 upper limit)
6	Provide support to Baseline survey and filling up of family Health Register	5 per Household (once a year)
7	Maintain records as per the desired norms like	Rs.50 per month

	Household Registers, Meeting Minutes, Outreach Camps registers	
8	Additional Immunisation incentives for achieving complete immunisation in among the children in her area of responsibility:	Rs. 5 per child
9.	Incentives/compensation in built in national schemes for ASHA under JSY, RNTCP, NVBDCP, Sterilisation etc. any other National programme	Similar norms would be applicable for USHA. The respective programme would be requested to issue necessary instructions in this regard.

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 USHAs with Photo ID card.

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

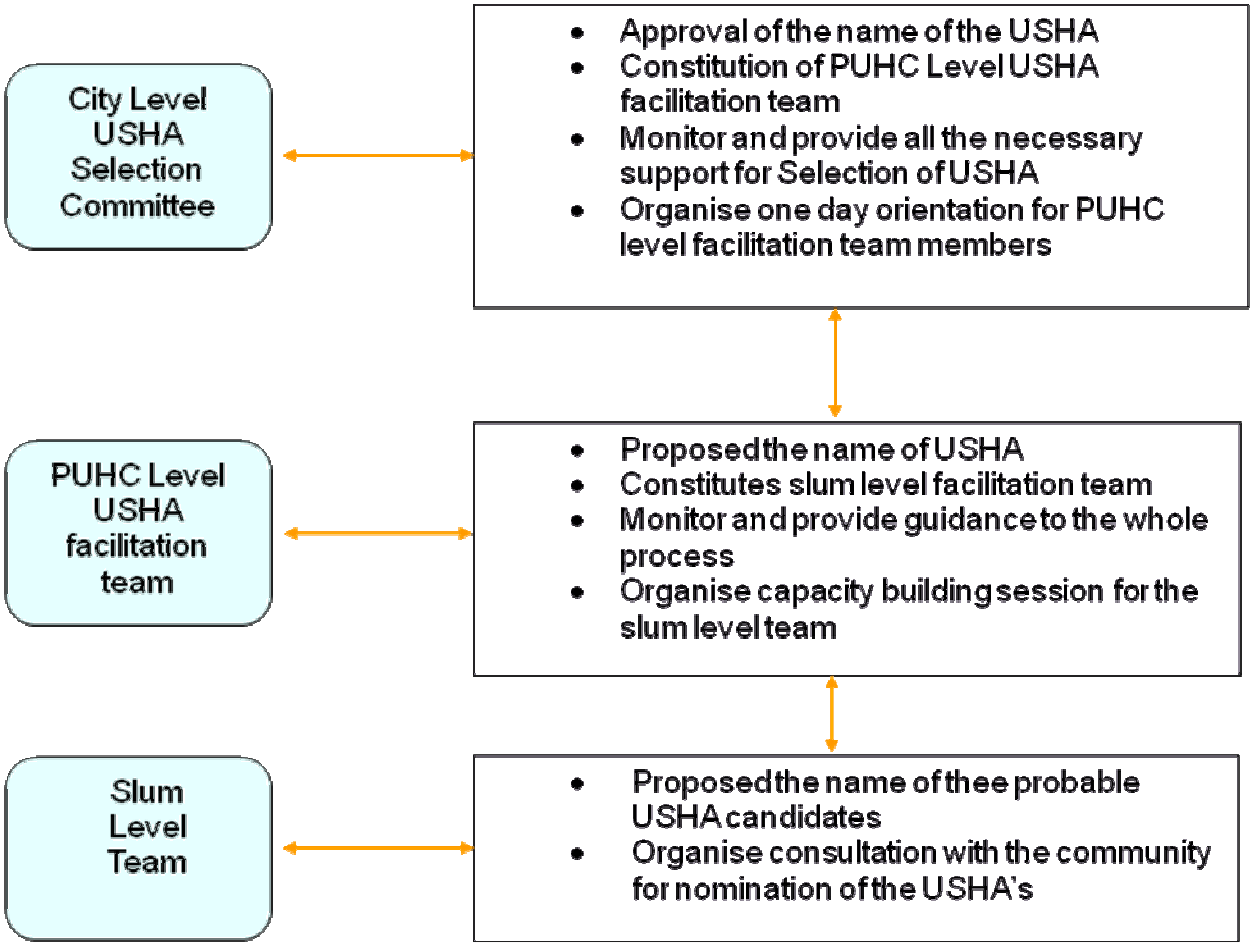
The USHA will be selected through a community driven process led by the Urban Local Body. To facilitate the selection process the District/ City level Mission would constitute a City Level USHA Selection Committee headed by the member of the urban local body. The CMO/CDMO; DPO-ICDS; and PO of JNNURM; 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 USHA Selection Committee would approve the names of the USHA proposed by the PUHC level facilitation committee. The selection committee would also provide all the guidelines for the selection of USHA. The City Level USHA Selection Committee would also be responsible for Constitution of health facility/unit level USHA selection committees. It will monitor and provide all necessary support to carry out the UHSA selection process including approval of the list of selected USHAs.

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

At the Slum level two local facilitators would be selected for 10,000 populations (catchment area of ANM). The ANM would chair the Slum level team for identification of the name of three probable USHA candidates. The slum level team may also have the members of the Neighbourhood group and other government employees like beldars and malaria workers. The Slum level Team would organize community level meetings for arriving at the name of USHA

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

Diagram: Selection Process of USHA



Mahila Arogya Samiti (MAS) – acts as community based peer education group, involved in community monitoring and referral. The MAS may consist of 20-100 households (HH) with an elected Chairperson and a Treasurer, supported by an USHA. This group would focus on preventive and promotive care, facilitating access to identified facilities and risk pooling. The following process may be adopted for constitution of the MAS

Constitution of Mahila Aarogya Samiti

To expand the base of health promotion efforts at the community level and to build sustainable community processes, each USHA 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/ NHG

groups wherever present would be encouraged to expand their scope of work to address health challenges in the community.

Process of promotion of Mahila Arogya Samiti :

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

Meetings with slum women: The team (USHA/CLV 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 Aarogya 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 200-330 families. The numbers will vary depending on the size of the slum (e.g. in case of a small slum with 100 families, the Committee will be promoted over 100 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.

Desired characteristics of members of Mahila Aarogya Samiti

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 USHA and others. Therefore the following should not be seen as eligibility criteria. However the common features emerging in this scene would be –

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

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.

Any woman identified as a 'Dai' or as an 'informal' birth attendant, and recognized by the community.

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

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

USHA 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. Each ANM will organize a minimum of one outreach session in the coverage population of the USHA. Four ANMs will be posted in each PUHC.

Outreach Medical Camps – Once in a month the MO would accompany the ANMs to the outreach sessions (may be called Outreach medical camps). It will include OPD (consultation), basic lab investigations (using mobile/disposable kits), and drug dispensing, apart from counselling. Each camp will be covering a responsibility area of two ANMs working in a PUHC. The PUHC can also partner with local General Practitioner for the camp.

These could be organized at designated locations mentioned in the aforesaid paras in coordination with USHA and MAS members.

All engagements would be contractual with no permanent liability to Government of India.

Basti Swasthya evam Vikas Manch

On lines of the Village health and Sanitation Committee under the NRHM a Basti Vikas Manch based ordinarily for population as per the prevailing local situation may be decided upon by the states, is envisioned for the urban health programme also. The Basti Vikas Manch under the stewardship of Ward Councilor under whose area the slum/ cluster is located would provide direction to the integrated efforts to health, water supply and sanitation. A provision of Rs 10,000/ as untied grants would be allocated to the slum / cluster committee. A joint account for the use of UGs would be opened in the name of Ward councilor and Medical Officer I/C/ PHN I/C of urban health facility attached to the slum/ cluster. The following may be the responsibilities of Basti Vikas Manch

Preparation of slum / cluster level plan

Implementation of the funds allotted under the untied grants to the slums.

Monitor the work of the community link worker.

Monitor the programme of Slum/ Cluster on monthly basis, and provide progress to District Health Society

Review of quality of work of the Health facility provided to the slum and community linkages

Provide solutions to problems at the Health facility provided to the slum by coordinating with the city officials

Carry out the health and sanitation assessment of the area which can be put up as proposals to DUDA through District Health Society under various schemes

Take up pertinent coordination/collaboration issues having a bearing on the health of the communities living in the area

Delegation of the responsibilities to concerned group member for adequate response to the identified need.

Sub-Centre/Swasthya Chowki for every 7500 population which would provide basic maternal and child health services, disease prevention services, would be somewhere between a health outpost and a rural Sub-Centre (within a radius of 1 km to 2 kms) may be provided for the slum/cluster. This could be manned by 1 ANM and a Helper. The basti sevikas can also be involved as helper on rotation basis. It has to be noted that the swasthya chowkis would be only for slum population and be located in slums. The city during the city level planning may also take the call on the number of swasthya chowki as may for slums near the health facility a swasthya chowki may not be needed and for situations where the slums are dispersed and located far off, there may be a need for a swasthya chowki for smaller population. All existing sub centers (A type HP and Type 1 UFWC and SC to be merged)

(b) Primary Urban Health Centre

Functional for a population of around approximately 50,000, the PUHC may be located preferably within a slum or a half kilometre radius, catering to a slum population of approximately 20,000-30,000, with provision for evening OPD also. The cities, based upon the local situation may establish a PUHC 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 PUHC level services provided will include OPD (consultation), basic lab diagnosis, drug /contraceptive dispensing, apart from distribution of health education material and counselling for all communicable and non communicable diseases. In order to ensure access to the urban slum population at convenient timings, the PUHC may provide services for 4 hrs in the morning and 2 hrs in the evening. For provision of certain services evening OPD if required, partnership with local General Practitioners through benchmarked performance indicators may also be explored. It will not include in-patient care.

