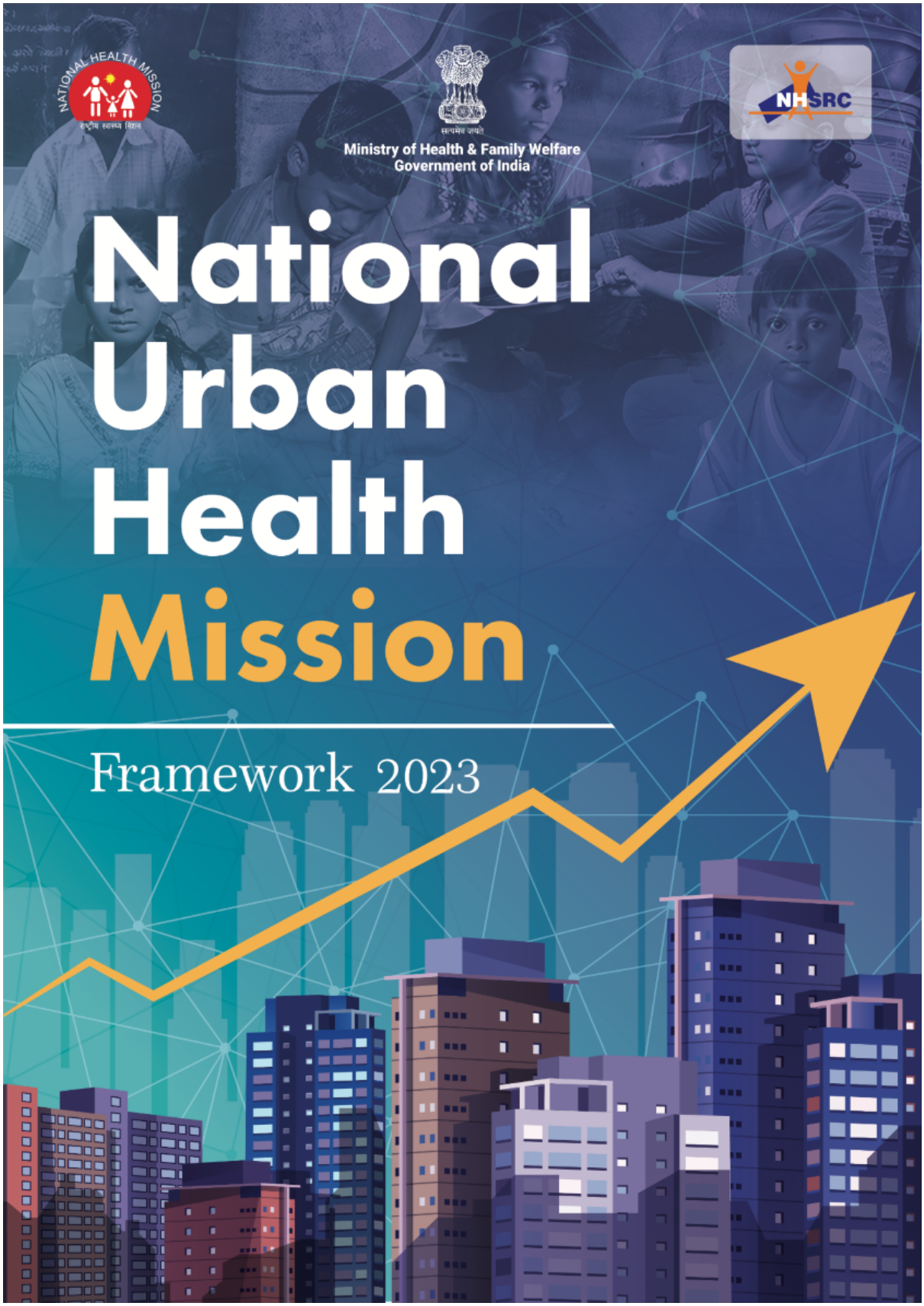

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15th FC	15th Finance Commission	NACP	National AIDS Control Programme
ABHA	Ayushman Bharat Health Account	NAS	National Ambulance Service
AB-HWCs	Ayushman Bharat Health and Wellness Centre	NHM	National Health Mission
AMC	Annual Maintenance Contract	NHP	National Health Policy
AMRUT	Atal Mission for Rejuvenation and Urban Transformation	NIUA	National Institute of Urban Affairs
ANC	Ante Natal Care	NNM	National Nutrition Mission
ANM	Auxiliary Nurse Midwife	NNMR	Neonatal Mortality Rate
ASHA	Accredited Social Health Activist	NTEP	National TB Elimination Programme
AWW	Anganwadi Workers	NUHM	National Urban Health Mission
AYUSH	Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy	NCD	Non-communicable Diseases
BCC	Behaviour Change Communication	NFHS	National Family Health Survey
BMC	Brihanmumbai Municipal Corporation	NGOs	Non-government Organisations
BPL	Below Poverty Line	NHSRC	National Health Systems Resource Centre
BMI	Body Mass Index	NIC	National Information Centre
BMMP	Biomedical Equipment Management and Maintenance Programme	NIN	National Identification Number
CAMC	Comprehensive Annual Maintenance Contract	NITI	National Institute for Transforming India
CBAC	Community-Based Assessment Checklist	NKP	National Knowledge Portal
CBO	Community Based Organisations	NLEP	National Leprosy Elimination Programme
CBRN	Chemical, Biological, Radiological, & Nuclear	NMHP	National Mental Health Programme
CDMO	Chief District Medical Officer	NPCC	National Programme Coordination Committee
CEEW	Council on Energy, Environment and Water	National NCD Programme	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke
CGHS	Central Government Health Scheme	NVBDCP	National Vector Borne Disease Control Programme
CHAP	City Health Action Plan	NPCB	National Programme for Control of Blindness
CMO	Chief Medical Officer	NPMU	National Programme Management Unit

CMHO	Chief Medical & Health Officer	NQAS	National Quality Assurance Standards
CPHC	Comprehensive Primary Health Care	NRHM	National Rural Health Mission
CPM	City Programme Manager	NSS	National Sample Survey
COVID 19	Coronavirus disease of 2019	NULM	National Urban Livelihoods Mission
CPMU	Central Programme Management Unit	OBD	Outbound Dialling
CSO	Civil Society Organisation	OOPE	Out of Pocket Expenditure
CSR	Corporate Social Responsibility	OPD	Outdoor Patient Department
DALY	Disability Adjusted Life Years	OVI	Objectively Verifiable Indicators
DH & SDH	District Hospital & Sub-District Hospital	PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
DHAP	District Health Action Plan	PHC	Primary Health Centres
DIPHL	District Integrated Public Health Laboratory	PHED	Public Health Engineering Department
DMEO	Development Monitoring and Evaluation Office	PHM	Public Health Manager
DPMU	District Programme Management Unit	PHR	Public Health Registry
DVDMS	Drugs and Vaccine Distribution Management System	PIP	Programme Implementation Plan
ECG	Electrocardiography	PMABHIM	Prime Minister Ayushman Bharat Health Infrastructure Mission
ECRP	Emergency Covid Response Plan	POSHAN	Prime Minister's Overarching Scheme for Holistic Nutrition
EHCP	Empanelled Health Care Providers	PPP	Public-Private Partnership
EPC	Empowered Programme Committee	PPM	Project Planning Matrix
ENT	Ear, Nose and Throat	PMJAY	Pradhan Mantri Jan Arogya Yojana
EQAS	External Quality Assurance Services	PMS	Programme Management System
ESIC	Employees' State Insurance Corporation	QOC	Quality of Care
FRU	First Referral Unit	QPS	Quality & Patient Safety
GIS	Geographic Information System	RBSK	Rashtriya Bal Swasthya Karyakram
GOI	Government of India	RCH	Reproductive and child health
GPS	Global Positioning System	RNTCP	Revised National Tuberculosis Control Programme
HNA	Health Needs Assessment	RGI	Registrar General of India
HFR	Health Facility Registry	RHS	Rural Health Statistics
HIG	High Income Group	RHTC	Rural Health Training Centre
HIV	Human immunodeficiency Virus	RKS	Rogi Kalyan Samiti
HMIS	Health Management Information	RMNCHA	Reproductive Maternal Neonatal Child

	System		Adolescent
HR	Human Resource	ROP	Record of Proceedings
HRH	Human Resource for Health	RWA	Resident Welfare Association
ICDS	Integrated Child Development Scheme	SBM	Swachh Bharat Mission
ICMR	Indian Council of Medical Research	SBP	Swasth Bharat Prerak
IDSP	Integrated Disease Surveillance Programme	SC	Sub centre
IEC	Information Education Communication	SDG	Sustainable Development Goals
IPD	Inpatient Department	SHSRC	State Health System Resource Centre
IMR	Infant Mortality Rate	SPMU	State Programme Management Unit
IHIP	Integrated Health Information Portal	SUMAN	Surakshit Matritva Aashwasan
IPCC	Intergovernmental Panel on Climate Change	SWOT	Strengths Weakness Opportunity Threats
IPHL	Integrated Public Health Laboratory	TRG	Technical Resource Group
IPHS	Indian Public Health Standards	TOR	Terms of Reference
IQC	Internal Quality Control	TB	Tuberculosis
IT	Information & Technology	U5MR	Under 5 Mortality Rate
JAS	Jan Arogya Samiti	UFWC	Urban Family Welfare Centre
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, questioning, intersex, pansexual, two-spirit, asexual, and ally	UHC	Urban Health Centre
LIMS	Laboratory Information Management System	UHI	Unified Health Interface
LMIC	Low- and middle-income countries	UHP	Urban Health Pool
M&E	Monitoring and Evaluation	UHTC	Urban Health Training Centre
MAS	Mahila Arogya Samitis	ULB	Urban Local Body
MBBS	Bachelor of Medicine and Bachelor of Surgery	UN	United Nations
MIG	Middle Income Group	UPHC	Urban Primary Health Centre
MIS	Management Information System	UCHC	Urban Community Health Centres
MSG	Mission Steering Group	UHND	Urban Health &Nutrition Day
MMR	Maternal Mortality Ratio	UHWC	Urban Health and Wellness Centres
MHU	Mobile Health Units	URDPFI	Urban and Regional Development Plans Formulation and Implementation
MoDWS	Ministry of Drinking Water and Sanitation	USG	Ultra Sonography
MoE	Ministry of Education	UT	Union Territory
MOHFW	Ministry of Health and Family Welfare	VA	Vulnerability Assessment

MOHUA	Ministry of Housing and Urban Affairs	VHSNC	Village Health Sanitation and Nutrition Committee
MOUD	Ministry of Urban Development	VHND	Village Health Nutrition Day
MPC	Metropolitan Planning Committee	WASH	Water Sanitation and Hygiene
MPW	Multipurpose Health Workers	WCD	Women and Child Development
MTP	Medical Termination of Pregnancy	WLCC	Ward Level Co-ordination Committee

Chapter 1

Background

The National Urban Health Mission (NUHM) was approved by the Cabinet on 1st May 2013. NUHM Implementation Framework was also released at the same time with the objective "to address the health concerns of 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 was followed by the constitution of a Technical Resource Group (TRG) on NUHM by the Ministry of Health and Family Welfare (MoHFW) on 25th July 2013 to provide recommendations on implementation strategies, broadly following the framework. The report of the TRG released on 26th February 2014 highlighted urbanization as one of the most significant demographic trends of the 21st century. Vulnerability of the urban poor was identified based on the report of the Hashim Committee, constituted by the Planning Commission, into residential, social and occupational vulnerability.

There has been a tremendous growth in urban population since the launch of NUHM in 2013 due to in-migration from rural to urban areas and natural population growth and the urban scenario has changed by leaps and bounds. The current urban health scenario is placed below:

1.1 The Urban Health Context – A Situational Analysis

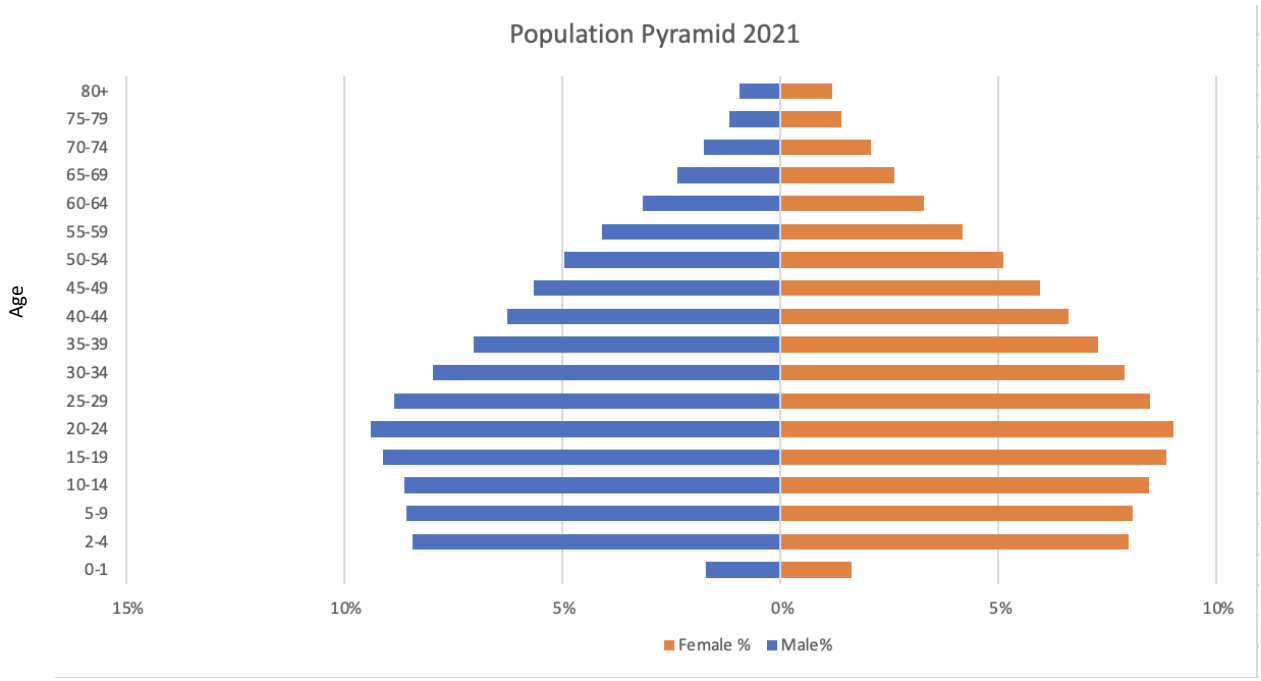
a. Urban Demography

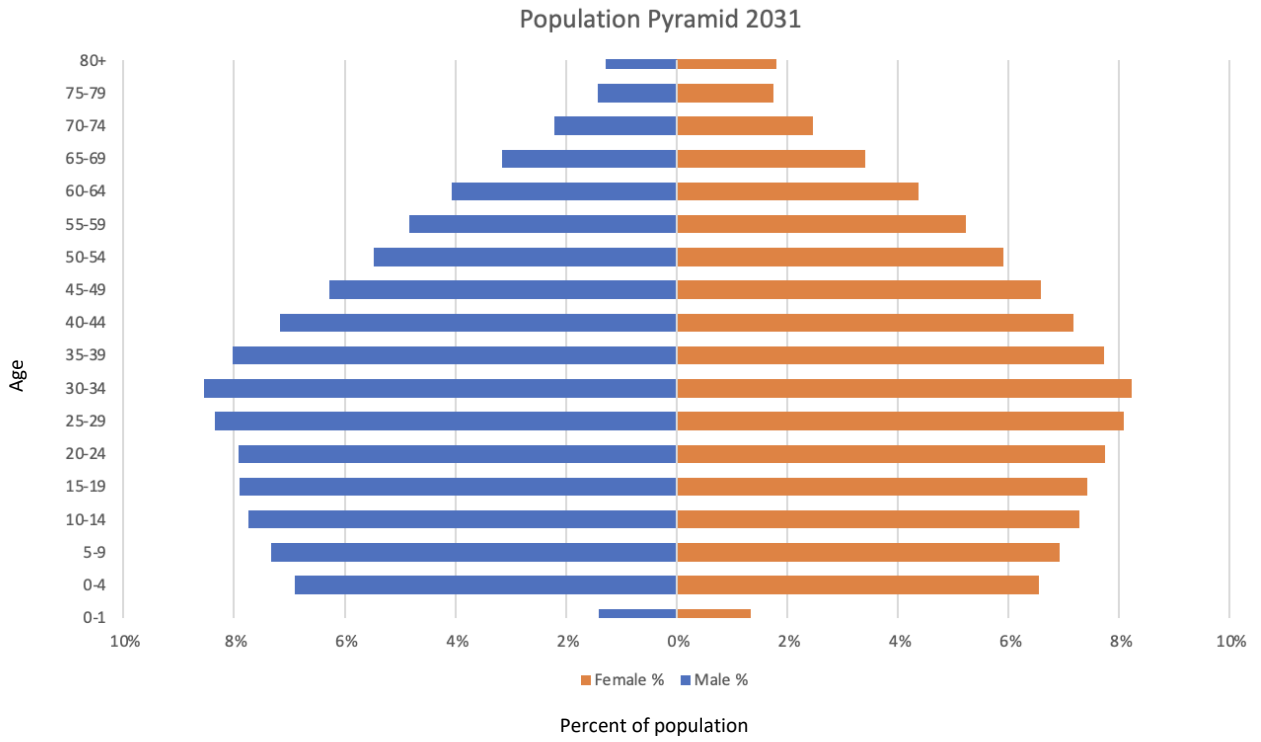
Recent decades have seen unprecedented population growth in India's urban areas. The total urban population in the country as per Census 2011 was approximately 38 Crores, constituting 31% of the total population. India will be almost 50% urban by 2050 (UN-Habitat, 2017). Estimations indicate that about 4.16 crore people will be added as urban dwellers in India between 2018 and 2050 (United Nations Report 2018). As per the 2011 census, the number of **internal migrants** (both inter-state and within-state) in India at 45.36 crore, making up **37% of the country's population.** As per the report released by the Ministry of Statistics and Programme Implementation in June 2022, **the migration rate was 34.9% in urban areas.**

b. Age-wise population projections

The population pyramids (Fig. 1 & 2) based on the projected urban population for 2021 and 2031 highlight not only the projected increase in overall population but also the age-wise shift of the population. The proportion of the population is higher in the working age group but also amongst the elderly. This demographic dividend is attributable to the country's declining fertility and death rates, which would be a significant contributor to the economic prosperity of the country. Thus, it indicates that there is a need to build strategies for these age groups, the majority of whom are at high risk for developing non-communicable diseases, and occupational and environmental health hazards.

Fig. 1 & Fig. 2: Age-wise urban population projections for 2021 and 2031 for India





(Source: Registrar General of India (2020).Population Projections for India and States 2011 - 2036)

c. Level of Urbanization

India's level of urbanisation varies significantly across the States and UTs. States such as Goa, Tamil Nadu, Kerala, Maharashtra, and Gujarat have attained over 40% urbanisation, whereas others such as Bihar, Odisha, Assam, and Uttar Pradesh continue to be at a lower level of urbanisation at 31.1%, which is the national average. Over 75% of the urban population of the country is residing in ten states viz. Maharashtra, Uttar Pradesh, Tamil Nadu, West Bengal, Andhra Pradesh, Gujarat, Karnataka, Madhya Pradesh, Rajasthan, and Kerala

Table 1: Trend of Urban and Slum Population in India

Population	Census 2001	Census 2011	Mid-Year (1st July 2020)	Projected population for year 2021
Total Population	102.8 Cr	121 Cr	135 Cr	139 Cr
Total Urban Population (%)	28.6 Cr (27.8%)	38.01 Cr (31.26 %)	46.30 Cr (34.21%)	47.21 Cr (34.53%)
Slum Population (%)	4.26 Cr (15%)	6.55 Cr (17%)	-	-

Source: State/UT wise Urban and Slum Population in India (2017)

1.2 Health Indicators in Urban areas

a. Health Indicators: Overall

Though NFHS-5 has shown improvement over NFHS-4 for urban areas in some of the key indicators like IMR, U5MR, OOPE, immunization coverage, and institutional deliveries, it simultaneously reflects the epidemiological transition, including the resurgence of communicable diseases as seen during COVID-19 (Table 2).

Table 2: Key Health Indicators

All India (Urban Indicators)		
Indicators	**NFHS-4**	**NFHS-5**
Infant mortality rate (IMR)	29.0	26.6
Under-five mortality rate (U5MR)	34.0	31.5
Sex ratio of the total population (females per 1000 males)	956	985
Institutional births in public facility (%)	46.2	52.6
Children aged 12-23 months fully vaccinated (%)	63.9	83.3

Women who are overweight or obese (BMI ≥25.0 kg/m^2) (%)	31.3	33.2
Men who are overweight or obese (BMI ≥25.0 kg/m^2) (%)	26.6	29.8
Blood sugar level - very high (>160 mg/dl) Women (%)	3.6	8.0
Blood sugar level - very high (>160 mg/dl) Men (%)	4.4	8.5
Mildly elevated blood pressure (Systolic 140-159 mm of Hgand/or Diastolic 90-99 mm of Hg) Women (%)	7.3	13.6
Mildly elevated blood pressure (Systolic 140-159 mm of Hg and/or Diastolic 90-99 mm of Hg) Men (%)	11.4	17.1
Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100 mm of Hg) (%) Women	NA	5.2
Moderately or severely elevated blood pressure (Systolic ≥160mm of Hg and/or Diastolic ≥100 mm of Hg) (%) Men	NA	5.9
Gender Based Violence		
Ever-married women age 18-49 years who have ever experienced spousal violence27 (%)	25.3	24.2
Ever-married women age 18-49 years who have experienced physical violence during any pregnancy (%)	3.5	2.5
Young women age 18-29 years who experienced sexual violence by age 18 (%)	1.1	NA
Tobacco Use and Alcohol Consumption among Adults		
Women age 15 years and above who use any kind of tobacco (%)	5.4	4.4
Men age 15 years and above who use any kind of tobacco (%)	38.9	28.8
Women age 15 years and above who consume alcohol (%)	0.7	0.6
Men age 15 years and above who consume alcohol (%)	28.7	16.5
	Global TB Report 2021	**Global TB Report 2023**
Prevalence of all forms of TB (per 1,00,000 population)	188	312

Source: NFHS 4 (2015-16), NFHS 5 (2019-20), Global TB Report 2021& 2023

The NSS 75th round also reports overall decline in anaemia and tuberculosis cases (in both rural and urban areas) from NSS 71st round levels, as under:

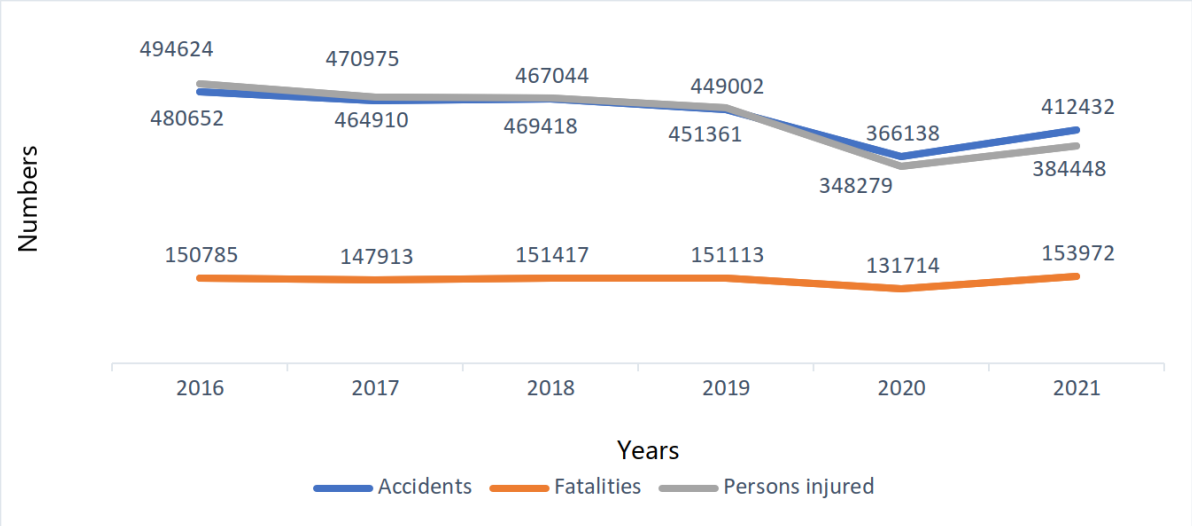
Table 3: Decline in anaemia and tuberculosis cases

	NSS 71stround	NSS 75thround
Cases of Anaemia (n)	5,96,200	8,80,700
Cases of Tuberculosis (per 1,00,000 persons)	76	38

Source: NSS 71st (January - June 2014) & 75th Round (July 17, June 18)

Road traffic injuries cause considerable economic losses to individuals, their families, and to nations as a whole. These losses arise from the cost of treatment as well as lost productivity for those killed or disabled by their injuries and for family members who need to take time off work or school to care for the injured. There is a need to achieve the SDG target (3.6) to halve the number of global deaths and injuries from road traffic accidents by 2030.

Figure 3: Trends in number of accidents, person injured and fatalities: 2016- 2021



Source: Road accident in India Ministry of Road transport and Highways 2021, Transport Research Wing, New Delhi

The findings from the NFHS 5 survey indicates that there has been a decrease in the proportion of women who reported experience of spousal violence in most parts of the country, compared to NFHS-4 carried out in 2015-16. Recognizing and addressing gender-based vulnerabilities is crucial to achieving equity in urban healthcare. Implementing policies and interventions that focus on creating safe and inclusive environments will lead to better health and well-being for the entire urban population.

b. Nutritional Determinants

Another challenge in urban areas is access to nutrition. Table 5 depicts the status of overall urban and rural nutritional indicators from NFHS 4 and 5. The status is better in urban than in rural India and has improved in the past few years, as indicated, for all such indicators like childhood stunting, underweight, and wasting among children and women. Anaemia, however, has shown an increased trend since 2015-16 and still poses a major challenge in both urban and rural areas.

Table 4: Nutrition indicators for overall urban areas of India

Indicators	NFHS 4 (in %)		NFHS 5 (in %)	
	Overall Urban	Overall Rural	Overall Urban	Overall Rural
Child Stunting	31.1	41.2	30.1	37.3
Child Underweight	29.2	38.2	27.3	33.8
Child Wasting	19.9	21.4	18.5	19.5
Anaemia among children (6-59 months)	56	59.5	64.2	68.3
Anaemia among pregnant women (15-49years)	45.8	52.2	45.7	54.3
Anaemia among non-pregnant women (15-49years)	51	54.4	54.1	58.7

Source: NFHS 4 (2015-16), NFHS 5 (2019-20)

c. Utilization of services in Public Health Facilities

The establishment of dedicated public health infrastructure with various other health initiatives by GOI, such as free drugs and diagnostics initiative, implementation of health programmes, expansion of the range of services, augmentation of human resources, etc., in urban areas, may have led to gradual improvement in the utilization of public health services for inpatient and outpatient as indicated in **Table 5.**

Table 5: Utilization of Services in Public Health Facilities in Urban areas

Utilization of public health facilities (urban areas)	NSS 71st round (2014)	NSS 75th round (2017-18)

Outpatient (%)	20	26
Inpatient (%)	32	35
Childbirth (%)	42	48

Table 6: Utilisation of health facilities in urban areas

Public		**Private**		**Charitable/NGO-run**	
Rural (%)	**Urban (%)**	**Rural (%)**	**Urban (%)**	**Rural (%)**	**Urban (%)**
46	35	52	61	2.4	3.3

Source: NSS 71 round values are computed from Unit records, and NSS 75th are from Health in India Report for NSS Health Round 2017-18

d. Expenditure on Health

The NSS 75th round survey shows that the average medical expenditure per case in public hospitals is more in urban facilities (Rs. 4,837) than in rural (Rs. 4,290) and that in private hospitals is also greater in urban areas (Rs. 38,882) as compared to that in rural areas (Rs. 27,347). The percentage of hospitalized cases in public facilities is lower in urban areas (35.3%) as compared to rural areas (45.7%). An Indian woman on average spends more in urban areas for hospital childbirth both in public and private hospitals

Table 7: Key Indicators of Social Consumption in India:

Indicators	Rural (INR)	Urban (INR)
Average medical expenditure (Rs.) per case by type of hospital: Government/Public	4,290	4,837
Average medical expenditure (Rs.) per case by type of hospital: Private	27,347	38,822
Hospitalized cases using public facility (%)	45.7	35.3
Hospitalized cases using Private facility (%)	51.9	61.4
Average expenditure (Rs.) on hospital childbirth: Government Hospitals	2,404	3,106
Average expenditure (Rs.) on hospital childbirth: Private Hospitals	20,788	29,105

Source: Health NSS 75th Round (July 2017 – June 2018)

1.3 Progress under NUHM

NUHM completed a decade in May 2023 and has been implemented in 35 States/UTs (except Lakshadweep) , was instrumental in streamlining the primary health care system, which was hitherto inadequate in urban areas. As per MIS March 2023, NUHM covers 1213 cities/towns with a population of 50,000 and above, district and State Headquarters with more than 30,000 population and seven Metropolitan cities viz Ahmedabad, Bengaluru, Chennai, New Delhi, Mumbai, Hyderabad, and Kolkata. The remaining cities with less than 30,000 population are being covered under NRHM. The total population being covered under these cities is approximately (27.5 Cr).

Over years of implementation, NUHM's achievement has been in terms of augmented infrastructure, increased human resources for health, dedicated facility-based services, improved outreach, and targeted interventions for the slum population and the urban poor.

Key areas of progress under NUHM since its launch are as follows:

a. Cities & towns covered under NUHM

Over the last nine years, the coverage of cities/towns has increased from 764 in FY 2013-2014 to 1213 in FY 2022-2023. Out of these 1213 cities/towns, 53 are million plus cities, 55 cities have a 5-10 lakh population, 369 cities between 1-5 lakh, and 736 are below 1 lakh population.