It will be staffed by One Doctor, 2 multi skilled paramedics (including a lab technician and pharmacist), 2 multi-skilled nurse, 4 ANMs (depending upon the population covered), apart from clerical and support staff and one Programme Manager for supporting community mobilization, behaviour 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 PUHC based on needs on reimbursement basis. PUHC 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 PUHC may also be explored, thus enabling the placement of AYUSH doctor and other AYUSH paramedic staff in the PUHC.

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, thus to create a uniform health care service delivery mechanism NUHM would encourage states to develop uniform IPHS for service delivery at PUHC. As part of the IPHS uniform staffing norms and service delivery along with monitorable indicators would be developed. The states/ cities during planning process would be encouraged to revisit the functioning of the existing health care facilities and take a decision to upgrade such centres to conform to uniform PUHC standards. The NUHM would provide support to the existing government health facilities (to be decided by the states based on rationalisation) in the urban areas in addition to already sanctioned funds under the Urban Health Centre scheme planned scheme for strengthening them to PUHC standard. In no case any support would be provided for already sanctioned staff, equipment or any other cost. The existing UHP/ UFWCs are already being supported through planned grant. Hence all the existing staff and health facilities in this scheme (Urban Health Posts, Urban Family Welfare Centres) should be rationalized, however as is being currently done under NRHM, the funds can flow through treasury route but the monitoring may be bought under the purview of the NUHM. The strengthening of UHP/UFWC will be to complement the already existing support and in no case duplication would be allowed.

Maximum effort would be made to strengthen the existing public health care infrastructure.

Where there are no government health facilities, existing private clinics/nursing homes operating in or near the slum clusters and having good institutional capacity may be empanelled/accredited and designated as PUHCs. For involving the private sector, input and output norms along with the rates may be listed and approved at the appropriate levels. The same would also be subject to approval of the City PIP by the NPCC at the GOI level. 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 PUHC will also be provided annual financial support in the form of Rogi Kalyan Samittee/ Hospital Management Committee Fund of Rs. 50,000 per PUHC per year, with the amount being proportional to the population covered (@ Re.1.00 per head, i.e. a PUHC covering 40,000 population will get Rs.40, 000 and a PUHC covering 75,000 population will be getting Rs. 75,000 per year).

All additional staff engagements as part of the strengthening process would be contractual with no permanent liability to Government of India.

(c) Referral Unit:

The cities based on the GIS mapping 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, critical illness, surgical cases etc. NUHM would provide strengthening support to the designated referral facilities as per the city PIP subject to approval at appropriate levels.

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.

An indicative cost of Rs. 4000 has been arrived at by inflating the NCMH cost by 100% for calculating the budgetary allocation for reimbursements under NUHM. Similar amount has also been reported as out of pocket expenditure by the NSSO 60th round (an expenditure of Rs. 3877 per hospitalisation case in government hospitals) and around Rs.7000 for private hospitals in urban areas.

However as the rates would vary from city to city (rates in Ranchi may not be applicable in Delhi). The states / cities would be encouraged to develop a rate for reimbursement for the services. The CGHS rates, which have been developed for different category of cities, may be taken as reference point for developing the rates of reimbursement after suitable adjustments for inflation. 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 levels. During the field visits it was observed that many of ULBs have maternity homes functioning with heavy case load but inadequate infrastructure, therefore the city may plan to strengthen the existing maternity hospitals on case to case basis as referrals.

The referral services will be cash-free for the beneficiary.

Collaboration with local Medical Colleges may be promoted for strengthening the training support and supplement human resource at the PUHC level.

(d) School Health Services

Schools can serve as nodal points for advocating healthy behavioural 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.

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.

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.

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

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.

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
- 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.
- 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.

(e) Improving access to vulnerable section of urban poor

To target special interventions on the vulnerable groups, in the cities mapping of the vulnerable groups (one time) would be undertaken. 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. For targeted IEC/BCC interventions, the details of which will be as per the city PIP, the provision is Rs.10 per capita for the target urban vulnerable population (in line with the provision for IEC/BCC under NRHM). This will also include community mobilisation and support through NGO/CSO. The details of this mobilisation strategy will be as per the city PIP.

Table: Indicative Service Norms by levels of Service Delivery *

Services**	Levels of service delivery		
	Community (Outreach)	First point of service delivery (PUHC)	Referral Centre - RC (Specialist services)
A. Essential Health Services			
A1. Maternal health	Registration, ANC, identification of danger signs, referral for institutional delivery, follow-up Counselling and behaviour promotion	ANC, PNC, initial management of complicated delivery cases and referral, management of	Delivery (normal and complicated), management of complicated Gynae/ maternal health condition,

Services**	Levels of service delivery		
	Community (Outreach)	First point of service delivery (PUHC)	Referral Centre - RC (Specialist services)
		regular maternal health conditions, referral of complicated cases	hospitalization and surgical interventions, including blood transfusion.
A2. Family welfare	Counselling, distribution of OCP/CC, referral for sterilisation, follow-up of contraceptive related complications	Distribution of OCP/CC, IUD insertion, referral for sterilisation, management of contraceptive related complications	Sterilisation operations, fertility treatment
A3. Child health and nutrition	Immunisation, identification of danger signs, referral, follow-up, distribution of ORS, paediatric cotrimoxazole post-natal visits/counselling 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 iodised salt, nutrition supplements to identified children and pregnant/ lactating women	Diagnosis and treatment of seriously deficient patients, referral of acute deficiency cases	Management of acute deficiency cases, hospitalization Treatment and

Services**	Levels of service delivery		
	Community (Outreach)	First point of service delivery (PUHC)	Referral Centre - RC (Specialist services)
	Promotion of breast feeding, complementary feeding for prevention of under-nutrition		rehabilitation of severe under-nutrition
A6. Vector-borne diseases	Slide collection, testing using RDKs, DDT Counselling 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	Diagnosis and treatment, referral	Management of complicated cases,

Services**	Levels of service delivery		
	Community (Outreach)	First point of service delivery (PUHC)	Referral Centre - RC (Specialist services)
	search and referral,	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, hospitalisation (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 hospitalisation, physiotherapy and rehabilitation
A13. Other surgical interventions	--- not applicable ---	Identification and referral	Hospitalisation 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. Counselling	Individual and group/family counselling –	Patient/attendant counselling	Patient/attendant counselling
B3. Personal & Social Hygiene	IEC on hygiene, community mobilisation for cleanliness drives, disinfection of water sources, etc.	--- not applicable ---	--- not applicable ---

*Norms adapted from NCMH Report

** Services based on situational analysis

4 (a) Indicative Norms for Empanelment of PUHC

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

- Medical care: OPD services: 4 hours in the morning and 2 hours in the evening.
- Services as prescribed under RCH II
- National Health Programmes
- Collection and reporting of vital events and IDSP
- Referral Services
- Basic Laboratory Services
- Counselling 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: proposed Human resource at PUHC

#	Staff Category	Number
1	Medical Officer	1
2	Multi-skilled Paramedic including Pharmacist/ Lab Technician etc.	2
3	Programme Health Manager	1
4	Multi-skilled Nurse	2
5	ANMs	4
6	Secretarial Staff including account keeping	1
7	Support staff	3

4 (b) Indicative Norms for Empanelment of Referral Unit

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 haematology
- X- Ray machine with minimum capacity of 60 MA
- Ultra-Sonography
- Any other based on epidemiological profile of the City

IX - 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. Mapping of all health care facilities as per cost of GIS mapping. Data base to be generated involving the Community Workers. Issuing clear entitlements to every household based on the mapping. Cost will vary in mega cities, million plus cities, and other categories of cities and towns.
2.	Preparation of slum/city specific plans	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.
3.	Community Worker for every 500 households	Community Worker to be women, local resident, at least Class 10 pass. To be paid performance based honorarium. Main task to be linking households to health facilities (government or private accredited).
4.	Capacity building, transport allowance, performance based payments, drug lit for Community Worker	Basic training modules for Community Workers to be developed. 30-40 day training every year in various aspects of public health. Compensation for training. Community Workers to be skilled over time to become Health Workers. Provision of basic drug kit with them. More thrust on preventive and promotive aspects.
5.	Community Organization (Basti Vikas Manch) for every slum/ group of 500 households.	Community Organization in homogeneous setting. Representation of women and vulnerable social groups to be guaranteed.
6.	Training and Capacity Development of Community Organization	Through NGOs. To ensure greater role in management of a decentralized health system.
7.	Mahila Arogya Samitis through Self Help Groups for every 20-100 households.	Self Help Group organization. Promote saving habit at all times for health care.
8.	Capacity development of Mahila Arogya Samitis	Through NGOs. In management of savings and in seeking services of accredited health care providers.
9.	Seed money of Mahila Arogya	Every MAS to get a seed money of Rupees 10,000.

	Samitis	Savings of households to be added to it. To function as a health need resource.
10.	Untied grant to Community Organization (Basti Vikas Manch	For public health action. Responsibility for keeping basti clean. Holding Monthly Health and Nutrition Days. Providing care to any household whenever needed. Every Basti Vikas Manch to get Rs. 25,000 every year for local public health action.
11.	One Female and One Male Health Worker for every 10,000 population	Female Worker from among ANMs with much greater public health responsibility. Male Worker from among unqualified local practitioners, etc. with appropriate training and skill development. Largely to manage public health challenges.
12.	Provision of drug kits, basic medical care facilities for Male and Female Health Worker	Every Primary Health Care Unit for 50,000 people to have a drug budget of at least Rs. 50 per capita. Medicines to be made available to Basti Vikas Manch level health team by PUHC.
13.	One Primary Urban Health Centre Unit for every 50,000 population	PUHC as nodal point. To function under government, NGO or private with well defined service guarantees and provisions for human resources, infrastructure, equipment, etc. Indian Public Health Standard developed for PUHC by Government of NCT Delhi to be adopted. Each PUHC necessarily to have evening OPD. All health workers in the PUHC area to work under PUHCs supervision and support. PUHC responsible for the health of all the people in that area.
14.	Training and Capacity Development of Ward level Standing Committee on health members under Urban Local Body	NGOs to be involved in training and capacity development of Ward level Standing Commmittees of health.
15.	Untied grants to Rogi Kalyan Samiti of Primary Urban Health Care Facility	Each PUHC to get Rs. 2 Lakhs as untied grant every year for local public health action and for its maintenance and upkeep.
16.	Physical infrastructure of PUHC	As per standard developed by GNCT Delhi.
17.	Equipments and medicines of PUHC	As per standard developed by GNCT Delhi.
18.	Human Resources of PUHC	As per Standard developed by GNCT Delhi. A Community Mobilization Officer and a Counsellor

		at each PUHC to meet communitization and counselling needs of Bastis.
19.	Untied grants for public health measures to Ward level organization	Rs. 5 lakhs for every Ward level Health Committee for promoting public health action.
20.	Resources for outreach services as per fixed schedule in urban slums by Male/Female Health Workers	Outreach services at Basti level as per schedule. Resource need as per standard need and population covered.
21.	Referral Transport funds at PUHC level	Ensuring household to health facility link.
22.	Fixed rate diagnostic services	As per transparent bidding process.
23.	NGOs for capacity development in PUHC area	As per independent accreditation process for NGOs to be carried out professionally and objectively.
24.	Hiring of NGOs/Private providers for PUHC services	As per standard deliverables and based on likely government spending to provide the same level of service.
25.	System of accreditation of private providers	Through an independent system like the Quality Council of India/ ISO, etc.
26.	Free secondary and tertiary care for BPL/Poor households	Costs as per assessments made by the National Commission on Macro economics and health. Costs developed by RSBY.
27.	Training of unskilled private practitioners	Intensive efforts will be made to involve unskilled private providers of care by compulsorily putting them through specially designed courses. Thrust will be on preventive and promotive and working under supervision of MBBS doctor. They will be taken as Male Health Workers along with ANM.
28.	Outsourcing of diagnostics	A per transparent bidding process.
29.	Enhancing planning capacity in urban local bodies	Provision for need based additional human resources in public health, management of health system, finance, MIS, planning , etc.
30.	Accreditation of Private providers	Through agency like the Quality Council of India.
31.	Interventions for adolescents	As per need. As per approved norms.
32.	Interventions against drug abuse, tobacco, alcohol.	As per norms developed for such interventions by other National Health Programmes.
33.	Mobile Medical Units	As per need and as per norms.
34.	Setting up of City Level health Mission	Coordination role in ensuring focused implementation of the urban health initiative.

35.	Behaviour Change Communication	IEC and BCC have a very important role especially in urban areas where the influence of media and advertizing needs to be countered effectively, especially against use of junk food, aerated drinks, etc. Provision of Rs. 10 per capita for IEC/BCC.
36.	Monitoring and Evaluation	Provision of Rs. 10 per capita for M&E.
37.	MIS for health in urban areas	As per need.
38.	Management cost for programme	Up to 10 percent of the Mission cost. Management cost is being kept high as many urban local bodies do not have the capacity for management of a large health care initiative.
39.	Interventions for making surveillance system effective.	As per norms of IDSP.
40.	Cost of hospitalized care	As per NCMH assessments.
41.	Special interventions for vulnerable groups like sex workers, street children, migrant labour, etc.	As per specific proposals and as through NGOs.
42.	Strengthening Secondary and tertiary care hospitals	As per need.
43.	Strengthening Medical Colleges for capacity development.	As per need.
44.	Community Monitoring	As per need.
45.	Partnerships with NGOs	As per set procedure, for specific tasks. Model schemes for guidance. .

X - FINANCIAL RESOURCE NEEDS FOR NUHM

The National Urban Health Mission would initiate planning activities in 2010-11. The sharing arrangement for NUHM will be in line with the NRHM – 85-15 in XI Plan and 75-25 in the XII Plan. It is also proposed that, in the XII Plan, 25% state contribution may be shared between states and the Urban Local Bodies (ULBs). For calculation purpose, it is assumed that state share would be 15% and ULBs share 10%. Keeping the above mentioned financing pattern, the estimates for the proposed National Urban Health Mission (2010-11 to 2016-17), are approximately Rs. 25,000 crores for the central government, Rs. 5000 crores for the state governments and Rs. 3000 crores for the ULBs, for a total Mission grant of Rs. 33,000 crores (approximately).

Population Assumptions underlying Financial Estimates for NUHM:

	Population	Numbers
1.	Urban Population 2001 (Census 2001)	28.61crore
2.	Projected Urban population 2006 (Census)	32.80crore
3.	Population of Cities less than 100,000	11.06 crore
4.	Total Projected Population (Urban)	21.07crore
5.	Slum Population in Cities with one lakh population (Projected Slum Population in 2008, of cities more than one lakh based on annual population growth rate of 7%)	6.25crore
6.	Population of Vulnerable Groups living outside the slums	75 lakh
7.	Cities with population above 1 million (10 lakh) as per 2001 Census	35
8.	Cities with population above 2 lakh but below 10 lakh as per 2001 Census	156
9.	Cities with population less than 2 lakh but more than one lakh as per 2001 Census	239
10.	Total Number of PUHC to be strengthened / set up under PPP	4214
11	Total Number of USHAs (1 for 2000 population)	31250
12	Total Number of Mahila Arogya Samitis (1 MAS for 500 hh)	1,25,000

Funds / Resource required

It is estimated that the NUHM will have the following components for which the funding would be needed:

Planning & Mapping

One-time Capital Cost, for initiating provider and beneficiary mapping through GIS, situation analysis including stakeholder consultation for identifying urban health issues and developing appropriate strategies. For this purpose, the financial resources envisaged are - 7 metro cities @ Rs. 40 lacs each: Rs. 2.80 crores; 28 cities with 10 lac+ population @ Rs. 30 lacs each: Rs. 8.40 crores; 395 other cities with 1 lac+ population @ Rs. 20 lacs each: Rs. 79.00 crores.

Apart from the above, annual planning exercise involving City-specific PIPs, are also envisaged from the 2nd year onwards (post the GIS mapping and stakeholder consultation). For this purpose, the funds estimates are - 7 metro cities @ Rs. 15 lacs each: Rs. 1.05 crores p.a. (Rs. 6.30 crores for 6 years); 28 cities with 10 lac+ population @ Rs. 10 lacs each: Rs. 2.80 crores p.a. (Rs. 16.80 crores for 6 years); 395 other cities with 1 lac+ population @ Rs. 5 lacs each: Rs. 19.75 crores p.a. (Rs. 118.50 crores for 6 years).

Program Management

Capital cost are estimated for office set-up and related equipment/furniture @ Rs. 5 lakhs for state PMU and Rs. 8 lakhs for city PMUs: Rs. 36.15 crores (for all states and cities for Mission period).

It is assumed that PMU's will come into effect from 2nd year onwards, hence recurrent cost to be accounted for 6 years. State Program Management Unit are envisaged to be combined with NRHM SPMU, with a separate Urban Health Cell, reporting to State Mission Director. As most of the cities would be the district headquarters too, separate District PMU for Urban Health is not proposed. City level PMU are aimed to strengthen the Public Health management capacity of ULBs, to be located within the ULB, reporting to the City Commissioner/Mayor (as may be decided by the respective state/city).

The Staff at SPMU-Urban Health Cell are proposed as under

State Urban Health Program Manager – salary Rs. 50,000 pm + mobility support of Rs. 15,000 pm + Communication & Miscellaneous Rs. 10,000 pm : Rs. 9.00 lacs pa.

State Urban Health MIS Manager – salary Rs. 45,000 pm + mobility support of Rs. 15,000 pm + Communication & Miscellaneous Rs. 10,000 pm : Rs. 8.40 lacs pa.

State Urban Health Finance Manager – salary Rs. 45,000 pm + mobility support of Rs. 15,000 pm + Communication & Miscellaneous Rs. 10,000 pm : Rs. 8.40 lacs pa.

Staff at City PMU level

Urban Health Program Manager – salary Rs. 45,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 10,000 pm : Rs. 7.80 lacs pa.

Urban Health Data Manager – salary Rs. 30,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 10,000 pm : Rs. 6.00 lacs pa.

Urban Health Accounts Manager – salary Rs. 30,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 10,000 pm : Rs. 6.00 lacs pa.

Consultant (Epidemiologist) – salary Rs. 60,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 5,000 pm : Rs. 9.00 lacs pa.
Consultant (Public Health) – salary Rs. 60,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 5,000 pm : Rs. 9.00 lacs pa.
Consultant (M&E) – salary Rs. 40,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 5,000 pm : Rs. 6.60 lacs pa.
Consultant (Community Participation) – salary Rs. 40,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 5,000 pm : Rs. 6.60 lacs pa.
Consultant (IEC/BCC) – salary Rs. 40,000 pm + mobility support of Rs. 10,000 pm + Communication & Miscellaneous Rs. 5,000 pm : Rs. 6.60 lacs pa.
The above mentioned rates of remuneration are indicative and can vary with state/city, with, preferably, additional contribution from ULB/state.

Training & Capacity Building

Capacity building of Urban Local Bodies

Orientation of ULBs – twice a year per city – in July for taking stock of the urban health issues and progress, and in January for budgeting for urban health related issues in the context of city specific situation and strategies.