Table 8: Classification of cities

Cities classified under NUHM	
Mega Cities	7* – Greater Mumbai, Kolkata, Delhi, Chennai, Bengaluru, Hyderabad, Ahmedabad
Million Plus Cities	53
Cities with 5-10 lakh population	55
Cities with 1- 5 lakh population	369
Cities below 1 Lakh	736
Total cities/towns covered under NUHM	1213

Source: NHM MIS March 2023 & Local Government Directory

b. City Planning & Mapping

A steady progress has been reported in the planning and mapping of health facilities and slums. However, the progress in vulnerability assessment and mapping has been very slow throughout the programme implementation across states. As per NHM MIS in March 2023, 1012 cities had completed health facility mapping, 999 cities had completed slum mapping, while vulnerability mapping was done for only 779 cities.

c. Infrastructure strengthening

Currently, 5195 UPHCs are operationalized under NUHM, of which 3973 UPHCs are functional with minimum staffing and service packages. About 3464 UPHCs are operating in government buildings and the remaining 1740 are in rented premises. A total of 512 UPHCs are functioning as 24X7 health facilities in the country and providing comprehensive primary health care services (*Source*- NHM MIS March 2023).

Similarly, out of the total, 225 Urban Community Health Centres (UCHCs) are functional as a secondary level of health care services, amongst which 205 UCHCs are functioning as 24X7 health facilities. Further, 42 districts are equipped with Mobile Medical/Health Units, 55 Mobile Health Units (MHUs), and 656 Health Kiosks are operational in the country under NUHM. (*Source*- NHM MIS - March 2023)

d. Human Resource in health

Since the inception of NUHM, nearly 46,000 health human resources have been provided to augment the availability of services as per gaps identified by the States/UTs. The human resources status under NUHM is presented below.

Table 9: Human Resources for Health in position

Activity Head	Approved FY 21-22	HR (In-position)	
	Number	Number	(%)
Clinical & Paramedical staff (A)			
Medical Officer	4379	3264	75
Specialist	537	266	50
Staff Nurse	10863	7693	71
ANM	19557	14852	76
Pharmacist	4142	3227	78
Lab Technician	4269	3328	78
Public Health Manager	752	448	60
Total (A)	**44499**	**33078**	**74**
Programme Management staff (B)			
At SPMU level	233	183	79
At DPMU level	803	637	79
At CPMU level	438	358	82
Total (B)	1474	1178	80

Total (A+B)	**45973**	**34256**	**75**

Source- HRH-HPIP Division, NHSRC

e. Community Processes

Strengthening community services through ASHAs is an important component of NUHM (one ASHA for 1000-2500 urban poor population) and Mahila Arogya Samitis (one MAS for 50 - 100 households). So far 79,466 (93%) ASHAs have been engaged against 84,919 approved in urban areas across the country. Out of 81168 ASHAs engaged, 70,927 have been trained in the induction module, and 64333 trained on Modules 6 and 7. ASHAs in urban areas are being trained in NCD modules from 2017 onwards, and from 2018, they are being trained for an expanded range of services under CPHC. 82,100 MAS have been formed, and all ASHAs have been trained on community action across the country (Source: MIS March 2023).

f. Outreach

Outreach in the form of Urban Health & Nutrition Day (UHND), special outreach camps and health melas have been integral in providing services to the uncovered and underserved urban vulnerable and slum population. 7,40,795 UHNDs have been held in FY 2021-22 and 10,18,695 UHNDs in FY 2022-23. The special outreach camps have also shown a steadfast increase over the last few years, with 81,906 special outreach sessions having been conducted in FY 2022-23. Outreach thus has played a critical role in providing services nearer to the community, apart from services through health facilities. (Source: MIS March 2023).

g. Improved Quality of health care in urban facilities

The quality of care in urban health facilities has improved due to various initiatives taken under the Quality Assurance initiatives of the Government of India.

NQAS: 233 UPHCs are quality certified at the National level and 172 UPHCs at the state level.

Kayakalp: The Kayakalp incentive scheme was expanded in 2017 to cover all the urban health facilities. Out of 35 States/UTs, 33 States and UTs declared Kayakalp incentives for FY 2021-22, and 1303 UPHCs and 22 UCHCs have been awarded Kayakalp certification.

Mera Aspataal: The Government has launched the "Mera Aspataal/My Hospital" initiative to empower patients by seeking their views on the Quality of experience in a public healthcare facility.1558 UPHCs out of 21 states and UTs have been integrated with the "Mera Aspataal' app. (Source: QPS Division, NHSRC 31st March 2023

1.4 Enablers and barriers in delivering urban health services

Enablers

- Defined structure present under NUHM at centre and state level
- Commitment of GoI on increasing budget and various National Health Programmes such as NUHM, 15th Finance Commission, health component under PM-ABHIM

Barriers/Risk

- Availability of land in urban areas
- Continuous growth in urban and migratingpopulation
- Uncertainty in roles and responsibilities between health department and ULBs and other key stakeholders
- Weak Institutional structure under major

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1.5 Challenges in NUHM Implementation

Despite the presence of a vast public health network, including the presence of dedicated primary health services, the utilisation of public health facilities is low, which results in high out-of-pocket expenditure on health for the urban population. The burgeoning urban poor in India are still struggling for basic services like housing, water, and sanitation. Striking differentials in the health and nutrition outcome indicators exist even among the urban poor and non-poor groups (as mentioned in Table 5). This may be attributed to the challenges that are unique to urban areas and have affected the implementation of NUHM at ground level.

The challenges mentioned below are inspired by field observations, report syntheses (Common Review Missions, NITI Report etc.), and review meetings at the National and State levels conducted from time to time.

Table 10: Challenges in Context of National Urban Health Mission

Challenges in Context of National Urban Health Mission

Push and pull factors	Several push factors in rural areas such as lack of livelihood opportunities, poverty, rapid population growth that surpasses available resources, poor living conditions, desertification, famines/droughts, poor healthcare, loss of wealth, natural disasters etc. lead people to migrate to urban areas. Factors that attract rural migrants to urban areas include job opportunities, better living conditions, political and/or religious freedom, superior education, welfare systems, better transportation, better communication facilities, etc. The interplay of these push and pull factors leads to a continuous increase in the urban-based population.
Diverse Urban Scenario	The urban health situation in the cities remains characterised by diversities in the organisation of the health delivery system in terms of the provisioning of health care services. The migratory, marginalised transit population and other high-risk population also comes to seek health services in urban and peri-urban areas. Workers in unorganized sectors or seasonal work may not have records or documentation of their employment or income. This mobility makes it challenging to establish a stable database of the urban poor, hindering efforts to provide continuous healthcare services and to identify and target them for social welfare programs.
Burden of disease in Urban Areas	The disease profile of urban population differs from those in rural areas due to varied exposure to risk factors between urban and rural areas, leading to variations in prevalence of NCDs. For example, cardiovascular diseases, obesity, are more prevalent in urban populations. However, the urban health systems had limited capacity to address wide range of health needs including infectious diseases, non-communicable diseases, RMNCHA needs, burden of mental health, epidemics along with tackling of public health emergencies due to natural or man-made disasters e.g., recent Covid 19 pandemic. The unique socioeconomic factors and other social determinants of health further add to this burden of diseases being faced by the urban population.
Coverage of cities/towns under NUHM	Presently, only 1213 cities/towns are covered under NUHM, however as per Census 2011 data, there are 474 Urban Agglomerations and 5697 Towns, this is because the definition of urban areas under NUHM and scope of urban health coverage in the 2013 NUHM framework is not in sync with the Registrar General & Census Commissioner- India definition which led to smaller cities/towns being left out.

Capacities of Urban Local Bodies to Manage Health Care	ULBs are generally functional as Municipal Corporations, Municipalities and Nagar Panchayats with varying human resources. The capacity of smaller corporations and municipalities is less than adequate to monitor the wide range of health services requirements of their urban population. In the metro cities and in some large cities the ULBs manage healthcare particularly the primary health care services in urban areas. But in the in smaller cities ULB involvement remains limited to only provisioning of public health initiatives like sanitation, sewerage, waste management, vector control, etc. The 74th Constitutional Amendment of 1992 gave directive to ULBs that all municipalities would be empowered with such powers and responsibilities as may be necessary to enable them to function as effective institutions of self-government. Health, including public health, is one of their prime responsibilities but the availability of human resources for health and governing infrastructure of health is still not adequate.
Utilization of urban public health facilities	Most patients in cities and towns still prefer to visit Medical College hospitals, DH & SDH, which therefore remain congested, and the referral pathways remain underutilized. Limited availability and continued access to quality medicines, laboratory and radiology services at primary health level are among the major challenges contributing to inadequacies and delays in patient management.
Human resources for health	As per RHS 2020-21, there is 30.8% shortfall of female health workers/ANMs and 9.9% shortfall of doctors in UPHCs and 33.8% shortfall of specialists (surgeons, obstetricians & gynaecologists, physicians and paediatricians) in UCHCs. Some of the key challenges related to HRH under NUHM include the following: Related to availability of HRH- 1. Lack of coordination and integration between the Department of Health and Municipal Corporation leading to in adequate distribution of resources 2. Lack of clarity between ULBs and Health department regarding ownership of the health facilities and human resources 3. Absence of regular sanctioned posts for urban health facilities 4. Vertical management of programs leading to irrational

	deployment of HR 5. Long recruitment cycles or delay in recruitment process 6. Remuneration provided might not be adequate. 7. Availability of other options of employment in urban areas 8. Lack of technical capacity in ULBs for management of HRH 9. Weak Health Systems components, for example, unavailability of medicines and supplies, equipment, poor infrastructure, unavailability of full complement of staff discourages people from joining public system and leads to attrition in Quality of services by HRH. 10. Lack of responsiveness and patient centric approach in the health care providers. 11. At times, inappropriate behaviour with patients, which may lead to dissatisfaction and decrease in trust of community in the public health system. 12. Lack of appropriate level of skills. 13. Lack of monitoring and supportive supervision. Inadequate availability of human resources for health as per norms coupled with high attrition remains a cause for concern in urban areas. Most of the HR has been employed under contractual arrangement and very often vacancies at the level of clinical and paramedical human resources in the primary health care structure persist. This acts as a deterrent for optimum functioning of urban facilities. Urban areas also have several informal practitioners without any formal medical qualification or registration, treating patients. Treatment from such practitioners may result in serious outcomes, putting the population at risk.
Coverage of non-slum areas with community-based structure	At present there is a gap in programme coverage, where non-slum areas and high, upper & lower middle-income groups are not covered by any community-based mechanism thus creating a disconnect with the urban health facility. This requires to be addressed on a priority basis and a community-based structure needs to be created.
Focus on Peri-urban /outgrowths /hinterlands and floating population areas	In most of the cities with the mushrooming of organised or unorganised colonies, there has been an expansion of the defined boundaries. These areas constitute the peri-urban areas. The coverage of these peri-urban areas through dedicated health infrastructure with availability of human resource and assured services are still lacking in majority of the states. With the ever-expanding peri urban areas, particularly in metros and other big corporations, there is an urgent need to pay attention to such areas to ensure smooth delivery of quality health services to the people residing there.

City-based planning process	The implementation of most of the health programmes under NHM is through the district institutional and planning mechanism. The NUHM framework in 2013 had suggested formulation of City Health Plans for incorporating priorities of the cities in the City PIP and city development plans as convergence component with various concerned Ministries. While City PIPs have subsequently been a crucial component of the District and State PIPs, these were not prepared as part of any comprehensive city health action plan. This has led to fragmented and patchy implementation of NUHM in the cities.
Presence of large private sector	The private sector has assumed prominence in urban areas and influenced the health seeking behaviour of urban population. Urban areas have the presence of a large private health sector, consisting mainly of three types of providers Corporate/ Multispecialty hospitals, nursing homes and individual medical practitioners providing OPD/IPD services. However, they have limited convergence and linkage to achieve public health goals.
Vulnerability Assessment and Disease Profiling	The NUHM framework 2013 had a commitment for assessment of the poor, marginalised urban population living in slums, below flyovers, near railway tracks, and other such habitats, mapping their vulnerabilities, assessment of their disease burden, and ensure services reach them. Despite availability of guidelines, some states are still in the process of completing vulnerability assessment, even after a decade of launch of NUHM in true sense. The key challenge of mapping urban population is Complex Socioeconomic Dynamics (difficult to distinguish the urban poor from the non-poor based on income and living conditions, multidimensional poverty in urban settings).
Socio-Economic Determinants	Social determinants pose challenges in urban areas, particularly in slums, like clustering of houses due to lack of space, enabled environment for physical activities like walking and playing is hindered, unhygienic living conditions, lack of potable water, sanitation facilities and toilets, presence of open drains, mosquito breeding grounds, environmental pollution, hazardous occupations (like rag picking, jobs in chemical factories, handling of glasses and other toxic substances) etc. Socioeconomic issues like substance abuse, domestic violence, and alcohol consumption can have significant impacts on urban areas. These issues are often interrelated and can create a cycle of social

	and economic challenges for individuals and communities. These socio-economic determinants of health need attention from various departments and convergence for improved health outcomes for the urban population at ULB level.
Climate Change	India is the seventh-most vulnerable country with respect to climate extremes (German watch 2020). An analysis by the Council on Energy, Environment and Water (CEEW) suggests that three out of four districts in India are extreme event hotspots, with 40 per cent of the districts exhibiting a swapping trend, i.e., traditionally flood-prone areas are witnessing more frequent and intense droughts and vice-versa (Mohanty 2020). Further, the IPCC states with high confidence that every degree rise in temperature will lead to a three per cent increase in precipitation, causing increased intensification of cyclones and floods. 27 of 35 states and UTs are highly vulnerable to extreme hydro-met disasters and their compounded impacts.

Chapter 2

Rationale of Revision

With the launch of NUHM, many achievements were seen in terms of access to healthcare services, rapid expansion of urban health infrastructure, augmentation of human resources for health, assured availability of medicines and diagnostics, platforms for community interaction and feedback, etc. However, some challenges in implementing the mission are

observed & the extent of implementation is differential leading to gaps in implementation (mentioned in chapter 1).

NITI Aayog report on the evaluation of Centrally Sponsored Scheme in the Health Sector documented that NUHM is on the path to achieving the targets for urban health indicators and holds its relevance to meet the healthcare needs of the urban population. Nevertheless, there is a strong need to set up a primary healthcare system in urban areas that deal with healthcare challenges and needs of urban populations in terms of shortage of infrastructure and human resources for health, to name a few (Source - Evaluation of Health Centrally Sponsored Scheme in Health Sector, Volume II, October 2020).

Studies that assessed the domains of Implementation, Evaluation, and Service-Based Studies in the context of NUHM collectively highlight barriers such as underutilized or inadequate funds, Human resource shortages, awareness gaps, and challenges in addressing multilevel determinants on a global/national scale that warrant ongoing attention to ensure the Mission's sustained impact in improving urban health in India.

Newer initiatives were introduced both by the Central and state governments over the years in urban areas, viz., the Comprehensive Primary Health Care by operationalizing Ayushman Bharat Health & Wellness Centre, Pradhan Mantri- Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) and XV Finance Commission grants for the health sector through the ULBs, having an impact on urban health scenario.

Consultations with various stakeholders, including policymakers, States, urban local bodies and NGOs, and subject experts also indicated a need for revision of the framework and paved the way further.

Hence, this implementation framework aims to address these gaps comprehensively, build upon and augment NUHM, and be relevant to the context by reflecting upon the learnings from the decade gone by. It does not intend to reinvent the wheel of urban health reforms but builds upon the existing health system for it to function in a more cohesive and coordinated manner to achieve better health outcomes and thereby progress further to achieve the SDGs and UHC goals.