Orientation workshops in metros @ Rs. 15 lacs per workshop, two workshops a year for 7 metros: Rs. 2.10 crores per year (Rs. 14.70 crores for 7 years). Orientation workshops in cities with 10 lacs+ population @ Rs. 10 lacs per workshop, two workshops a year for 28 cities: Rs. 5.60 crores per year (Rs. 39.20 crores for 7 years). Orientation workshops in other cities with 1 lac+ population @ Rs. 5 lacs per workshop, two workshops a year for 395 cities: Rs. 39.50 crores per year (Rs. 276.50 crores for 7 years)

Capacity building of healthcare professionals

Week-long orientation of ANM, Nursing and Paramedical staff (government staff) on public health issues in urban context, followed by two refresher courses focusing mainly on community mobilization and inter-sectoral convergence around the urban health issues and challenges. The training cost is estimated at Rs. 5000 per ANM/Nurse/Paramedic per training, for 50,000 staff (@ 500 ANM, Nurse, paramedic per metro city, 200 per city with 10 lacs+ population and 100 per other city with 1 lac+ population, which is 48,600, rounded off to 50,000), for 3 rounds of training: Total Rs. 75.00 crores.

Week-long orientation of Medical Officers on public health issues in urban context, followed by two refresher courses focusing mainly on community mobilization and inter-sectoral convergence around the urban health issues and challenges. The training cost is estimated at Rs. 10,000 per MO per training, for 25,000 MOs (half the estimated number of ANM, Nurse, paramedic), for 3 rounds of training: Total Rs.75.00 crores.

Fortnight-long orientation (may be broken down, as per the city specific training plans) of Specialists (government staff) on communicable/non-communicable diseases in the urban context, with special focus on the urban poor and vulnerable groups, followed by one refresher course. The training cost is estimated at Rs. 20,000 per Specialist per training, for 5,000 specialists (one-tenth the estimated number of ANM, Nurse, paramedic), for 2 rounds of training: Total Rs.20.00 crores.

The above costs are indicative and the costs per trainee are "package" cost including cost of logistics, resource persons, and also that of developing training modules.

Orientation of community based workers and institutions

Quarterly orientation meeting per MAS - 1,25,000 MAS @ Rs. 10,000 per orientation workshop, four times a year in the first year, thereafter once a year, for 5 years (assuming MAS would be formed in the 2nd year): Total Rs. 1,125.00 crores

Orientation of Basti Vikas Manch (BVM) members, annually, on urban public health issues: 25,000 BVM @ Rs.10,000 per workshop (Total Rs. 150 crores).

Orientation of link-worker (USHA), on the lines of ASHA-training, but adapted for urban health context - 31,250 link workers @ Rs.20,000 per trainee (Total Rs.62.50 crores)

The above costs are indicative and the costs per trainee are "package" cost including cost of logistics, resource persons, and also that of developing training modules.

Strengthening Healthcare

Outreach services

One outreach session (in the identified slums/other areas) under each MAS, every month, coordinated by designated Swasthya Chowki (Health Post). To be managed in a PPP mode, with doctors and ANMs (government or private) contracted specially for such outreach clinics on a monthly basis. It is estimated that for 1,25,000 MAS @ Rs. 10,000 per outreach clinic per month, i.e. 12 clinics per year: Rs. 1,500.00 crores per year - Rs. 7,500.00 crores will be needed for 5 years, in the XII Plan period. This may also encompass Health and Nutrition Day activities, in partnership with ICDS.

PUHC (Primary Urban Health Centre)

It is estimated that of the total 4214 PUHCs estimated as needed for the urban areas, 50% (2107) will be government owned, of which two-third (1412) are assumed to be already in place in some, so requiring minor upgradation (@ Rs. 10 lacs per PUHC, as per IPHS estimates for PHCs). The remaining 695 are assumed to require major upgradation (@Rs. 40 lacs per PUHC, as per IPHS estimates for PHCs).

For Recurrent cost, it is estimated that it will be applicable for all 4214 PUHCs, whether government or private owned. Annual grant per PUHC will be provided at the rate of 50% of estimated Rs. 30 lacs per year (as per NCMH, for PHCs). Rest of the recurrent cost to be borne by the state govt./ULB, and the private provider (in case of empanelled private provider). The operating cost grants are estimated to be Rs. 15 lacs per PUHC per year for 4214 PUHCs: Rs. 632.10 crores per year (Rs. 3,792.60 crores for 6 years, assuming PUHCs would become functional from 2nd year)

Referral services

No capital costs are envisaged as investments in secondary level institutions (District/Sub Division Hospital) incurred under NRHM, and tertiary/medical college level institutions covered under separate central scheme.

Referrals to be organized through a network of accredited clinics, nursing homes, hospitals and diagnostic centers, which would be reimbursed against each patient, based on pre-agreed rates (preferably CGHS/RSBY rates). The network institutions may consist of both public and private institutions. The referral arrangement may be complimentary to schemes like RSBY, Arogyashri, etc., to cater to urban poor not covered/left-out under those schemes. The payment mechanism under referral services may be arranged as a demand-side financing scheme (like a voucher scheme).

It is assumed that annual recurrent cost will be Rs. 655 per capita (as per NSSO-60th round, for urban areas) for projected urban poor population of 6.25 crores. Also assuming half of this population (3.13 crores) will not be covered under insurance schemes like RSBY/Arogyashri, and thus would need to be covered under the referral services. Thus the cost estimates for referral services component under NUHM is @ Rs.655 per capita for 3.13 crore urban poor - Rs. 2,046.88 crores per year (Rs. 10,234.38 crores for the XII plan period).

Emergency Medical Services

One-time provision of Rs. 20 crores for metros, Rs. 10 crores for cities with 10 lacs+ population and Rs. 5 crores for other cities with 1 lac+ population, for upgradation/strengthening of trauma, cardiac and other emergency care facility in identified government hospitals. This grant may be over and above existing grants for facility upgradation under NRHM and other central schemes for medical college hospitals. Thus the estimate is 7 metros @ Rs. 20 crores; 28 cities with 10 lacs+ population @ Rs. 10 crores; 395 other cities with 1 lac+ population @ Rs. 5 crores: Total Rs. 2,395.00 crores.

No recurrent cost grant envisaged for trauma, cardiac and other emergency care facility, as these are supposed to be maintained by respective state governments.

For Emergency Transportation, provisions are there under JSY and ERS (ambulance services) being implemented under NRHM; so no additional allocation is envisaged.

IEC/BCC with focus on local public health issues

Recurrent cost estimated @ Rs. 10 per capita (as suggested by NCMH and NRHM), for the entire estimated urban population. IEC/BCC allocation for 21.07 crore urban population @ Rs. 10 per capita per year: Rs. 210.70 crores per year (Rs. 1474.90 crores for 7 years).

Urban RCH

No additional financial allocation envisaged. The Urban RCH component of RCH-II to be apportioned under this component, although RCH-II may maintain the overall technical supervision on this component.

Communicable diseases program (urban)

These will include the estimated proportion for urban areas, from the national communicable diseases program, including immunization. The estimates, based on XI plan allocations are as follows:

Program	XI Plan Allocation (Rs. Crores)	Apportion for Urban areas (20%)	Estimate for XII Plan (assuming 30% increase)
NVBDCP	3,190.00	638.00	829.40
RNTCP	1,447.00	289.40	376.22
NLEP	268.00	53.60	69.68
NPCB	1,550.00	310.00	403.00
NIDDCP	155.40	31.08	40.40
IDSP	341.45	68.29	88.78
RI	2,457.16	491.43	638.86
PPI	3,994.18	798.84	1,038.49
TOTAL (Rs. Crores)	13,403.19	2,680.64	3,484.83

The above estimate is not additional allocation for Urban Health Mission, but apportioned from the existing/projected allocation to the above programs under the XI/XII Plans.

Non-communicable diseases program (urban)

These will include the estimated proportion for urban areas, from the national non-communicable diseases (NCD) program. The estimates, based on XI plan allocations are as follows:

Program	XI Plan Allocation (Rs. Crores)	Apportion for Urban areas (20%)	Estimate for XII Plan (assuming 30% increase)

Mental Health program	1,000.00	200.00	260.00
Tobacco control program	471.92	*235.96	306.75
NACP	5,728.00	*2,864.00	3,723.20
Cancer program	2,400.00	*1,200.00	1,560.00
TOTAL (Rs. Crores)	9,599.92	4,499.96	5,949.95

* 50% apportioned for urban areas, given the predominantly urban centric nature of the health risks

The above estimate is not additional allocation for Urban Health Mission, but apportioned from the existing/projected allocation to the above programs under the XI/XII Plans.

Regulation & Quality Assurance

Regulation and Quality Assurance activities would mainly involve formation of an overarching Quality Assurance Committee (QAC) at city levels and one or more Quality Assurance Teams (QAT), composed of renowned specialists and senior technicians. The Quality Assurance teams would be responsible for recommending accreditation of clinics/ hospitals/ nursing homes/ diagnostic centers and pharmacies for empanelment for outreach services/ PUHCs/ referral centers. 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.

For this purpose, it is proposed to allocate a lumpsum amount of Rs. 50 lacs per year, per metro city, Rs. 20 lacs per city with 10 lac+ population, and Rs. 10 lacs per other city with 1 lac+ population. Total would be Rs. 48.60 crores per year, or Rs. 291.60 crores of 6 years (assuming QA Committees and Teams would be functional from second year of the Mission). These funds would also include provision for orientation and training of QAC/QAT. But these provisions do not include funds for certification of government hospitals, as such funds are available under NRHM PIP.