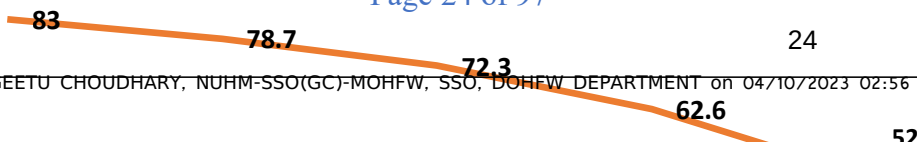
Some factors that impacted the urban health scenario & paved the way for revision of the previous framework are:

2.1 Socio-demographic dynamics in urban areas

a. Population Overgrowth of India

It is estimated that around 2050, the urban population will outgrow the rural population in the country and a majority of the population will be constituted by the urban dwellers. To cater to the specific health needs of this ever-increasing urban population a comprehensive health policy is imperative.

Figure 4 : A Rapidly Growing Urban Population



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Source: *Reconstructed graph using data from United Nations, Department of Economic and Social Affairs (DESA), Population Division (2012): World Urbanization Prospects*

b. Epidemiological transition

India is facing an epidemiological transition with a triple burden of disease. Over the last two decades, the country's disease pattern has shifted drastically. In 1990, out of the total disease burden in India measured as DALYs, 61% was due to communicable, maternal, neonatal, and nutritional diseases which dropped to 33% in 2016. There was a corresponding increase in the contribution of non-communicable diseases from 30% of the total disease burden in 1990 to 55% in 2016 and injuries from 9% to 12% (Source- India: Health of the Nation's States, ICMR, 2016). It is known that many factors prevalent in urban areas like sedentary lifestyle, pollution, processed food etc. are major contributors to developing NCDs. Apart from NCDs, other factors like alcoholism, substance abuse, and tobacco consumption are also emerging problems in urban areas. Hence, a revised comprehensive strategy is needed to address the triple burden of disease.

2.2 Commitment to Universal Health Coverage

GoI is committed to achieving universal health coverage. India's National Health Policy, 2017 also prioritizes "addressing the primary health care needs of the population with special focus on poor populations living in listed and unlisted slums, and other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants etc.

The policy directs to focus on convergence among the wider determinants of health – air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, climate resilience and reduction of violence and urban stress. The healthcare needs of the people living in the peri-urban areas are also addressed under the NUHM. Better primordial and preventive care also needs to be integrated into the urban health strategy. It recommends addressing the growing challenges of urban health and

advocates scaling up the National Urban Health Mission (NUHM) to cover the entire urban population with sustained financing.

SDG 3 sets the larger target of healthy lives and well-being for all the population, while other SDGs are indirectly linked to health by reducing hunger, providing clean water and sanitation and moving towards affordable and clean energy. These need to be adopted in the Indian urban health context. The *new urban agenda,* promoted by the World Health Organization, also highlights the wider role of the health sector with active engagement with urban planners in addressing cross-cutting areas. It promotes urban development alongside the advancement of the health and well-being of the broader urban population.

2.3 Newer Initiatives

Some of the major health system initiatives post the launch of NUHM in 2013 are described below:

a. National Quality Assurance Standards for UPHCs (2015)

NQAS have been developed for the measurement and improvement of the quality of services at both Urban PHCs and Urban CHCs. The quality standards are defined to build a system of continuous assessment of health facilities, action planning for the closure of identified gaps, supportive supervision and for monitoring of the quality of services by various stakeholders like facility staff, district health administration, and certification bodies. Apart from the NQAS, initiatives like LaQshya and MusQan to improve services to mothers, infants and children have also been undertaken.

b. Ayushman Bharat Health & Wellness Centres (2018)

In 2018, Ayushman Bharat was launched wherein the existing sub-centres and primary healthcare centres in urban and rural areas are being converted to Ayushman Bharat Health & Wellness Centres, with the principle being “time to care” not more than 30 minutes. As mandated in Ayushman Bharat, the Urban PHCs under NUHM are being strengthened as Ayushman Bharat - Health and Wellness Centres (UPHC-HWCs) to deliver Comprehensive Primary Health Care (CPHC).

c. Fifteenth Finance Commission & PM ABHIM (2021)

Through XV FC health grants & PMABHIM, Comprehensive Primary Health Care would be provided by setting up Urban Health and Wellness Centres (UHWCs) and upgrading selected Urban Primary Health centres (one for every 2.5 to 3 lakhs population) to Specialist UPHC or polyclinic-based upon the context of the local area to provide in-person specialist services on a fixed day every week.

Public health-related actions and strengthening the continuum of care for bidirectional linkages, improving access to high-quality care, minimising the out-of-pocket expenditure incurred on healthcare services, and decongestion of secondary and tertiary healthcare facilities are envisioned by operationalizing UHWCs.

Several other components have also been initiated under PM- ABHIM for urban areas like expanding IT-enabled disease surveillance system, effectively delivering One Health through the Integrated Health Information Portal (IHIP) at the National and State levels,

strengthening laboratory capacities at district, regional and national level to identify novel and highly contagious infectious agents, etc.

d. Indian Public Health Standards (2022)

Indian Public Health Standards 2022 has specifically defined standards and norms for urban health facilities for the first time, and these need to be reflected in the NUHM framework. It has adequately captured the needs of urban health and defines the population norms as well as service delivery at each level of health facility in urban areas. The effort to comply with IPHS norms shall ensure assured availability of services, including medicine, and diagnostics and would aid in reducing the OOPE. IPHS compliance would also ensure the availability of assured primary and secondary care in urban areas.

2.4 Expanding Public Health Surveillance

The COVID-19 pandemic posed several challenges to public health systems worldwide and initiated a phase of uncertainty, bringing several economies to a standstill. The pandemic was non-discriminatory in its impact, affecting all sections of human society in both rural and urban areas. It re-emphasized the need to focus on social determinants that affect health outcomes; simultaneously, the public health surveillance systems need to be strengthened for early identification of warning signals and thereby aid in better planning for managing any epidemics. It is important that learnings from the COVID-19 pandemic should translate to better preparedness for future health emergencies. The need for a robust public health surveillance system is thus a factor for revising the framework.

2.5 Models for urban healthcare in Low- & Middle-Income Countries

Urban health policies have evolved significantly in recent years in countries like Bangladesh, Nepal and Thailand. Nepal's 2015 policy upgraded Urban Health Centers to Urban Health Promotion Centres, focusing on non-communicable diseases. Bangladesh's 2020 strategy prioritized quality care through local coordination. Thailand's initiatives involved telemedicine programs and digital innovations like the MorDee App, ensuring urban healthcare access. Regarding governance, these nations employ diverse strategies. Bangladesh's Surjer Hashi clinics and Thailand's digital volunteer programme engage NGOs and communities. Inter-sectoral collaborations and private sector involvement, seen in Thailand's collaborations with private pharmacies, enhance service delivery. In terms of service delivery, Thailand's Mobile Telemedicine units address urban healthcare gaps. These strategies collectively shape an inclusive and efficient urban health landscape and are good replicable models.

Chapter 3

Goals and Objective

3.1 Goal

The NUHM framework aims to provide universal access to affordable, equitable and quality comprehensive primary and secondary healthcare services to all sections of the urban population with effective intersectoral convergent actions to address wider social determinants of health.

It aims to achieve these in the synchronised vision of National Health Policy 2017 and ultimately strive towards achieving the UHC and SDGs. To achieve these goals, NUHM will adapt/ focus on the following approaches:

1. Forge a partnership between the central, state and local governments and other stakeholders
2. Set up a platform for involving the urban local bodies and community in the management of primary health infrastructure and programmes.
3. Provide primary and secondary healthcare services.
4. Provide opportunities for promoting equitable access to health.
5. Facilitate increased access and utilization of quality health services by all.
6. Promote inter-sectoral convergence for preventive and promotive health care.
7. Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.

3.2 Objectives

1. Increase utilization of urban public health facilities with assured service delivery.
2. Improve access to integrated comprehensive primary health care services, including prevention, management and control of communicable, non-communicable, locally endemic diseases, disease outbreaks, etc.
3. Establishment of an appropriate referral mechanism.
4. Improve the early warning, risk reduction systems and management of national health risks.
5. Improve public health functions such as surveillance viz., syndromic, environmental (air, water, foodborne), vector-borne, chronic disease, occupational etc. to reduce out-of-pocket expenditure.
6. Strengthen community processes and address determinants of health in urban areas.
7. Strengthen the prevention, promotion and adoption of healthy lifestyles and behaviour (tobacco, alcohol and substance abuse, including narcotic drug abuse).
8. Develop policies, regulations, and actions to mitigate pollution and maintain a clean and safe environment.

The expected outcomes envisaged through the implementation of the framework are as follows:

The expected outcomes from NUHM as committed in NHP 2017 and SDGs are:

- Reduce NNMR to 12/1000 and U5MR to 25/1000 live births by 2030.
- Reduce the Maternal Mortality Ratio to 70/100,000 live births by 2030.
- Reduce by one-third premature mortality from non-communicable diseases by 2030.
- Achieve and maintain a cure rate of >85% in new sputum-positive patients for TB and reduce the incidence of new cases to reach elimination status by 2025.
- Eliminate malaria (zero indigenous cases) throughout the country by 2030.
- Reduce prevalence of blindness to 0.25/ 1000 by 2025 and disease burden by one-third from current levels.
- Leprosy Prevalence Rate reduced to less than 1/10,000 population at sub-national and district levels.
- Reduce the number of global deaths and injuries from road traffic accidents to half by 2030.
- Achievement of all Indian Public Health Standards compliant health facilities by 2030.
- Achievement of all National Quality Assurance Standards (NQAS) certified health facilities by 2030.
- Decrease in the proportion of households facing catastrophic health expenditure from the current levels by 25% by 2025.

Chapter 4

Approach of Implementation

Approach of Implementation

To achieve the goals mentioned in Chapter 3, it is imperative to chalk out a roadmap to achieve the goals in the upcoming years. The approaches for implementation need to be comprehensive, futuristic, and scalable but, at the same time, replicable. Prioritisation of activities like redefining population coverage, expanding coverage of towns, cities and peri-urban areas, redefining vulnerable and reaching out to them, expanding health infrastructure for wider access to the population, ensuring dynamic mapping in urban areas, strengthening health systems, building a robust intersectoral convergence, capacity building etc. need to be ensured with adequate institutional structure and functional collaboration. The key activities to achieve the desired outcome are placed below:

4.1 Classification and coverage under NUHM

The classification of urban areas under NUHM needs to be aligned with that in the Census of India. The constitution specifies that a Nagar Panchayat is to be constituted for areas in transition (from rural to urban), a Municipal Council for small urban areas and a Municipal Corporation for large urban areas. The Constitution also specifies metropolitan regions as those areas with a population that exceeds one million, comprised of one or more districts and consisting of two or more Municipalities or Panchayats or other contiguous areas specified by the Governor by public notification. As per Census 2011, the urban system of India consists of 7933 settlements, classified broadly as statutory (4041) and census towns (3892).

4.2 Expanded coverage of cities and towns under the NUHM framework

The NUHM Framework 2023 envisages that all cities and towns classified as urban under the Registrar General of India (RGI) with a minimum population coverage of 15,000 for public health facilities need to be brought under the purview of NUHM. However, states will have the flexibility to identify and categorise each health facility either under urban or rural health Missions.

This would also help improve health care services in peri-urban areas/ hinterland/outgrowths, which are located on the outskirts of metros and other bigger corporations. To ensure adequate coverage, it is important to have convergence between States and different neighbouring municipal corporations and municipalities to discuss the issues of coverage and quality of services and provide necessary support through coordinated activities. Thus, the population coverage through NUHM facilities needs to be expanded to peri-urban/outgrowth areas.

Classification of cities and towns

The classification of cities and towns under NUHM needs to be aligned with the classification of cities given in the MoHUA and Census of India (2011) to the extent possible.

This is pertinent as NUHM initiatives need to be implemented and followed up on a routine basis to achieve the desired health outcomes. Hence, such a classification is important, keeping in mind the practicalities for ease of implementation, follow-up, and reporting. It would facilitate building focus on the urban health and non-health issues specific to the population residing in these cities, as well as assist in better supervision, monitoring and evaluation of the Mission programs and activities.

The Urban and Regional Development Plans Formulation and Implementation (URDPFI) Guidelines, 2014, have been referred to keeping in view the emerging scenario in the planned development of cities and towns in urban areas.

Table 11: The classification of cities and towns

SN o.	Classification	Sub-category	Population Range	Governing Local Authority	Number of Cities as per Census of India, 2011
1	Small Town*	Small Town I	5,000 – 20,000	Nagar Panchayat	7467
		Small Town II	20,000– 50,000	Nagar Panchayat/ Municipal Council	
2	Medium Town	Medium Town I	50,000 to 1,00,000	Municipal Council	
		Medium Town II	1 lakh to 5 lakh	Municipal Council	372
3	Large City	—	5 lakh to 10 lakh	Municipal Corporation	43
4	Metropolitan City	Metropolitan City I	10 lakh to 50 lakh	Municipal Corporation/ Metropolitan Planning Committee	45
		Metropolitan City II	50 lakh to 1 Crore	Same	5
5	Megapolis	—	More than 1 Crore	Same	3

Note: Names of Local Authorities may vary as per States' traditions and laws.

Source: Modifications for the URDPFI, MoHUA Guidelines based on census classification and State experiences.

4.3 Mapping in urban areas

Mapping in urban areas is required to be undertaken for the whole urban population, indicating the type of habitation and the adjoining surroundings, which will help in addressing various determinants of health. The mapping may also include the public health facilities and their catchment areas so that linkages can be developed for the provision of preventive, promotive and curative health care services.

During the ten years of NUHM implementation, most of the states have completed city and health facility mapping in urban areas in collaboration with Municipal Corporations, municipalities, and stakeholders. However, the progress in vulnerability assessment has been slow. Further, the urban population is dynamic, and the catchment area of urban health facilities keeps growing and mapping of these areas often remains a challenge.

The framework encompasses four types of mapping in urban areas to understand the urban population in every urban town/city:

1. **City Mapping**
2. **Health Facility Mapping**
3. **Vulnerability Mapping**
4. **Health Needs Assessment (HNA)**

4.4 Vulnerability of urban population

Vulnerability mapping is a concurrent exercise with city mapping, assessment and health facility mapping, which envisages a selective to universal approach for vulnerability. So, it is important that the health functionaries at each level of the facility closely collaborate with their counterparts in ULBs and ensure that any additional area or population requiring inclusion in the existing city/town map may be done. Special attention is to be given to assessing the health needs of the population and mapping should indicate the extent of coverage of such health needs, linked with a time-bound action plan for its completion.

The earlier vulnerability assessment had two levels, namely, Slum-level vulnerability assessment and Household Vulnerability Assessment. *(link to the national guidelines and tools of vulnerability mapping and assessment for urban health: https://www.nhm.gov.in/images/pdf/NUHM/Guidelines_and_tools_for_vulnerability_mapping.pdf)* While the slum level assessment may be continued, it should also be clubbed with ward-level health needs assessment as part of community health needs assessment. The household vulnerability assessment may be part of the population enumeration and empanelment exercise already in progress under Ayushman Bharat Health and Wellness Centres.

The core focus remains on the marginalized population but those residing in other parts of the urban areas, for example. High-rise buildings, housing societies, individual houses, etc., also need to be oriented and assessed through RWAs, housing societies, etc.

a. Redefining Vulnerability

In the growing multidimensional and evolving context of health in urban areas, vulnerability is defined as *"a risk factor/condition related to the residential, social, occupational and environmental factors, which determine the extent of the health impact."*

With the commitment towards achieving Universal Health Care underpinned by the principles of a "health for all" strategy emphasising equity, participatory governance and intersectoral collaboration to address the social determinants of health, the framework of the National Urban Health Mission aims to provide public health services to the entire urban population holistically not limited to the urban poor and slum population.

Therefore, vulnerability assessment is required for the entire gamut of the urban population residing in high-rise buildings, posh residential colonies, authorised and unauthorised slums, slum-like habitations and peri-urban localities. However, the type and nature of vulnerability of the population would be variable in terms of disease profile and patterns and the influencing social determinants of health, which needs to be understood, highlighted and addressed.

Based on these, the NUHM framework 2023 classifies urban vulnerability **as social, health-related, occupational, residential and environmental.**

Figure 5: Image representing the interconnectedness of vulnerabilities impacting health in urban areas

Social Vulnerability:

Social vulnerability is faced by people who are discriminated against based on their social status, i.e., their caste, class, ethnicity, religion, gender and gender-based violence, age, social isolation or illness etc. Children, women, pregnant women, senior citizens, LGBTQIA+, women-headed households, child-headed households, disabled persons, persons suffering from debilitating illnesses such as HIV/AIDS, Leprosy, TB, mental illness, persons belonging to scheduled castes and scheduled tribes, migrant workers, religious minorities etc. face such vulnerabilities. The middle-aged and elderly persons with co-morbidities irrespective of their socio-economic and financial status, would also belong to this category.

Health Related vulnerability

An individual's susceptibility to communicable and non-communicable diseases is determined by social, economic, political, and health inequalities, which can also accentuate these vulnerabilities by rendering some individuals less able to adhere to and access primary, secondary and advanced healthcare.

The health conditions may vary from nutritional deficiencies, infections, etc., in slums, slum-like and peri-urban areas to obesity, hypertension, diabetes mellitus and mental health conditions across all geographies. Furthermore, the varied health-seeking behaviour of different sections of the urban population, the baseline status of health, morbidity and mortality and the ease of access to health care services also need to be captured to define health-related vulnerability and design strategies to mitigate them.

Occupational vulnerability

Persons/households that face occupational vulnerability include those without access to regular employment, are susceptible to significant periods of unemployment, and those who face occupational hazards due to unsafe working environments. They may often work as bonded or semi-bonded workers in undignified and oppressive conditions. These include informal, unorganised workers in hazardous occupations such as rag pickers, rickshaw pullers, head loaders, construction, brick and lime kiln workers, factory workers, transport hubs (truck drivers), commercial sex workers, domestic workers, and even self-employed service providers with marginal income.

Residential vulnerability

This group would include the urban poor population living in notified and non-notified slums, migrants, and the floating population.

Urban slums, which are growing exponentially due to urbanisation and migration, will continue to remain the prime focus of urban health. The NUHM framework adopts a definition of ‘‘slum’’ as a human settlement that has the following characteristics: 1) inadequate access to safe water; 2) inadequate access to sanitation and other infrastructure; 3) poor structural quality of housing, 4) overcrowding, and 5) insecure residential status. It is a well-established fact that these various vulnerable groups, as mentioned above, face the perpetual burden of ill health.

· ***Urban Poor-*** Urban poor living in urban slums are considered one of the most vulnerable groups and encompass a diverse range of vulnerable populations including the

homeless, rag-pickers, street children, rickshaw pullers, etc. This group also comprises the population living near areas prone to landslides or flooding, hazardous industries, sewage lines, those living on roadsides, under bridges, flyovers, along railway tracks, in institutions like night shelters, homeless recovery shelters, orphanages and schools for specially-abled children, and leprosy homes.

· ***Migrants and floating population-*** Considering that urban areas have a constant migration stream, issuing Below Poverty Limit (BPL) cards does not keep pace with the migration of poor people from rural to urban areas in search of a livelihood. Many poor households are also not necessarily based in slums. This means that mere spatial targeting will also not suffice. So, the urban migrants and other temporary migrants also fall into the category of the most vulnerable population, which needs to be mapped and recorded.

Environmental vulnerability

In recent years, the possible effects of climate change in urban areas have made climate adaptation a priority. Urban areas are expected to face increased extreme events, including droughts, floods, storms, and heat waves which can impact the dynamics of infectious diseases like Vector-Borne Diseases, Waterborne Diseases, Airborne Diseases, Foodborne Diseases, and Emerging Infectious Diseases. Exposure to environmental risks and hazards is an outcome of socioeconomic processes that accelerate rapid urbanisation, infiltration of the population with defined geography, high population density, and the influx of population occupying peri-urban areas and hinterlands. These concentrations substantially increase disaster vulnerability, particularly in the lower strata. Migrants, for example, settle in peri-urban areas that are either originally unsafe (susceptible to floods, landslides, etc.) or create the potential for man-made disasters (environmental degradation, slum fires, health hazards, etc.)

b. Health Needs Assessment

Health Need Assessment (HNA)

Community health needs assessment is a process that describes the state of health of local people, enables the identification of the major risk factors and causes of ill health, mapping of opportunities and community resources for effective actions to address the issues. HNA should be used for planning action related to health and health determinants. HNA should be carried out at least once every two years to monitor the outcomes of programme implementation.

While the population-based screening for NCD will continue with a targeted approach for addressing disease burden, special focus has been stressed on the Health Needs Assessment (HNA) of the households.

Process of Health Need Assessment:

Health Needs Assessment (HNA) of the population is envisaged as a tool to understand the disease burden in various contextual settings and the enabling factors to facilitate access to universal, affordable, and equitable health services in urban areas. HNA may be conducted on the lines of the Community Based Assessment Checklist (CBAC) at the individual level in

each house in the urban areas, and family folders need to be created, as envisaged under the Ayushman Bharat Health and Wellness Centres (AB-HWC) program.

HNA should be linked with the implementation/ action plans related to health and non-health areas to deliver results that foster positive change in the indicators of the urban population, including those of the vulnerable population.

4.5 Various Levels of Urban Health Facilities

The 2013 NUHM framework described the service delivery through two types of fixed health facilities in urban areas, viz. UPHC has a 50,000 population (preferably located within or near slums), and UCHC at 2.5 lakh population (5 lakh in metros). Outreach functions in the catchment area of the UPHC are undertaken by ANMs and ASHAs, with a normative coverage of a population of 10,000 by one ANM and 1000-2000 population by one ASHA. Mahila Arogya Samiti (MAS) is functional in urban areas covering a population of 50-100 households (250- 500 population). The platforms for service delivery have been augmented in IPHS 2022, along with details of service delivery.

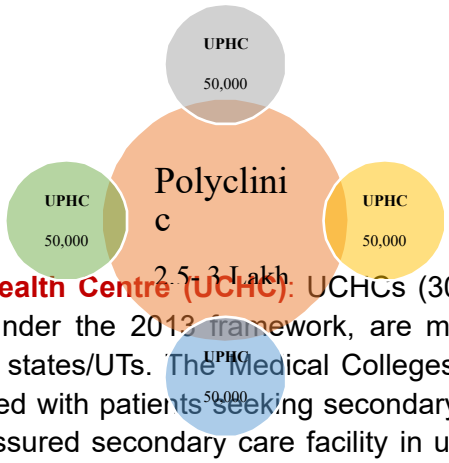
The NUHM framework 2023 envisages the following four levels of urban health facilities to provide comprehensive primary and secondary care services to the entire urban population-

a. Urban Health and Wellness Centre (UHWC) will be established for a 15,000-20,000 urban population. It is suggested that the construction of UHWCs be undertaken wherever suitable land is available within 2-3 km of the periphery of the slum/slum-like population. The location and population coverage of the Urban HWCs could be flexible depending on population densities and the presence of vulnerable and marginalized population subgroups. The urban HWCs are expected to increase their reach in urban areas and cover the vulnerable and the marginalized by acting as satellite centres to be established under the UPHCs. Each UPHC that caters to a population of approximately 50,000 is expected to have 2-3 UHWCs under it, depending on the vulnerable population of the urban local body.

b. Urban Primary Health Centre-HWC (UPHC) at 30,000-50,000 urban population (to saturate all urban areas)

c. Specialist UPHC/Polyclinic at 2.5-3 lakh population by strengthening one out of 5-6 existing UPHCs.

Figure 6: Polyclinic and its linkages with UPHCs



d. Urban Community Health Centre (UCHC): UCHCs (30-50 bedded in-patient facilities), which were envisaged under the 2013 framework, are minimally functional or even non-functional in most of the states/UTs. The Medical Colleges providing tertiary care in urban areas are still overcrowded with patients seeking secondary as well as tertiary care. Hence, there is a need for an assured secondary care facility in urban areas through defining and

implementing a robust referral network. The UCHCs, as defined under IPHS 2022, should provide assured secondary care services to 2.5 lakh population in non-metros and five lakhs in metros. *(Can be optional if assured secondary care through SDH/DH is available).*

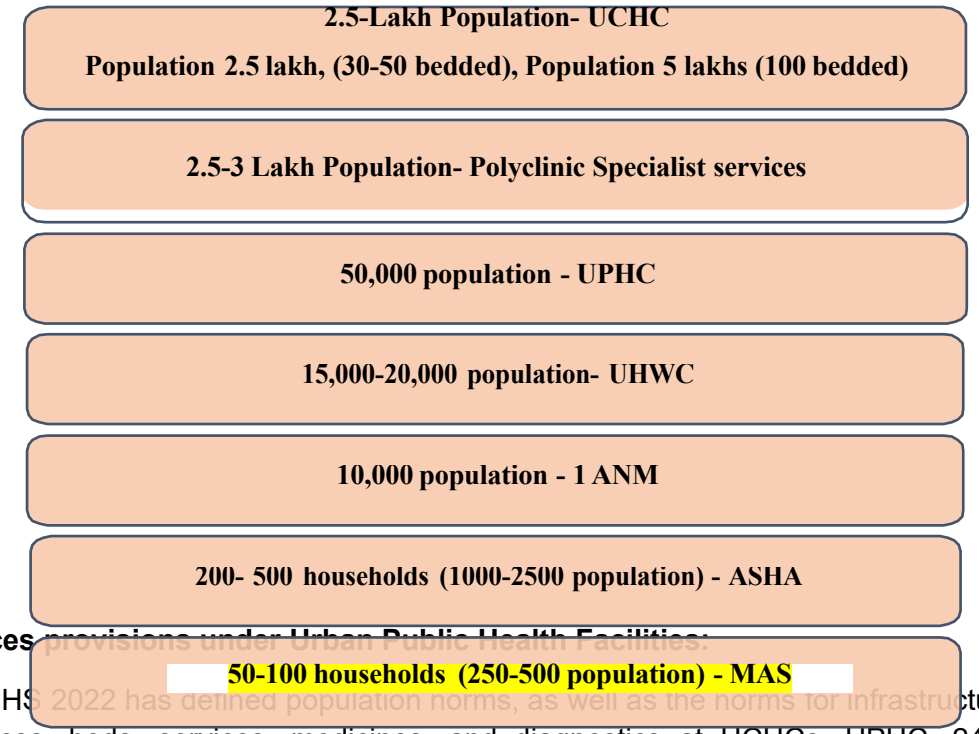
Where existing UCHCs are available, they can either be upgraded to function as a full-fledged 50-bedded secondary care facility like SDH (100-bedded in metros and 50 50-bedded in non-metros) with a complete range of secondary care services (as defined under IPHS 2022), or they may be converted into polyclinics with all assured services.

Note:

The States and UTs have the flexibility to plan the various levels of health facilities in any given City/District based on a critical gap analysis of the total urban population, existing health facilities (*UPHC, UCHC, SDH or a DH or any State level Dispensaries / Public Health Facilities)* and the required numbers of urban health facilities as per their local context and needs. The number of urban health facilities may be planned to saturate the entire urban population in the City/District. The UHWCs covering the 15,000-20,000 population may be established in peri-urban/outgrowth areas if they have no existing health facilities.

In some states, pre-existing UPHCs are functioning as 24x7 UPHCs-HWCs with indoor beds and providing delivery services. Such facilities shall continue to function as 24x7 facilities. The States would have the flexibility for establishing UPHC-HWCs at 30,000-50,000 urban population and 15000- 20000 population through UHWCs as per the local context

Figure 7: Urban Health Services



Services provisions under Urban Public Health Facilities:

The IPHS 2022 has defined population norms, as well as the norms for infrastructure, human resources, beds, services, medicines, and diagnostics at UCHCs, UPHC, 24x7 UPHC, Polyclinic and UHWCs. All urban health facilities need to comply with the IPHS 2022 norms and build public health facilities resilient to any future pandemic or calamities. This will

continue to be supported under NHM within the permissible resource envelopes of states and UTs.

Table 12: Services provisions

Urban Health and Wellness Centres	• To provide all 12 packages of services envisaged under Ayushman Bharat-Comprehensive Primary Healthcare. • National health programmes with a focus on preventive/promotive activities, population-based screening, assured medicines, diagnostics, teleconsultation, need-based outreach activities and public health actions. • Enable strengthening the continuum of care through providing access to high-quality care closer to the urban community, ensuring upward and downward linkages, minimizing out-of-pocket expenditure, and acting as gatekeepers to decongest secondary and tertiary health care facilities. • Enable improved disease surveillance and reporting for epidemics/outbreaks and risk factor mitigation through health promotion and wellness activities.
Urban Primary Health Centre	• To provide all 12 packages of services envisaged under Ayushman Bharat-Comprehensive Primary Healthcare. • To provide routine OPD care including preventive, promotive, rehabilitative, and palliative care along with other public health interventions.
Polyclinics	• In urban areas, currently, 5-6 UPHCs are catering to a population of 2.5-3 lakhs; one of the UPHCs, among these 5-6 UPHCs, would be identified to be upgraded as a Polyclinic (depicted in image below). • Ensure a continuum of care by providing specialty services (medicine, obstetrics and gynecology, paediatrics, ophthalmology, dermatology and psychiatry) closer to the community. • Polyclinic should plan and provide oral, physiotherapy and/or optometrist services also, as per local requirements. • Diagnostic services for all the specialties concerned along with point-of-care testing should be made available at polyclinics.

	• Some of the specialized services such as X-ray, USG, CT scan, etc. are not essentially needed to be there but if required can be linked with the facility available nearby like FRU CHC, SDH or DH. • For areas with functional Urban CHCs (UCHCs) providing specialist services, separate polyclinics may not be required.
Urban Community Health Centres	• If UCHCs are non-functional and a functional SDH exists, the States can strengthen SDH to provide secondary care services instead of creating a new UCHC. The District Hospital would be the apex referral centre for every district/city for the urban population. • The services at UCHC will include emergency services, OPD services, integrated counselling services, IPD services, diagnostics and referral services. • NHPs should be delivered through the UCHCs with Integration with other existing programmes to provide comprehensive services.