Community Processes

Basti Viskas Manch (BVM): @ Rs. 10,000 per year, for 6 years for 25,000 BVMs

Mahila Arogya Samiti (MAS): @ Rs. 2500 per year for 6 years for 1,25,000 MAS

Urban Social Health Activist (USHA)/link-worker: @ Rs. 2000 pm (maximum) for 31,250 workers

NGO involvement for facilitation of communitisation processes: Rs. 50 lakhs per city

Special Program for the Vulnerable Sections

Lumpsum funds every year for designing and implementing innovative approaches to target specific health needs of the vulnerable sections in the cities like homeless, rag-pickers, rickshaw-pullers, beggars, etc. Lumpsum funds proposed (per year) for innovative actions for the

vulnerable sections in the cities @ Rs.1 crore for metro cities, Rs.50 lacs for cities in 10 lacs+ population and Rs.10 lacs for other cities.

Innovative Public Health Action

Lumpsum funds every year for designing and implementing innovative approaches to address the city specific urban health issues. Lumpsum funds for innovative actions proposed (per year) @ Rs.50 lacs for metro cities, Rs.20 lacs for cities in 10 lacs+ population and Rs.10 lacs for other cities.

Monitoring & Evaluation

Annual Health survey/Concurrent Evaluation: Rs. 10 lakhs per city every two years

Software and hardware for bio-metric card system (N-BITS), HMIS, IDSP, etc.: One time capital cost – lump-sum Rs. 5 crores

Community audit of healthcare providers/programs: Rs. 1 lakh per city

Other evaluations like CRM/third-party evaluation, etc.: Rs. 5 lakhs per state per year.

OTHER ISSUES

Other issues of concern, for which no additional allocation is envisaged, but is important in the urban health context, which the Mission needs to take into account, are:

Health Insurance/Assurance

As discussed in component 4(c), the service delivery mechanism under the Urban Health Mission, especially for secondary and tertiary level healthcare is proposed to be organized as complimentary to the central and state government supported health insurance schemes like RSBY and Arogyashri. The Mission would fund the referral (treatment and transportation) costs for those urban poor, who are estimated to be left out of the enrollment process of the larger insurance schemes. But eventually, when all the urban poor are enrolled under the schemes, additional funds would not be needed. It may also be noted that, health expenditure not covered under existing schemes (like expenditure over Rs. 30,000 under RSBY), may be provided from funds allocated under component 4(c).

Hence no additional funds are proposed under component 6, although this would need coordination by the City program management Unit with the insurance scheme managers and stakeholders to ensure comprehensive referral services for the urban poor.

Inter-sectoral Convergence

No additional funds are proposed under Urban Health Mission, as budgets already provided for under various departments and programmes.

The state and city level PMUs, as well as the public health managers in PUHS and USHAs need to coordinate with the following departments/programmes in their respective areas of responsibility.

- School Health
- Occupational Health
- Nutrition
- Clean Water
- Sanitation
- Convergence with other national programs

The total resources needed, component-wise are as under:

Components	Non-Recurrent	Recurrent	Total	%
1. Planning & Mapping	90.20	141.60	231.80	1%
2. Program Management	36.15	1,540.26	1,576.41	5%
3. Training & Capacity Building	0.00	1,837.90	1,837.90	6%
4. Guarantee of Health Services	2,814.20	23,001.88	25,816.08	78%
5. Regulation & Quality Assurance	0.00	291.60	291.60	1%
6. Community Processes	0.00	2,292.50	2,292.50	7%
7. Special Program for Vulnerable	0.00	363.00	363.00	1%
8. Innovative PH Action	0.00	340.20	340.20	1%
9. Monitoring & Evaluation	5.00	245.25	250.25	1%
TOTAL	2,945.55	30,054.19	32,999.74	100%

The resources needed per year, and allocated between central, state governments and ULBs, are as follows:

Year	GOI	States	ULBs	Total	Remarks
2010-11	926.54	163.51	0.00	1,090.05	GOI-85%; State-15%
2011-12	3840.38	677.71	0.00	4,518.09	GOI-85%; State-15%
2012-13	4185.01	837.00	558.00	5,580.02	State-15%; ULB-10%
2013-14	4125.76	825.15	550.10	5,501.02	State-15%; ULB-10%
2014-15	4065.14	813.03	542.02	5,420.19	State-15%; ULB-10%
2015-16	4102.64	820.53	547.02	5,470.19	State-15%; ULB-10%
2016-17	4065.14	813.03	542.02	5,420.19	State-15%; ULB-10%
Total	25,310.62	4,949.96	2,739.16	32,999.74	

Thus, as per the above estimation, central contribution envisaged for NUHM in the remaining two years of XI-plan is Rs. 4,766.92 crores, and Rs. 20,543.69 crores for the XII-plan period. The total central grants being Rs. 25,310.62 crores for the entire Mission period.

Approximate resource availability for the Urban Component of Major schemes from National Rural Health Mission

While seeking approval for the National Rural Health Mission, the Ministry has taken note of the calculations of the National Ciommission on Macroeconomics nad Health. The National Commission on Macro Economics and Health has made a detailed assessment of investment requirements, based on bare minimum standards, costs and needs, largely at Government prices that are 30-50% lower than in the private sector. The Commission has recommended additional non-recurring investment of Rs. 33,811 crores and a recurring investment of Rs. 41,006 crores. This was assessed for rural as well as urban areas. This expenditure would be made over a period of five to seven years. The additional recurring requirement is worked out for the 7th year. This includes health promotion, regulatory systems, enforcement of regulations, human resources for health, training, research and development, delivery of health care services, and social health insurance. It covers the entire health sector including establishment of new medical colleges, etc., that are not the focus in the National Rural Health Mission.

While projecting the resource needs for NRHM, the needs of urban areas had also been looked at as the NCMH assessments did not disaggregate urban and rural area needs. Even by a modest investment of an additional Rs. 400 per capita for the 6.25 crore urban poor, the resource need comes to nearly Rs. 2500 crores per annum for the urban poor. Over a 7 year period, this will mean an additional Rs. 17, 500 crores. Add to it the investments needed to meet the public health challenges, the modest requirement will work out to nearly Rs. 35,000 crores over a 7 year peiod. Assuming that nearlyRs. 2,000 crores in urban areas comes through various components of NRHM every year, there would still be a need for an additional allocation of Rs. 20,000 crores for the 7 year period of the NUHM.

Norms for release of funds to the state governments

In order to ensure that the state specific focus is retained in planning and management of NUHM the following indicators would be given appropriate weight-age for release of the funds to the States.

Urban Population

State backwardness criteria as being used in NRHM

For consistency and authoritativeness of data, Slum Census 2001 data is used as the basis. The slum population at the city level has not been taken as the basis as slum population for the cities like Ranchi, Lucknow and Patna as listed by Census 2001 may be at variance from the actual slum population in the cities. The same was crosschecked through meetings and workshops, whereby the state authorities suggested that actual slum population would be in the range of 20-30% of the total urban population. Therefore appropriate flexibility in approval

process would be provided to accommodate such variance. The tentative state wise financial envelope is given as Annexure 8. However, actual release would depend upon the actual State Level PIP based on respective city level PIPs subject to approval by the NPCC at the Central level.

Sustainability

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.

The analysis from the field visits has also demonstrated that judicious exercise of user fee, based on the exclusion of the BPL category, can be an effective mechanism for mobilization of resources for facility improvement, quality care and patient welfare. States/ Cities would be facilitated to develop mechanisms for income generation through realization of service charges by cross subsidizing the beneficiaries (urban poor) and by levying service charges to non-beneficiaries which could be utilized for sustenance of the project during the post mission period. The user fees collected can be used to develop a community health fund to be managed by the respective Rogi Kalyan Samiti as is being done in West Bengal. 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.

The State/City Plan would mandatorily reflect the components of sustainability for resource support from the Centre.

Detailed cost estimations of NUHM

Year-wise consolidated costs

Components	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
1. Planning & Mapping	11.20	102.60	23.60	23.60	23.60	23.60	23.60	231.80
2. Program Management	1.75	291.11	256.71	256.71	256.71	256.71	256.71	1,576.41
3. Training & Capacity Building	107.20	593.03	218.03	278.03	197.20	247.20	197.20	1,837.90
4. Guarantee of Health Services	701.30	3,027.40	4,528.68	4,389.68	4,389.68	4,389.68	4,389.68	25,816.08
5. Regulation & Quality Assurance	0.00	48.60	48.60	48.60	48.60	48.60	48.60	291.60
6. Community Processes	215.00	346.25	346.25	346.25	346.25	346.25	346.25	2,292.50
7. Special Program for Vulnerable	0.00	60.50	60.50	60.50	60.50	60.50	60.50	363.00
8. Innovative PH Action	48.60	48.60	48.60	48.60	48.60	48.60	48.60	340.20
9. Monitoring & Evaluation	5.00	0.00	49.05	49.05	49.05	49.05	49.05	250.25
TOTAL	1,090.05	4,518.09	5,580.02	5,501.02	5,420.19	5,470.19	5,420.19	32,999.74

Non-Recurrent (Capital) Costs

(Figures in Rs. Crores)

Components	Units	No. of Units	Rates (Norms - Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
1. Planning & Mapping	Metros	7	4,000,000	2.80	0.00	0.00	0.00	0.00	0.00	0.00	2.80
	10lac+ cities	28	3,000,000	8.40	0.00	0.00	0.00	0.00	0.00	0.00	8.40

Components	Units	No. of Units	Rates (Norms - Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
	other cities	395	2,000,000	0.00	79.00	0.00	0.00	0.00	0.00	0.00	79.00
Total (1)		430		11.20	79.00	0.00	0.00	0.00	0.00	0.00	90.20
2. Program Management	State PMU	35	500,000	1.75	0.00	0.00	0.00	0.00	0.00	0.00	1.75
	City PMU	430	800,000	0.00	34.40	0.00	0.00	0.00	0.00	0.00	34.40
Total (2)				1.75	34.40	0.00	0.00	0.00	0.00	0.00	36.15
3. Training & Capacity Building											
(a) ULBs				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(b) Govt. Health staff				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(c) USHA & CBOs				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total (3)				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4. Guarantee of Health Services											
(a) Outreach				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(b) PUHC	minor upgradation	1,412	1,000,000	70.60	70.60	0.00	0.00	0.00	0.00	0.00	141.20
	major upgradation	695	4,000,000	0.00	139.00	139.00	0.00	0.00	0.00	0.00	278.00

Components	Units	No. of Units	Rates (Norms - Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Total 4(b)		2,107		70.60	209.60	139.00	0.00	0.00	0.00	0.00	419.20
(c) Referral				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(d) Emergency Services	Metros	7	200,000,000	140.00	0.00	0.00	0.00	0.00	0.00	0.00	140.00
	10lac+ cities	28	100,000,000	280.00	0.00	0.00	0.00	0.00	0.00	0.00	280.00
	other cities	395	50,000,000	0.00	1,975.00	0.00	0.00	0.00	0.00	0.00	1,975.00
Total 4(d)				420.00	1,975.00	0.00	0.00	0.00	0.00	0.00	2,395.00
(e) IEC/BCC				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total (4)				490.60	2,184.60	139.00	0.00	0.00	0.00	0.00	2,814.20
5. Regulation & Quality Assurance				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6. Community Processes				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
7. Special Program for Vulnerable				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
8. Innovative PH Action				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
9. Monitoring &	H/S'ware	lump-		5.00	0.00	0.00	0.00	0.00	0.00	0.00	5.00

Components	Units	No. of Units	Rates (Norms - Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Evaluation		sum									
GRAND TOTAL				508.55	2,298.00	139.00	0.00	0.00	0.00	0.00	2,945.55

Non-Recurrent (Capital) Costs

(Figures in Rs. Crores)

Components	Units	No. of Units	Rates (Norms – Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
1. Planning & Mapping	Metros	7	1,500,000	0.00	1.05	1.05	1.05	1.05	1.05	1.05	6.30
	10lac+ cities	28	1,000,000	0.00	2.80	2.80	2.80	2.80	2.80	2.80	16.80
	other cities	395	500,000	0.00	19.75	19.75	19.75	19.75	19.75	19.75	118.50
Total (1)		430		0.00	23.60	23.60	23.60	23.60	23.60	23.60	141.60
2. Program Management	State PMU	35	2,580,000	0.00	9.03	9.03	9.03	9.03	9.03	9.03	54.18
	City PMU	430	5,760,000	0.00	247.68	247.68	247.68	247.68	247.68	247.68	1,486.08
Total (2)		465		0.00	256.71	256.71	256.71	256.71	256.71	256.71	1,540.26

Components	Units	No. of Units	Rates (Norms – Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
3. Training & Capacity Building											
(a) ULBs	Metros	7	1,500,000	2.10	2.10	2.10	2.10	2.10	2.10	2.10	14.70
	10lac+ cities	28	1,000,000	5.60	5.60	5.60	5.60	5.60	5.60	5.60	39.20
	other cities	395	500,000	39.50	39.50	39.50	39.50	39.50	39.50	39.50	276.50
Total 3(a)		430		47.20	47.20	47.20	47.20	47.20	47.20	47.20	330.40
(b) Govt. Health staff	ANM/ Nurse/ Paramedic	50,000	5,000	25.00	0.00	0.00	25.00	0.00	25.00	0.00	75.00
	MO	25,000	10,000	25.00	0.00	0.00	25.00	0.00	25.00	0.00	75.00
	Specialists	5,000	20,000	10.00	0.00	0.00	10.00	0.00	0.00	0.00	20.00
Total 3(b)		80,000		60.00	0.00	0.00	60.00	0.00	50.00	0.00	170.00
(c) USHA & CBOs	MAS	125,000	10,000	0.00	500.00	125.00	125.00	125.00	125.00	125.00	1,125.00
	BVM	25,000	10,000	0.00	25.00	25.00	25.00	25.00	25.00	25.00	150.00
	USHA	31,250	20,000	0.00	20.83	20.83	20.83	0.00	0.00	0.00	62.50
Total 3(c)				0.00	545.83	170.83	170.83	150.00	150.00	150.00	1,337.50
Total (3)				107.20	593.03	218.03	278.03	197.20	247.20	197.20	1,837.90
4. Guarantee of											

Components	Units	No. of Units	Rates (Norms – Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Health Services											
(a) Outreach	MAS	125,000	10,000	0.00	0.00	1,500.00	1,500.00	1,500.00	1,500.00	1,500.00	7,500.00
(b) PUHC	PUHC	4,214	1,500,000	0.00	632.10	632.10	632.10	632.10	632.10	632.10	3,792.60
(c) Referral	50% Urban poor	31,250,000	655	0.00	0.00	2,046.88	2,046.88	2,046.88	2,046.88	2,046.88	10,234.38
(d) Emergency Services				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
(e) IEC/BCC	Urban Population	210,700,000	10	210.70	210.70	210.70	210.70	210.70	210.70	210.70	1,474.90
Total (4)				210.70	842.80	4,389.68	4,389.68	4,389.68	4,389.68	4,389.68	23,001.88
5. Regulation & Quality Assurance	Metros	7	5,000,000	0.00	3.50	3.50	3.50	3.50	3.50	3.50	21.00
	10lac+ cities	28	2,000,000	0.00	5.60	5.60	5.60	5.60	5.60	5.60	33.60
	other cities	395	1,000,000	0.00	39.50	39.50	39.50	39.50	39.50	39.50	237.00
Total (5)		430		0.00	48.60	48.60	48.60	48.60	48.60	48.60	291.60

Components	Units	No. of Units	Rates (Norms – Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
6. Community Processes	BVM	25,000	10,000	0.00	25.00	25.00	25.00	25.00	25.00	25.00	150.00
	MAS	125,000	2,500	0.00	31.25	31.25	31.25	31.25	31.25	31.25	187.50
	USHA	31,250	24,000	0.00	75.00	75.00	75.00	75.00	75.00	75.00	450.00
	City (NGOs)	430	5,000,000	215.00	215.00	215.00	215.00	215.00	215.00	215.00	1,505.00
Total (6)				215.00	346.25	346.25	346.25	346.25	346.25	346.25	2,292.50
7. Special Program for Vulnerable	Metros	7	10,000,000	0.00	7.00	7.00	7.00	7.00	7.00	7.00	42.00
	10lac+ cities	28	5,000,000	0.00	14.00	14.00	14.00	14.00	14.00	14.00	84.00
	other cities	395	1,000,000	0.00	39.50	39.50	39.50	39.50	39.50	39.50	237.00
Total (7)		430		0.00	60.50	60.50	60.50	60.50	60.50	60.50	363.00
8. Innovative PH Action	Metros	7	5,000,000	3.50	3.50	3.50	3.50	3.50	3.50	3.50	24.50
	10lac+ cities	28	2,000,000	5.60	5.60	5.60	5.60	5.60	5.60	5.60	39.20
	other cities	395	1,000,000	39.50	39.50	39.50	39.50	39.50	39.50	39.50	276.50
Total (8)		430		48.60	48.60	48.60	48.60	48.60	48.60	48.60	340.20

Components	Units	No. of Units	Rates (Norms – Rs.)	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	Total
9. Monitoring & Evaluation											
(a) Health Survey/Conc. Evaluation	Cities	430	1,000,000	0.00	0.00	43.00	43.00	43.00	43.00	43.00	215.00
(b) Community Audits	Cities	430	100,000	0.00	0.00	4.30	4.30	4.30	4.30	4.30	21.50
(c) CRM/3rd-party Eval	States/UTs	35	500,000	0.00	0.00	1.75	1.75	1.75	1.75	1.75	8.75
Total (c)				0.00	0.00	49.05	49.05	49.05	49.05	49.05	245.25
GRAND TOTAL				581.50	2,220.09	5,441.02	5,501.02	5,420.19	5,470.19	5,420.19	30,054.19

Management costs

It is imperative that management capacities be built at each level. To attain the outcomes, the NUHM would provide management costs up to 10% of the total annual plan approved for a State/City. 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.

NRHM provides for 6% of the total annual outlay for management costs[18]. However, the total budget outlay of NRHM is much higher as compared to what is envisaged for NUHM. As the total budget outlay goes down, the percentage management cost will obviously go up.

The management cost in case PEPFAR had earlier been 7% but had to be revised on a higher side and was replaced with a series of metrics that country teams used to evaluate the appropriate alignment of M&O (Management & Operations) costs[19]. Similarly, Department of Public Health, Los Angles, also stipulates 10% of total costs as management costs[20].

It is also important to note that there are wide variations in the existing capacities of various states/ cities/ ULBs. While some states have a much better existing management and administrative capacities, other states lag far behind. The tour report (refer Annex 1) by the team from Ministry which visited 20 cities also mentions that "in States like UP, Bihar, Jharkhand, MP, the ULBs do not have the fiscal or managerial capacity to manage the program". A meeting was held at Mumbai on 28-29 March, 2008 to discuss NUHM with State and City officials including Additional Chief Secretary, Additional Principal Secretary and Joint Secretary, Public Health and they also opined that 6% management cost may not be sufficient for NUHM (minutes of this meeting are at Annex 1 after tour reports).

The variable capacities are also reflected in the health status of the states.