Table 13: Comprehensive Primary Healthcare Package

The UHWCs and UPHCs would serve as AB HWCs and provide comprehensive primary care through the expanded range of services covered, namely-

1. Care in pregnancy and childbirth
2. Neonatal and infant health care services
3. Childhood and adolescent health care services
4. Family planning, Contraceptive services and other Reproductive Health Care services
5. Management of Communicable diseases, including National Health Programmes
6. Management of Common Communicable Diseases and Outpatient care for acute simple illnesses and minor ailments
7. Screening, Prevention, Control and Management of Non-Communicable diseases
8. Care for Common Ophthalmic and ENT problems
9. Basic Oral health care
10. Elderly and Palliative health care services
11. Emergency Medical Services
12. Screening and basic management of Mental health ailments

e. Outreach

Community-based outreach enables the establishment of a strong linkage between the health system and inhabitants of the local community, provides scope for community participation and ensures the necessary continuum of care for the population between the three levels of health care (i.e., primary, secondary and tertiary) and the community, especially the slums and vulnerable groups in urban areas. Moreover, outreach has a very crucial role not only in preventive function but also in health promotion. Preventive strategies aim to slow down the incidence of disease, disability (and its social impacts), and premature death through a reduction in the prevalence of disease precursors and associated risk factors in the population.

However, with the inclusion of UHWCs and Polyclinics under NUHM, the **need for regular UHND and special outreach will be reduced as both primary and specialist care is being provided closer to the community but may be planned as per local contextualisation.**

The outreach should continue with a focus on preventive and promotive activities. Curative services may be continued if already being provided. Instead of program-specific outreach, a convergent model of outreach that comprehensively covers more than one programme would be preferred. Hence, depending upon requirements, the UHND and special outreach sessions may be planned to comprehensively cover socio-demographic and health programs-related aspects with the aim to:

1. Reach out to under-served and vulnerable communities who fail to access facility-based services with quality doorstep services (preventive and promotive)
2. Undertake population-based screening
3. Assess the risk of the community members for non-communicable diseases (through CBAC)
4. Generate awareness and disseminate knowledge within the community regarding social determinants of health through BCC intervention strategies
5. Enhance health-seeking behaviour through social and behavioural change communication.
6. Strengthen community engagement through ASHA and ANMs
7. Routine public health surveillance activities.

The two categories of outreach for urban areas are to be planned as below:

1. Urban Health and Nutrition Day (UHND)

Monthly UHND may be planned especially for the population with lesser access to services at UHWC or UPHC. Such UHNDs, which basically correspond to VHNDs in rural areas, should focus on preventive and promotive activities along with nutritional counselling. Curative services will be optional and as per local needs.

2. Need based Outreach

Need-based periodic outreach sessions with various kinds of specialised field-based services for identified slums/vulnerable population subgroups, to be organised as per the specified local healthcare needs or to tide over exclusive circumstances (such as disasters, CBRN, etc.). The various categories of need-based outreach may be:

a) Program-specific outreach
b) Special health drives, vaccination drives
c) Convergence activities like Poshan Pakhwada, health meals other community-based events by involving other departments/ministries
d) Public health surveillance and outbreak investigation (beyond that routinely done through UPHC/UHWC)
e) Disaster mitigation/ disaster management activities
f) Targeted interventions

f. Public Health Surveillance

In the scenario of urbanization and international migrations, the threat of public health emergencies and emerging diseases of pandemic potential (COVID-19, Influenza, Ebola, NIPAH, etc.) is increasing alongside endemic conditions such as tuberculosis, leprosy, malaria, typhoid, dengue and hepatitis infections. Meanwhile, the epidemiologic transitions are giving rise to a steep increase in the non-communicable disease burden. These NCDs can be addressed only by concurrent public health surveillance and response systems at national and sub-national levels with a focus on disease prevention.

The States are encouraged to develop strategies for creating an urban disease surveillance system and a plan for rapid response in times of disasters and outbreaks to feed into the IDSP/IHIP portal ultimately. It is envisioned that an integrated GIS-based

system should be developed and integrated into the disease surveillance and reporting system on a regular basis. This system should also be synchronized with the IDSP surveillance system, which shall enable the provision of data on the stratification of disease outbreaks in urban areas. Further, all such epidemics, outbreaks, etc., need to be reported at the District Integrated Public Health Laboratory (DIPHL) for timely public health actions.

The framework recommends enhancing disease surveillance for both communicable and non -communicable diseases in urban areas by fostering synergy among various programs. This is achieved through an integrated and interdisciplinary approach at the city level, promoting collaboration and coordination among Disease Control Programs, the National AIDS Control Programme (NACP), programs associated with the National Urban Livelihoods Mission (NULM), and Disaster Management initiatives. Urban Local Bodies (ULBs) are tasked with overseeing these efforts to facilitate early disease detection, preparedness, efficient surveillance, and timely interventions. A rapid response team with a multi- disciplinary officials which includes a district administrative head - Commissioner Municipal Corporation/ municipality/ town panchayat, ULB Chief Medical Officer, District Public Health Officer, epidemiologist, entomologist/zoologist, food safety officer, animal husbandry official, representation from the police department, drug controller and academic representation from Medical College (Community Medicine/ General Medicine), needs to be in place in every identified urban area, under the district collector for timely and effective management of any potential outbreaks in the future.

This approach aims to strengthen the urban healthcare system's ability to respond promptly and effectively to health threats.

4.6 Public-Private Partnership

Over the three rounds of the National Sample Survey (NSS), more than two-thirds of the respondents (79.3%, 75%, 70%) availed of outpatient care in the private sector. People from Jammu and Kashmir have availed maximum services (69 per cent) from the public sector, whereas 86 per cent of the population in Uttar Pradesh availed services from the private sector. In the 75th round of data, it is seen that nearly three-fifths of the hospitalized cases (58 per cent) were treated in the private sector.

Urban areas often have higher population densities, which can strain public healthcare systems. PPPs can help expand in various ways, such as healthcare infrastructure, such as hospitals and clinics, preventive and promotive functions, thereby making it easier for residents to access health services. Under the ambit of PPPs, any private sector consisting of individual practitioners, small nursing homes, clinics, private hospitals, not-for-profit organisations, charitable hospitals, or those run by NGOs, CBOs, CSRs, etc., can be roped in to strengthen the healthcare system towards increased sustainability.

Previous experiences in NUHM implementation suggest that most of the private sector rendering health care in urban areas are largely providing curative services only. The preventive and promotive aspects of primary care, along with outreach coverage, are generally left out. So, the PPP mode for services should comprehensively provide primary or secondary care, bringing more agility and innovation in adopting new technologies and diversification of services (both clinical and wellness services).

It is therefore important that, while the public health system should endeavour to provide quality, assured and accessible services, collaboration with private partners, wherever required, can be undertaken through **strategic purchasing, which can be used in various areas of healthcare systems, including those involving PPPs, to optimize the use of available funds and improve healthcare outcomes.**

Who can collaborate?

The potential partners for public-private partnerships:

a) Private service providers or NGOs/CBOs, trusts and charitable/philanthropic organizations/CSRs
b) Public partnerships, i.e., partnerships with Railways hospitals, ESIC, Public sector Unit hospitals, etc.

Various Modes of PPP:

The system should select a rational mode for PPP. There are many modes popular in the country for various types of services. Partnerships can be *Contracting in* or *contracting out*, *Grant in Aid*, *Leasing* or *Rentals*, *Profit sharing*, and *Subsidies.*

To strengthen the existing public health systems, partnerships between the private and public sectors may be developed through three basic models:

1. **Infrastructure–based model** – to build or refurbish public healthcare infrastructure
2. **Discrete Clinical Services model** – to add or expand service delivery capacity
3. **Integrated PPP model** – to provide a comprehensive package of infrastructure and service delivery

In the context of NUHM, the possible areas for public sector support can be explored for Public health functions and Health Systems strengthening:

Capacity building and training of the healthcare staff and ULBs
Service provisioning and outreach through tie-ups with private practitioners at the community level, in schools, etc., referrals for secondary/ tertiary care services
Mentoring of ASHAs and MAS, etc.
IT-related services
Diagnostics – (Low volume, high-cost tests through private labs) and Radiology services (Including various radiology models like teleradiology, empanelled radiology facilities, etc.)
Ensuring easy availability of generic drugs through pharmacies
Public health surveillance
Providing Human Resources for Health
Innovations in healthcare
Strengthening infrastructure and clinical services at existing UPHCs, UHWCs, Polyclinics
Provision of high-end diagnostic services at U-PHC and U-HWCs in the hub and spoke model

An optimal mix of the above needs to be considered to augment the urban healthcare system. The decision as to which is the best mix for any State may be taken by the State in the best interests of the urban population needs.

Key features of a robust, transparent, reciprocating outcome-oriented PPP:

Well-defined TOR: The partnership should comprise of well-defined agreement (and monitoring of ongoing PPPs & TORs) between the two parties in terms of payment mechanisms, key performance indicators, quality parameters, contingency planning, CSR and or NGO engagements, roles and responsibilities, etc.

Monitoring and Evaluation: The system should devise a well-defined monitoring mechanism to evaluate the working of the PPPs.

Regulation: An adequate mechanism should be developed to prevent malpractices by private partners.

Accountability: A grievance redressal mechanism should be developed as an integral part of service delivery, which can help in identifying and addressing the existing pitfalls in the designs, planning, and implementation of programmes.

State scenario

4.7 Corporate Social Responsibility Engagement

Support from corporate citizens, including CSR funding, can provide a fillip to the government's efforts to build focus on urban healthcare. The need for financing addition to / upgradation of the healthcare delivery infrastructure and supporting large skilling programs for healthcare workers and paramedics will be a worthwhile investment of CSR funds. This opportunity can be harnessed for urban healthcare, following a model similar to that of Aspirational Districts. Furthermore, there is a need for promoting the potential of Centres of Excellence and establishing an Urban Health Innovation Mission to inject new energy into the urban healthcare landscape.

CSR initiatives

4.8 Innovations

Innovations are stated as a strategic path that can be adopted by the States and ULBs/Municipal Corporations to achieve the goal of universal access to equitable, affordable, quality healthcare services. Innovations under NUHM should have a holistic approach, be evidence-based, and be designed to address the priority challenges of the urban population.

Due to the enhanced scope of services in urban areas, innovations need to be encouraged and taken up in a planned manner in areas such as strengthening the public healthcare referral system, supply chain mechanisms, preventive and promotive approaches and continuum of care.

Areas Innovations

The areas for innovations in urban areas may include health systems, service delivery- better referral systems, communitisation, BCC, programme and process, and IT innovation (New Vaccines and Drugs, Medical Devices, IT, m-health, and telehealth/ E-health).

Besides, some possible areas that can be explored under innovations: blended financing options such as municipal bonds, green bonds, and health bonds; insurance and risk protection models; models at the intersection of health and livelihoods – community health entrepreneurs, care-economy-centric models; kiosk-based service delivery models in public places such as metro stations, bus stops etc.

The State/ULB should explore further areas requiring innovative approaches to deliver effective and efficient health services in their urban areas.

They offer a range of routine healthcare services, such as general health check-ups, antenatal and postnatal care, safe delivery guidance, immunization, childhood disease management, birth spacing advice, adolescent health counselling, laboratory services, TB detection through sputum collection, referrals, and health education.

A recent initiative involves weekly OPD sessions by Medical Officers, with support from medical colleges in Amritsar and Patiala, along with outreach camps conducted by specialists from these medical colleges. Additionally, weekly counselling services are provided by ICTC counsellors covering topics like adolescent health, family planning, RTI/STI, and HIV testing. These kiosks aim to improve healthcare access and awareness among urban communities.

4.9 Information, Education, Communication (IEC) and Behaviour Change Communication (BCC)

The behaviour of individuals and populations has a direct role in reducing disease morbidities and mortalities. Thus, for a community to be healthy, promoting positive health behaviours is as important as providing healthcare services. IEC and behavioural change communication is the key to ensuring positive health behaviours are inculcated in the community. While the States are actively engaged in IEC and BCC activities, their effectiveness in terms of generating awareness and promoting the use of health services in public health facilities has been limited. Therefore, enhanced focus is needed for IEC and BCC to create awareness about primary care health facilities within easy reach of the community. This initiative holds the potential to alleviate the issue of overcrowding at secondary and tertiary health care facilities.

The revised framework impresses upon Information, Education, Communication (IEC) and Behaviour Change Communication (BCC) as a systematic application of interactive, theory-based, and research-driven communication processes and strategies to address change at an individual, community and societal levels.

The BCC strategies should be able to:

i. Increase knowledge and change attitudes of individuals, families, communities, and health providers towards health
ii. Promote an environment where communities and key influencers support positive health behaviours
iii. Reduce barriers for vulnerable populations to demand and access health services
iv. Increase the faith of people in the public health system

States/UTs need to undertake action in the following areas to bring about health promotion and behaviour change communication:

i. Employ digital technologies to encourage and support behaviour change for health promotion.
ii. Coordination with stakeholders involved in implementing social determinants of health, such as housing, livelihoods, water, sanitation, education etc., to promote societal well-being.
iii. The health facilities maintain a schedule of Weekly Wellness Clinics throughout the year.
iv. The promotion of wellness will be integrated with the appropriate 42 calendar health days observed by AB-HWC teams.

The Ayushman Ambassadors/Health and Wellness Ambassadors programme intends to ensure age-appropriate, skill-oriented, theme-based sessions for school children. Every Tuesday is dedicated to Health and Wellness Day in the schools.

Stakeholders other than health functionaries in behaviour change include State Governments-Law and policymakers, Urban Local Bodies (ULBs), NGOs, Self-Help Groups, Community Health Volunteers, Anganwadi Centres, Media- social media, TV channels, radio, etc. and the private sector in health.

Community Platforms for BCC activities

The engagement of community platforms like MAS, ULBs, Community Health Volunteers and Self-help groups has impacted in modifying the behaviour of the population in seeking health services. To further this impact, it is essential to provide training in integrated counselling for frontline health workers and MAS members.

Behaviour Change Communication (BCC)

1. Generating awareness:

- Health behaviours
- Health services

2. Use mass media, posters, pamphlets, etc.

a. Facility-based BCC

- Citizen Charter
- Program-related posters

Impact behaviour

- Lifestyle changes
- Health-promoting habits

Individual, family, groups, community, etc.

b. Community-based BCC

- Outreach sessions
- Counselling

Household production of health

With the advent of newer initiatives in urban health and the provision of health closer to the community, it is now imperative to focus on the approach of 'communitisation' of health by making it a people's movement. **Details on Communitisation can be accessed in Chapter 6.**

Chapter 5

Health Systems Strengthening

WHO recognises the building blocks of the health system as service delivery, health workforce, information, medical products, vaccines, and technologies, financing, and leadership and governance (stewardship). While service delivery and financing are indeed discussed in separate chapters (Chapter 4 and Chapter 9 respectively. The other relevant health system strengthening components are described as part of the Indian Public Health Standards (IPHS).

5.1 Indian Public Health Standards

To improve the quality of services and provide a uniform benchmark to assess the functionality of public health facilities, a set of standards known as the Indian Public Health Standards (IPHS) was first developed in 2007, updated in 2012 and revised in 2022. These standards cover Sub Health Centres (SHCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDHs) and District Hospitals (DHs) in both rural and urban areas. IPHS provides guidance on the infrastructure, human resources, services, medicines, diagnostics and quality requirements for delivering health services at these facilities.