This picture of inter-State disparities in health status in India provides a dark picture. Although LEB (Life Expectancy at Birth) improved remarkably in India during 1970-2000 from 49.7 to 61.7 years, the inter-State disparity is substantial. Kerala's LEB during 1995-99 was 73.5 years and that of Madhya Pradesh was as low as 56.4 years, a difference of 18.1 years. Similarly, the difference observed between Kerala and Orissa,

[18] NRHM, Framework for Implementation, 2005-12

[19] PEPFAR (President's Emergency Plan for AIDS Relief) Country Operational Plan (COP) guidance 2010

[20] Budget preparations instructions, Department of Public Health, Office of AIDS programs and policy, County of Los Angles

the lowest and highest among IMR is, respectively 14 and 95 per 1000 live-births, a phenomenal gap of 81 per 1000 live-births. Interestingly, the second State with the lowest IMR is Maharashtra with 48, nearly three times higher than Kerala's IMR. This clearly shows that even States with a better health status have a long way to go to 'catch up' with Kerala.

Then there are inequalities across other categories of economically and socially deprived groups. The poor face a disproportionately greater share of the burden of ill health, as reflected in IMR and malnutrition rates.

Keeping this in mind, NUHM would provide management costs up to 10% of the total annual plan approved for a State/City.

Norms for release of funds to the state governments

In order to ensure that the state specific focus is retained in planning and management of NUHM the following indicators would be given appropriate weight-age for release of the funds to the States.

Urban Population

State backwardness criteria as being used in NRHM

For consistency and authoritativeness of data, Slum Census 2001 data is used as the basis. The slum population at the city level has not been taken as the basis as slum population for the cities like Ranchi, Lucknow and Patna as listed by Census 2001 may be at variance from the actual slum population in the cities. The same was crosschecked through meetings and workshops, whereby the state authorities suggested that actual slum population would be in the range of 20-30% of the total urban population. Therefore appropriate flexibility in approval process would be provided to accommodate such variance. However, actual release would depend upon the actual State Level PIP based on respective city level PIPs subject to approval by the NPCC at the Central level.

Sustainability

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.

The analysis from the field visits has also demonstrated that judicious exercise of user fee, based on the exclusion of the BPL category, can be an effective mechanism for mobilization of resources for facility improvement, quality care and patient welfare. States/ Cities would be facilitated to develop mechanisms for income generation through realization of service charges by cross subsidizing the beneficiaries (urban poor)

and by levying service charges to non-beneficiaries which could be utilized for sustenance of the project during the post mission period. The user fees collected can be used to develop a community health fund to be managed by the respective Rogi Kalyan Samiti as is being done in West Bengal. 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.

The State/City Plan would mandatorily reflect the components of sustainability for resource support from the Centre.

XI - PLANNING PROCESS OF NUHM

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

Its functions would inter alia include approval of the city specific plans for funding under the NRHM, identification and mapping of the referrals in each area, rationalization of manpower, mapping and accrediting the private sector , ensuring private sector participation, providing technical resources to aid city specific planning, accessing funds under JNNURM etc., for strengthening public health facilities.

The needs of the mega city may be different from those of medium and small cities. Therefore situation specific modification to the City UH plans may be considered. Moreover, the cities also differ in terms of availability of health infrastructure and presence of stakeholders and also in terms of distribution of slum population; hence city specific planning based on the need would serve the purpose. The process to be adopted for city specific planning is illustrated as follows. The illustration depicts the recommended road map to development of urban health propsals for identified cities.

Step 1: Constitution of City level health and sanitation planning Committee

The District Health Society as peer the communication received from the state government would call a meeting and issue the notification for the constitution of the City level health and sanitation planning Committee. The District health Society would also ensure that a nodal person is appointed.

Step 2: Situation Analysis

would help in identifying the strengths, existing health resource, manpower and also the gaps. An assessment of primary health care needs of the urban poor of the city, description of all existing health services run by public and private sector including non profit organizations along with their functional status and services being provided by them will be the critical information base for program development and planning. This will entail conducting facility survey, household survey and access to secondary data sources, compiled service statistics and also any published studies. The Facility Survey and Household survey formats as developed in NRHM may be adopted for urban settings.

Step 3: Identification and mapping of target population

This task involves the identification of underserved and unrecognized slums for better targeting of efforts. A map depicting the location of the urban slum population across the city, the major health providers and other stakeholders would be developed to guide the implementation plan and serve as a monitoring tool. This will help define the catchment areas for first tier Urban Health facilities (existing21, or newly proposed) and outreach of health to underserved slum areas. The definition as suggested in the note would be adopted for identification of the slum population. Key steps in the process:

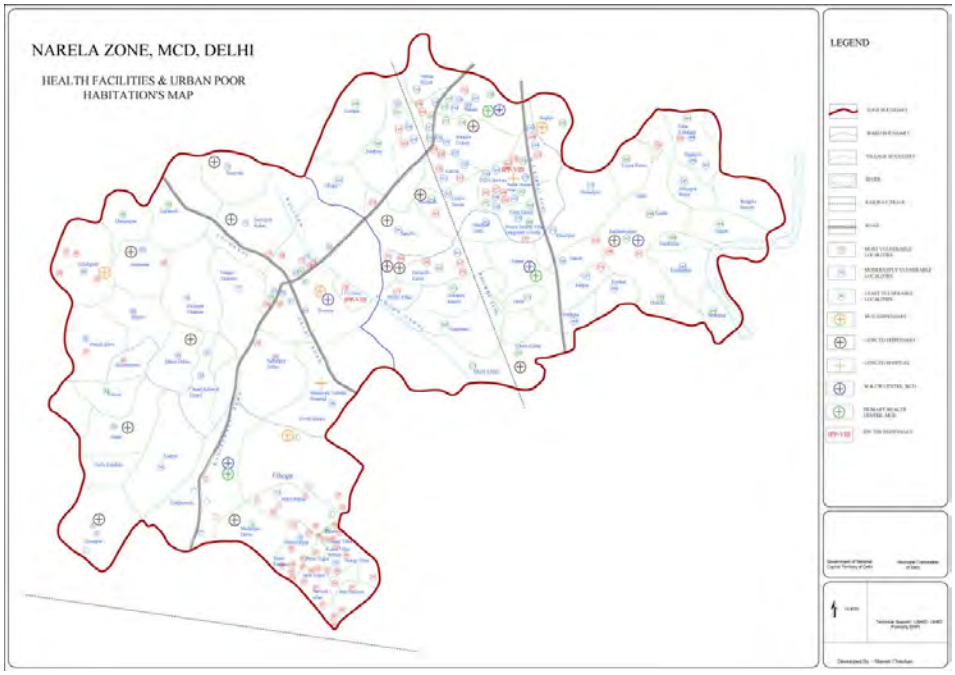
Build a list of all slums. This could be done through accessing slum lists viz.: Municipal lists, Slum Clearance and Rehabilitation Act list, Slum lists from the District Collector's/Magistrate's office, List at Mayor's office or prepared by any developmental agency. It is possible that these lists will not include unregistered poverty pockets, and these can be identified through site visits and discussions with local people.

Visit bastis of different levels of development to have a first hand understanding and infrastructure mapping (facility and manpower).

Develop criteria to distinguish the most needy population based on available data from the Situational analyses. Classify urban slums and triangulate with stakeholders.

[21] Existing health facilities could be in the form of Urban Family Welfare Centers, Health Posts, Health Check Posts, State Allopathic Dispensaries, Civil Dispensaries or Post-partum Centers.

On a city map, mark the location of all slums and health providers /facilities



Step 4: Stakeholders' Consultations

There are multiple service-providers and stakeholders in a city. These represent government systems and civil society institutions and informal groups. The urban health proposal for the city should be built on the existing resources in the city (infrastructure as well as human). Many small stakeholders consultation for ex with AWW, malaria inspectors, private and charitable service providers have to be conducted to understand about the various stakeholders.

Step 5: Project planning workshop:

The findings of the situation analysis, slum situation and the stakeholder strengths has to be shared in a planning workshop and suggestions invited for strategies to be adopted for improving the health care delivery. Develop program directions based on collective thinking and discussions between all groups so that concerned people develop a stake and ownership about the program.

- Each Municipal Corporation, Municipality and Notified Area Committee (NAC) must develop their own plans as per norms especially developed for them
- NAC and Municipality plans could be projected as a sub plan in the District Health Action Plan of NRHM
- Municipal Corporation Plans could be stand alone urban plans
- Plans should follow the "public health" approach and not just the "targeted approach"
- Targeted approach needed where out-of-pocket expenses may be involved but not for preventive/promotive care

XII - APPRAISAL AND APPROVAL PROCESS OF NUHM

Process of release of funds and appraisal: The City Programme Implementation Plan (CPIP)

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 release 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 additonalities 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 but 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.

The existing funding for the Urban Health Posts and the Urban Family Welfare Centres which is through the Treasury funds would continue. However identified centres would be strengthened to reach the PUHC level. The City /State PIP would also clearly articulate the funds required for urban component of the various National programmes and the funds would be released by the Programme Divisions.

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.

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.

XIII - ROLE OF THE NON-GOVERNMENTAL SECTOR IN NUHM

NUHM envisages to have transparent partnerships with non-governmental providers for health care services.

Recognizing that government health facilities do not have adequate reach in urban slums leading to low demand and poor utilization, contracting the delivery of health services to the private sector has emerged as a viable option. Many state governments have experimented with this approach with different levels of success. Some 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.

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 resource 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. the following options may be explored

In cities or parts of a city where first tier public sector health infrastructure (by way of Health Posts or UFWCs) is already available, a partnership with NGOs could be considered for enhancing utilization of these existing Public Sector services through identification and training Link Volunteers, women's groups, social mobilization and supporting IEC/BCC activities ; and

In cities or parts of a city where no public sector first tier facility is available, the entire first tier service delivery component may be contracted out through partnership with a charitable hospital or an NGO or any appropriate private agency with requisite capacity.