The component-wise details as per IPHS 2022 are elaborated below:

a. Infrastructure

- The 2013 framework suggested setting up and operationalising urban health facilities in rented premises since the availability of land is an issue in urban areas. However, it is now time to strengthen the health systems in the country in the urban areas as in the rural areas so that they sustain themselves in the long run.
- The UPHCs which are running in rented premises be gradually shifted to the appropriate government buildings as far as possible. States need to plan in such a way that each UPHC has its own building and none of the facilities operate in a rented building. Hence, wherever suitable land is available with the State/State Health Department or any other government department/Ministry or is provided by the ULBs/Municipal Corporations in urban areas, new construction of buildings for UPHCs and UHWCs needs to be undertaken.
- However, the states/UTs may continue providing services through rented UPHCs/UHWCs, where land is not available, or it is not feasible to undertake construction. Geotagging of all urban health facilities (UCHC/UPHC/Polyclinics/UHWCs) is a pre-requisite, irrespective of the source of funding, viz. NHM, PM-ABHIM or XV Finance Commission health grants for urban areas.

b. Medicines, Diagnostics and Equipment

Availability of medicines and diagnostic services is one of the key enablers for improving access to healthcare in public health facilities, leading to improved health outcomes. All levels of urban health facilities need to provide a complete package of quality medicines, diagnostics and necessary equipment as per the norms prescribed in the IPHS 2022 and Free Drugs and Diagnosis Services Initiative.

Medicines-

- Medicines are an integral component of the public health system. The unavailability and stockouts of essential medicines are leading causes for the increase in Out-of-Pocket expenditure.
- The Free Drugs Service Initiative was started with the objective of strengthening the availability of medicines in public health facilities with the funds available under NHM/NUHM. The standards for the provision of medicines through urban health facilities would follow the IPHS 2022 for all levels of urban facilities ensuring the availability of essential medicines as per the Essential Medicines Lists (EMLs) along with norms of NHM Free Drugs Services Initiative and AB-HWC guidelines.

- Essential medicines list is a commensurate list that is also dynamic in nature, and changes can be made in EML based on facility service provision, number of beds, and programme guidelines.
- In urban facilities provisions must be made for dispensing monthly requirement of medicines to the patients. Uniform Standard Operating Procedures (SOPs) for indenting, stocking and transportation of medicines, vaccines and logistics need to be ensured.
- All essential medicines should be available free of cost in all UHWCs/UPHCs/U-CHCs under the 'Free Drug Service Initiative' of GoI. Also, ensure the drugs for the management of chronic illnesses such as diabetes and hypertension for long-term dispensing (one to three months).
- Centralised procurement under NHM with robust supply chain management would be required for the timely and adequate provision of medicines at various urban facilities.
- An IT enabled platform DVDMS (Drugs & Vaccine Distribution Management System) which functions with multiple modules for automating the workflow of the procurement, supply chain, quality control, etc., is to be ensured.

Diagnostics

- It should be ensured that an in-house strengthening of laboratories at primary healthcare facilities in urban areas is to be planned with the funds available under NHM/NUHM as well as the XV Finance Commission health grant for diagnostics. However, Gap analysis needs to be undertaken for the required diagnostic infrastructure, duly factoring in HR availability and diagnostic care policy of the State/UT.
- For urban areas, the aim should be to ensure access to free-of-cost and quality essential diagnostic services to all sections of society including poor, middle- and high-income groups.
- May include diagnostic sample collection facility with Barcode/QR coded sample containers for sample labelling, identification, transportation and tracking. Effective LIMS for assured linkages with the hub labs and ensuring quick turnaround time.
- Ministry of Health and Family Welfare, Government of India has launched the revised guidelines on Free Diagnostics which ensure the availability of an expanded basket of essential tests in public health facilities including Urban settings which is to be referred for compliance and adherence.
- For urban areas, no single service delivery model can be the best fit for the challenges imposed in service delivery of diagnostics. The thrust should be to strengthen the diagnostic services through an inhouse model, particularly for point-of-care diagnostics and routine high-volume low-cost tests.
- For higher-end advanced diagnostics services, a hub and spoke model within public health facilities may be adopted. The hub can be a District Hospital Lab/ Integrated Public Health Laboratories at the district or Medical College or any other public laboratory set up for the purpose. The availability of a robust Lab Information Management System for recording and reporting test results for achieving quick turnaround time is essential in the urban setting.
- Protocols for sample collection, transportation and reporting need to be defined. Private laboratories are to be roped in areas where no public labs are available. e-

Sanjeevani platform to be utilised for investigations like ECG, X-rays & USG in urban polyclinics and higher facilities.

- The teleradiology & tele-imaging services can be planned either in-house or through PPP model wherever radiologists are not available. PPP outsourcing in urban settings may also be useful for high-end low-volume tests like viral markers, hormonal assays, etc.

Medical equipment

- The equipment mentioned under IPHS should be included in the list of essential equipment at different levels of facilities. However, the list is not exhaustive and additional equipment, if required, can be procured to provide the full range of services being offered at the facility.
- All the necessary equipment to provide clinical, support and other services should be meeting essential quality parameters through the state procurement policies and procedures. The Biomedical Equipment Management & Maintenance Programme (BMMP) is an initiative by the Ministry of Health and Family Welfare to provide support to state governments to outsource medical equipment maintenance comprehensively for all facilities to improve the functionality and life of equipment, Internal Quality Control (IQC), External Quality Assurance Services (EQAS) and Validation of procedures and equipment need to be incorporated as an essential measure.
- Centralised procurement under NHM with robust supply chain management and digitised indenting mechanisms (centrally connected) are required for timely and adequate provision of drugs, diagnostic tests at facilities and improved quality of record keeping along with timely forecasting for drugs.

c.Human Resources for health

Human Resources for Health are essential for the development and sustainability of healthcare systems. The National Sample Survey (NSS) data from the 75th round (July 2017 to June 2018), reports a significant difference in HRH density between the rural and urban areas. In urban areas, the density of allopathic doctors is 11.4 times that in rural, whereas the same for nurses and midwives is 5.5 times higher.

Despite this, the non-availability of doctors and specialists (clinicians) in required numbers has been an area of concern for urban areas, which may be attributed to factors like lower pay scales, lack of professional satisfaction, opportunities in the private sector, juggling with administrative works etc.

Hence, robust HR policies and governance, recruitment, and implementation of public health management cadre for managing issues like attrition, competitive salary structure, career progression, job safety etc. need to be ensured.

Some HRH strategies for improving human resource availability in urban areas in the revised framework include:

- Integration and streamlining of recruitment processes and shortening of recruitment cycles using established methods. For example, using empanelled agencies.
- State to provide staff from the Regular cadre for the urban health facilities as is being given for rural areas for ensuring sustainability and better health outcomes.

- Contextualization of the HRH strategy and plan as per local requirement.
- Arrangement of adequate financing to create sanctioned posts as per IPHS.
- Ensuring full operationalization with a full complement of staff to retain the trust of the community and provide quality care.
- Providing lucrative salaries to ensure all posts are filled. To tackle the issue of attrition of HR in urban areas the salary offered may be kept at par with the State Govt /NHM norms. If required, the adoption of the "You quote We pay" scheme under NHM may be undertaken for specialists.
- Insourcing of specialists as per requirement.
- Some initiatives such as utilising retired clinical HR, and use of nursing students, trainees and interns from various government training institutes could also be considered.
- Provision for paying performance-based team incentives after achieving over and above the defined threshold of performance.
- Leverage not-for-profit organizations/ private sector/ CSR.
- Developing capacities of ULBs, and health departments in managing HRH for urban areas.
- In case of high footfall facilities with long queues, multiple shifts (morning/ evening/ afternoon) may be planned with the help of empanelled agencies.
- The Availability of nurses, ANMs, lab technicians and health workers like ANMs, MPWs is also an issue in urban areas largely because of the wider availability of job opportunities in the private sector. They form the core workforce for facility-based, community-based health services including outreach. Recruitment for frontline workers can be undertaken in convergence with other welfare departments like NULM etc.
- The public health managers (PHM) may be appointed for the day-to-day management of UHWC and UPHC-HWC and overseeing the implementation of initiatives affecting social determinants of health as per the requirement and caseload of the health facilities.

Capacity Building

- One of the weak areas in NUHM had been staggered efforts at capacity building of the human resources at the facility, district/city, and state level. The revised NUHM framework reiterates the importance of effective, timely and comprehensive capacity building and skill development exercises of health functionaries in urban areas, right from service delivery to programme management staff., to meet the goals and objectives of NUHM.
- Institutions to be identified for supporting the capacity-building initiative for urban health in the states. Direct mentoring and handholding on various guidelines and norms should be encouraged and undertaken periodically by the MoHFW/NHSRC for the district/city and block-level functionaries. The use of virtual platforms for such mass training to be explored to build capacities of large numbers of health functionaries across the states and UTs.
- Capacity building of Human Resources for Health in addressing diverse population health needs including behavioural aspects of health service providers.

- A capacity-building module for ULBs needs to be developed at the National and State levels. Standard modules to be developed for the newer training outlined for Comprehensive Primary Health Care.
- Supportive supervision mechanisms for assessing the quality and implementation of training programmes need to be ensured.

d. Quality Assurance

National Quality Assurance Standards

- Considering the urban health infrastructure and explicit scope of service provision for urban primary health care, the NQAS was developed exclusively for Urban Primary Health.
- Centres (UPHCs) in the year 2016 helped states create a credible quality management system that offers a standardised process for monitoring and evaluating the quality of healthcare services. Updating the standards for Urban Primary Health Centres (UPHCs) and creating standards for Urban Health and Wellness Centres (UHWCs) is in progress.
- 'Operational Guidelines for Improving Quality in Public Healthcare Facilities-2021' defines the roadmap for ensuring Quality of Care (QOC) in the delivered services in Public Health Facilities.
- It would be necessary for the large metropolitan cities with independent ULBs to create their own Metropolitan/City Level Quality Assurance Committee under the respective Municipal Commissioners, Chief Medical Officer, and ULB Level Quality Assurance Nodal Officer in line with norms for Regional Quality Assurance Units as per Operational Guidelines for Improving Quality in Public Healthcare Facilities-2021. The state Nodal Officer Quality may be part of this body to ensure integration with the state-level quality organisational structures and state certification process.

Kayakalp Initiative

- In addition to the NQAS, the 'Kayakalp' initiative is also under the ambit of the National Quality Assurance Framework, which extends to Urban Primary Healthcare facilities. With the launch of Swachh Bharat Abhiyan by the Prime Minister on 2nd October 2014, which focuses on promoting cleanliness in public spaces, the Ministry of Health & Family Welfare, Government of India launched 'Kayakalp Incentive Scheme' in May 2015 as a National Initiative to give awards to public health facilities that demonstrate high levels of cleanliness, hygiene, and infection control.
- The Kayakalp incentive scheme was extended to urban health facilities in FY 2017-18 to recognize and incentivize all the public healthcare facilities with exemplary performance.

Mera Aspataal Initiative

- The "Mera Aspataal/My Hospital" an ICT-based platform was launched to empower patients by seeking their views on the quality of experience in a public healthcare facility. The feedback for the services received at the public healthcare facilities is solicited through multiple user-friendly channels such as Short Message Service (SMS), Outbound Dialling (OBD) mobile app, and web portal in seven different languages within 7 days for the health facilities visited in the last 7 days. The

integration of urban health facilities of UPHC upwards is progress across all states and UTs.

- Attainment of Patient Satisfaction is a key criterion for NQAS certification for all levels of public health facilities. The Mera Aspataal score has also been integrated with the Kayakalp initiative through a weighted average scoring system for the Kayakalp awards.

5.2 Referral System

The NUHM emphasizes the establishment of an appropriate referral mechanism as one of the key components of delivering a continuum of care in urban areas. The urban healthcare facilities are envisaged to have effective referral mechanisms for all types of healthcare services like maternal health, child health, communicable and non-communicable diseases, trauma care, emergency care, surgical care, orthopaedic complications, dental surgeries, mental health, deafness control, cancer management, tobacco counselling, and palliative care.

Procedures for establishing effective linkages shall be developed, for eg., referred patients could have a referral slip, that ensures that a help desk in higher facilities attends to them, helping them navigate the complex hospital terrain for meeting the right doctor and getting diagnostics done on a faster pace which could be incrementally digitized as electronic referrals or referral app may be developed based on institutional capacity.

NUHM also seeks to improve the health status of the urban population particularly the urban poor and other vulnerable sections by facilitating their access to quality primary health care. For this the National Ambulance Services (NAS) is also to be utilized in the urban areas.

Taking into consideration the multiplicity of service providers in the urban areas, with the ULBs and State Governments jointly provisioning health care services, efforts are needed to have clear referral pathways, with defined facilities providing primary care, secondary and tertiary level care.

Some general points for consideration while placing ambulances for assured referral in the urban areas are -

- Ambulance services in states are to be organized in a way that there is universal access to services for the entire population through a systemic response mechanism, particularly during emergencies.
- Location or point of deployment of the ambulance should be determined both by the density of the population as well as the time-to-care approach.
- Response time: Once a call is centralized the response time for the ambulance to reach the patient/beneficiary should not be more than 20 minutes in urban areas. To accurately record the distance travelled and the response time, it is a prerequisite to install GPS tracking devices in all ambulances.
- Ideally, every call centre may be equipped with an updated and real-time directory of hospitals/health facilities for the provision of emergency medical services in its jurisdictional area. It also requires a similar directory for the availability of blood, diagnostics, trauma care and other lifesaving conditions. The call centre should also have a directory of Urban State officials, District CMOs, CPMs, and other programme officers, along with similar information about the health facilities & and their in-charges.

- To ensure an efficient ambulance service network, it is essential to monitor performance and utilization of each ambulance as well as of the call centre, based on indicators to measure performance, efficiency, efficacy and utility.

5.3 Information Technology & Teleconsultation

The vast IT platform for the provision of universal health care for the entire urban population can be effectively utilised. This framework promotes utilisation of National Teleconsultation Service, Tele-MANAS and e-Sanjeevani OPD for the urban population.

a.Healthcare technology

Teleconsultation

National Teleconsultation Service is the first of its kind online OPD service offered by a government to its citizens. National Teleconsultation Service aims to provide healthcare services to patients in their homes. Safe & structured video based clinical consultations between a doctor in a hospital and a patient in the confines of his home are being enabled. This platform provides telemedicine services for the communities through– a hub and spoke model which connects AB-HWCs (spokes) to district hospital/medical colleges (Hubs) for specialist consultation services and the other type of telemedicine services includes patient-to-Doctor (eSanjeevani OPD) teleconsultations which provides outpatient services to citizens in the confines of their homes.

Comprehensive Primary Healthcare IT ecosystem

The CPHC IT ecosystem at AB-HWCs would support the staff to understand health dynamics of the population by creating a database of the population in the catchment area of the facility. This would aid in recording the details of the beneficiaries seeking at the facility, track follow up of cases, disease surveillance and identifying any disease outbreak in the community.