Private medical practitioners could also be engaged on part-time basis for first as well as second tier facilities (based on the experience in IPP VIII in Kolkata and neighboring cities).

2nd tier services (including laparoscopic tubal ligation and no-scalpel vasectomy services) and diagnostic services may be outsourced to private medical facility on

reimbursement basis. A uniform rate list if feasible may be considered for such services by the States. Wherever worthwhile and feasible, second tier services can also be contracted out to charitable hospitals, with proven credentials.

Role of NGOs in strengthening health services for the poor

The presence of active NGOs in several cities presents a unique and powerful opportunity to provide improved health care. 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. the support for Link Volunteers and Women's Health Committees can also be routed through NGO, going by the examples of the reasonably well functioning approach adopted in States like Karnataka, of NGOs being out-sourced the responsibility for identifying, training, mentoring, supervising and managing performance based compensation of link volunteers. However, where such an arrangement is found infeasible, all possible efforts may be made by the concerned implementing agencies to encourage and promote/invoke NGOs in such an endeavor inter-alia by means of offering necessary support to them to initiate and participate in the health programme.

The presence of active NGOs in several cities presents a unique and powerful opportunity to provide improved health care. Under the Mission NGOs would be encouraged and supported to get suitably involved in the planning and implementation of the urban health projects. The following options may be considered in so far as the functional domain is concerned:

For undertaking situational analysis, identification and mapping of slums

Identification of one Field NGO which would primarily be involved in community organization, identification & capacity building of Link Volunteers and IEC/BCC activities.

Supporting outreach clinics and linkage of services with slum communities.

Management of Urban Health Centres, including OPD services and regular outreach services

XIV - ROLE OF COMMNITY ORGANIZATIONS/ULBs IN NUHM

The 74th Constitutional Amendment Act has transferred the management of health care facilities in urban areas to the Urban Local (Municipal) Bodies almost a decade back. However, the capacity of the Urban Local Bodies (ULBs) to lead, plan and manage UH Programme is not only limited in most cases, but also varies from state to state; therefore the Task Force recommends that, depending upon the levels of involvement of the ULBs in the health related activities as also on the extent of decentralization, differential strategies be adopted on the lines mentioned below:

In the states where traditionally and over the years, the urban local bodies (ULBs) have been playing a substantial and significant role in provisioning of health care services, the Task Force recommends that the 'Mayor' or 'Chairperson' – Municipal Corporation can be made 'Co-Chair'; and Municipal Commissioner as 'Co-Convenor' of the Governing Body of District Health Society. The District Health Society may include few more members viz. Chairpersons of other smaller Municipalities/Town Area Committees in District, Project Officer District Urban Development Agency (DUDA) and Municipal Health Officer/Nagar Swasthya Adhikari to its Governing Body. Similarly, it may also include Municipal Commissioner and Project Officer, DUDA and Municipal Health Officer/Nagar Swasthya Adhikari to the Executive Committee of District Health Society.

The primary UH infrastructure in the city be managed by the Urban Local Body, keeping the 'Ward' as the basic unit of planning and implementation. In the case of such states, the Task Force further recommends that the 'Slum' or 'Slum Cluster' Level Health, Water & Sanitation Committee (similar to the role envisaged for Village Health Committee in NRHM) be vested with the responsibility to guide all UH activities at the slum level. This committee will be responsible for developing the slum health plan, with the support of ANM, Link Volunteer, AWW (wherever present) and slum level community organizations (like Basti Sudhar Samiti). In the case of states in this category, the Task Force further recommends the strengthening of the health department/wing of the Municipality inter alia by devolution of funds and strengthening of Human Resources.

In the other states where traditionally and over the years, the urban local bodies (ULBs) have not been playing a substantial and significant role in provisioning of health care services the states should take the lead in planning and implementing urban health programme and concurrently also take appropriate steps to gradually phase out the responsibility of managing UH infrastructure to ULBs.

In the case of States (for example West Bengal) and in Metropolitan cities, where the ULBs have been able to implement Urban Health Programme satisfactorily in the past, under an already functional institutional arrangement, the concerned states if they so feel, may choose to continue with existing arrangements.

In case of other States where the ULBs are still to develop into entities strong enough to efficiently manage the Urban Health Program/activities in their jurisdiction, even while doing all it takes to enhance their professional and management (including financial) capacities to the required levels, till such time that happens, the Municipal Health Officer (or equivalent) and one or two elected representatives associated with the Health function of the ULB may be included as integral constituents viz. members of the District Urban Health Committee. The functioning of this committee may, in the interim, be coordinated by a Deputy CMO level official of the Health Dept. with the District Magistrate as its Chairperson. As quickly as possible, and in a sustainable manner, in the medium/long term, the responsibility for formulating and implementing Urban Health Program may be handed over to the ULB in line with the provisions of the 74th Constitutional amendment.

Capacity building of the ward councilors in the areas of planning and management of UH care delivery services needs due attention to be paid. In these states, efforts should also be made to involve the 'Slum' or 'Slum Cluster' Level Health & Sanitation Committee in planning and guiding all UH activities at the slum level with the support of ANM, Link volunteer, AWW (wherever present) and slum level community organizations (like Basti Sudhar Samiti).

The decentralized management of public health responsibilities calls for a detailed framework of delegation and devolution to the Basti Vikas Manch under the umbrella of the urban local bodies. Slum level community organizations need to be developed within the framework of elected representatives at Ward level. Decentralization must be deepened in urban areas for communities to manage their health needs better.

XV - REGULATION AND DEFINING STANDARDS

The Government of NCT Delhi has developed Indian Public Health Standard for Primary Urban Health Centres. The same will be circulated to States for consultation. Work on the National Health Bill will also be pursued to develop regulation and to define standards and obligations more effectively.

I. Devolution of power and creation of empowered institutional mechanism in the form of City Health Mission and Society. The city health mission and society will become the nodal institution for initiating all the activities
II. Adoption of a cascading planning model whereby the cities create a blueprint for a healthy city, formulate visions and put all the ingredients on a time frame. The process will not only delineate a Plan for creating a road map for health infrastructure development, devolution of funds and creation of city specific health cadre
III. Increase funding support to the cities : NUHM will also ensure increased funding with an objective of creating healthy cities. It will also mandate a certain set of reforms for improved health governance
IV. Launch an incentive funds for catalyzing positive action on part of the states and cities for achieving the objective of healthy cities.
V. Initiate more spending for public health in the tier 2 , 3 and 4 cities which have a history of under investment to bring these cities at par with the minimum standards of basic infrastructure for delivery of health care services.
VI. Enhance the management capacity of the cities and creation of sustained capacity building process. The city visits have revealed that even if the funds are made available along with a framework, the capacity to implement is lacking. The NUHM will strengthen the capacity of the states and cities by providing funding for deployment of programme management unit to be staffed by specialists for effective planning, management of PPP projects, improved participatory health governance, implementation on the ground. At the same time it will also leverage the network of urban resource institutes created under JNNURM and support new ones if required for sustained capacity building of states and cities.
VII. Develop framework, regulatory mechanisms and implementation models. Though each state and city will develop its own framework of regulatory mechanisms and models of health care delivery, central government will play the role of catalyst and develop model frameworks to enable the states and cities to develop their own models for driving the agenda of healthy cities.
VIII. The whole process of reform would be implemented in close convergence with JNNURM. The government has launched JNNURM with an objective of integrated and holistic renewal of cities. The JNNURM will also catalyse investments in urban sector for the same while at the same time intiate a reform agenda for improving governance in the cities. The whole process would be supported by capacity development to ensure sustainability and also enhance the capacity. The NUHM will leverage the reform agenda of JNNURM for pushing the reforms required for fulfilling the vision of healthy cities. A fact ot be recognized here is that the states and cities will decide upon the reform agenda based on the requirements. The reforms will be need based and the states will be given the

flexibility for deciding the pace. In the beginning the process can start with few cities and the learning's can be integrated in the process for more deeper reforms.

XVI – DIVERSITY OF FINANCING MODELS IN URBAN HEALTH

Community Health Insurance & Risk Pooling

Health insurance is purchase of health care coverage in advance by paying a premium over the period. It also ensures that emergency cash need in case of health emergency would be met to the limit for which s/he is insured. In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals. Currently only about 10% of the total population are ensured. Majority of them working in organized sector. As in urban slums majority of the workers are in unorganized sector, health insurance schemes based on the capacity and need of the target population has to be developed. Under the NRHM the government has decided to support the premium for BPL families. The upper ceiling is Rs. 300 for a family of five.

Monitoring and Evaluation Plan

Community Level/based Monitoring is recommended at slum level. Under NRHM, there are already institutional mechanisms proposed to supervise and monitor mission work at various levels. The same monitoring mechanisms to be utilized effectively for the UH programme also. The M&E plan should include an appropriate process for benchmarking, development of urban HMIS consistent with the national MIS, mechanism for monitoring of key processes and results, pertaining to monitoring locally prevalent / endemic diseases and outbreaks/ epidemics along with periodic monitoring of coverage of Maternal & Child Health services, locally prevalent /endemic diseases and outbreaks/ epidemics along with periodic assessments of field activities, and also end-line evaluation.

XVII- ENGAGING WITH THE LOCAL HEALTH PROVIDER

As studies have indicated, there is a need to integrate the local health provider within the framework of primary health care. The Male Worker at the Swasthya Chowki level is largely to be filled up by local health care providers who undergo training and certification that equips them to practice basic care. The study in Delhi made the following recommendation:

Train less-than-fully qualified practitioners to provide basic primary care and to recognize and refer complicated cases to government facilities. Clear definition of parameters for enrolment, standard treatment guidelines and care protocols need to be framed to define the exact nature of their functions;

NUHM will engage with such local health providers.