Ayushman Bharat Digital Mission

It is created with an aim of developing the backbone necessary to support the integrated digital health infrastructure of the country. It will aid in bridging the existing gap amongst different stakeholders of the Healthcare ecosystem through digital highways. Important tools for which are ABHA, HFR and PHR. In urban areas also, creation of ABHA IDs for citizens and integration of the above building blocks will help in the development of a unique health database through digital public goods which can cater to the health needs of urban population and deliver services accordingly.

Chapter 6

Community Processes in Urban Context

People have the right and duty to be involved in the decisions affecting their healthcare. Communities can play a vital role in promotion of healthy behaviours and prevention of diseases.

The National Urban Health Mission envisages effective participation of the community in planning and management of health care services

For strengthening the health service delivery component, community processes are devised with a multisectoral approach, mandating special attention for reaching out to urban poor and vulnerable sections like construction workers, rag pickers, sex workers, brick kiln workers, rickshaw pullers and street children.

Both Public Healthcare systems, PPP modes and other innovative models, as deemed suitable by the states can be utilized for establishing the community processes in the urban areas. The former portion of this chapter describes the community level structures for establishing the community processes and the latter half deals with the execution models of the community process.

6.1 Existing Community Structures

a. Household level

ASHAs

- The **ASHA program** is a key component of the National Health Mission intended to achieve the goal of increasing community engagement with the health system.
- The **Urban ASHAs** play a significant role as **frontline health workers** in the urban areas. They serve effective demand–generating link between the health facility (UHWC/Urban Primary Health Centre) and the urban population.
- An ASHA covers a **population** ranging from **1000-2500** in urban areas
- ASHAs are the key drivers of **community-based care**, which has been entrusted to maintain interpersonal communication with the beneficiary families and individuals to promote the desired health-seeking behaviour

ASHA Facilitators

- ASHA facilitator needs to be provided in urban areas to **co-ordinate** the community processes.
- She/He is expected to be a **mentor, guide, and councillor to the ASHA**. She/He is also expected to provide support, supervise, build capacity of the ASHA and monitor the progress of the individual ASHA in their given area
- As in rural areas, **one ASHA facilitator for every 20 ASHAs** in a population of around 20,000 may be provided.
- In areas where there is no dedicated ASHA Facilitator, the Public Health Manager/ANM shall play the role of ASHA Facilitator

ANMs

- Auxiliary Nurse Midwife (ANM) is the key component of the urban health care delivery system.
- They form an important link between the Urban Primary Health Centers and the community, ensuring no one is left without access to basic primary health services.
- ANM through her services shall aim to overcome these barriers and provide accessible primary health care facilities to those who are unable to physically, financially and 'socially' access them.
- Each ANM is expected to provide services for a population of 10,000 (or 2000 households). She will have 4-5 urban ASHAs under her supervision, each responsible for a population of 1000-2500 (200-500 households).
- She will work closely as part of a team, which will include the MO, staff nurse and other functionaries at the UPHC, the Urban ASHAs she supervises and the AWWs in her catchment area.
- This will also help ensure continuum of care from the community and primary care facilities to higher referral centers, where appropriate

- The ANM will spend at least 2 days of the week in the field with her community. For conducting home visits, she will visit all cases flagged by the ASHAs, high risk pregnancies, service resistant households, families facing acute or chronic illness and unable to come to the UPHC.

Anganwadi Workers

- Anganwadi workers are women inducted through the ICDS scheme to manage the day -to-day functioning of an Anganwadi Centre
- Anganwadi workers perform outreach activities for collecting information on newborns, children less than 6 years of age, expectant mothers, and adolescent girls in their ward/allocated area.
- In addition to carrying the responsibilities of ICDS scheme, they assist the ASHAs and ANMs in the implementation of healthcare service delivery viz. immunisation, health check-up, antenatal care, postnatal care etc.
- Anganwadi Centres are the preferred location to hold Urban Health Nutrition Days

Other Volunteers

- For a well-co-ordinated community engagement, various programs and the local NGOs/CSOs have appointed volunteers for community mobilization.
- The peer educators under the adolescent health program, school teachers engaged in school health program, Community Health Volunteers, other local health care providers can be roped in to be a part of the community process

b. Community Level

Community platforms are constituted with an aim to promote healthy behaviour in the community, support & facilitate frontline health workers in community mobilisation and healthcare delivery, support community-based monitoring, ensure regular meetings and to foster social accountability of public health facilities. The MAS, RWA, WLC are the community-based platforms.

Ward Level Co-ordination Committee

- The Ward Level Coordination Committee (WLCC) can be constituted under the chairpersonship of Ward Councillor/Corporator, with adequate representation from ward functionaries
- These committees shall help in taking important decisions for dealing with health programs and social determinants of health, as mentioned in Chapter 7.

MAS

- The hitherto Mahila Arogya Samiti (MAS) needs to be strengthened to enhance its scope, capacity and empowerment, by ensuring participation of representatives from different backgrounds for effective addressal of social determinants of health
- Mahila Arogya Samitis is to be formed at the slum /vulnerable population level which will have representation from both male & female and from the sections considered most vulnerable in the local community.
- Wherever feasible, MAS may be made more inclusive by involving volunteers and members of all genders so that it is representative of the urban community

Resident Welfare Association (RWAs)

- In the non-slum areas, Resident Welfare Associations/Co-operative housing societies etc. may be considered as community-based platform.
- In areas where there is no dedicated ASHA, the Public Health Manager needs to coordinate with the housing societies/areas with no RWA/societies involving ANMs and other health workers so that no areas are left out.

6.2 Facility Level

a. Jan Arogya Samitis (JAS)

- JAS are Facility-based platforms formed for strengthening services available in Ayushman Bharat, constituted at Urban Health and Wellness Centres & Urban Primary Health Centres for community participation in management, governance and ensuring accountability, with respect to provision of healthcare services and amenities at these facilities
- JAS are also responsible to Mobilise resources (both monetary and non-monetary) from urban local bodies, other Government Schemes and Programmes, Corporate

Social Responsibility (CSR) Funds, and Philanthropy and Charity Organisations, and ensure its use for improving quality of services and undertaking Health Promotion activities at AB-HWCs

- The details of the team constituting a Jan Arogya Samiti, functioning and roles and responsibilities is mentioned at https://nhsrcindia.org/sites/default/files/2023-02/Guidelines%20for%20Jan%20Aarogya%20Samiti_0.pdf (Refer to annexure 1)

b. Rogi Kalyan Samitis

- Similar to the Jan Arogya Samitis, Rogi Kalyan Samitis are established societies constituted in all District Hospitals (DH), Sub District Hospitals (SDH), Urban Community Health Centers (CHC), and equivalent facilities.
- The Rogi Kalyan Samiti, as the name suggests holds the hospital administration and management accountable for ensuring access to equitable, high-quality services with minimal financial hardship to service users.
- These committees Serve as a consultative body to enable active citizen participation for the improvement of patient care and welfare in health facilities
- The RKS, as a part of the endeavour to enable assured health services to all who seek services in the government health facility will allow the hospital in charge to procure essential drugs/ diagnostics not available in the health facility out of the RKS funds
- The detailed structure and functions are laid out in the operational guidelines of Rogi Kalyan Samitis.

Figure 8: Community Structures under NUHM

c. Execution of Community Processes: Communitization

One of the key strategies, for effective execution of the roles and responsibilities of the structures envisaged under community processes, through a co-ordinated mechanism is termed communitization.

Figure 9 : Guiding principles for community processes in urban context

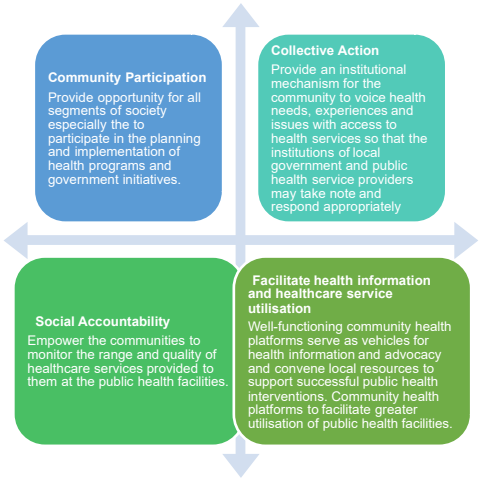


Figure 10: Objectives of executing community processes

6.3 Community platforms in NUHM:

NUHM envisages to proactively reach out to the urban poor settlements by way of regular outreach sessions and monthly health, sanitation and nutrition day. States are encouraged to involve NGOs to facilitate communitization process, build the capacity of ASHA and MAS and carryout IEC/BCC activities. It mandates special attention for reaching out to other vulnerable sections with a poor health seeking behaviour

a.Urban Health and Nutrition Days

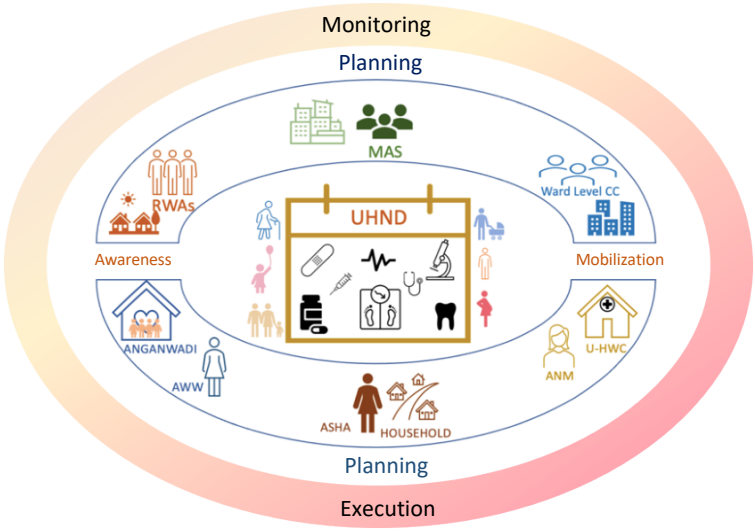
- In accordance with the village health and nutrition day, Urban health and nutrition days are envisaging, to be held at an Anganwadi centre or any other available community space focusing on outreach services
- All the community structures mentioned above, essentially till the community level should participate in planning and execution of the urban health and nutrition days
- In addition to the immunization, and other MCH services, the UHNDs serve as platforms for imparting health education and other program related IEC/BCC activities
- The funding for executing the UHNDs is provisioned in the NUHM flexipool, and the states can propose the same in the PIPs

b.Need based Outreach Activities as a part of various health programs

- Screening activities conducted as part of programs like NP-NCD, NTEP, SUMAN, RBSK etc. either on a house-to-house basis or camp-based approach constitute an important part of the community platforms

- Such activities are essential in both knowing the health status of the area and recognizing the citizens needing disease specific interventions, at a facility level.
- Accordingly informed decisions can be taken in the MAS while formulating the area level health action plan.

Figure 11 – Execution of Urban Community Platforms (UHND)



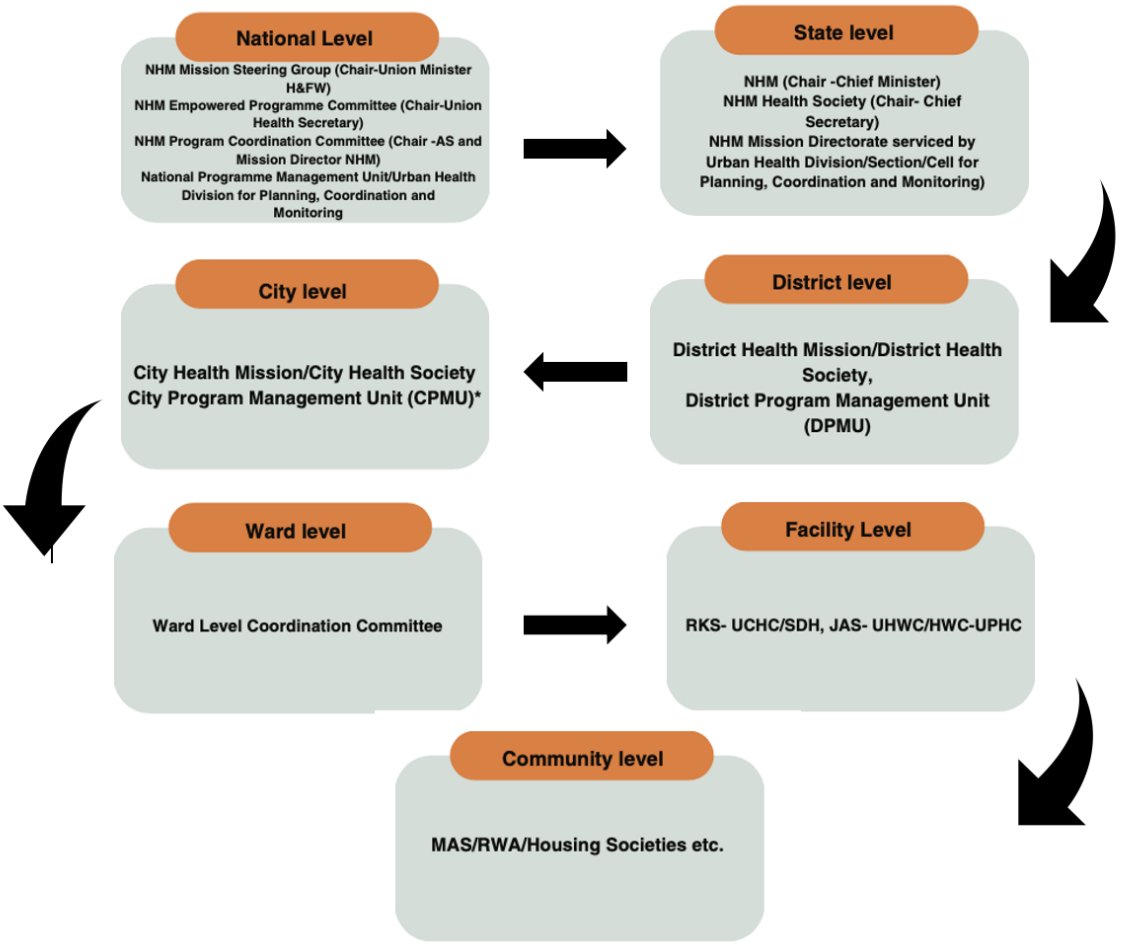
Chapter 7

Institutional Mechanism

7.1 Institutional Mechanism for Urban Health Mission

NUHM utilises the existing NHM institutional structures at the National, State, and District levels to operationalise Mission activities. There is a need to strengthen health department structures across all levels, develop a robust institutional mechanism, and establish structures for institutional convergence with the local bodies.

Figure 12: Schematic representation - Institutions for effective health planning



** CPMUs to be set up in Cities with Municipal Corporations*

1. National Level

The MSG under the Union Minister of Health and Family Welfare, the EPC under the Secretary (H&FW), with representations from MoHUA, and the NPCC under the Additional Secretary and Mission Director (AS & MD) NHM would continue providing overall guidance and making policy-level decisions. The Urban Health Division of the Ministry, with support from NHSRC, would continue to facilitate the planning, coordination and monitoring of NUHM in the States and UTs.

Under the Secretary (H&FW), EPC holds periodic meetings at defined intervals to monitor the progress under NHM. NUHM being a sub-mission of NHM, the same committee will be utilised for making decisions on urban health issues. At this level, inter-ministerial committees can also be formed to oversee health-related activities involving various ministries. MOUs may be signed between different ministries for convergence areas. For

example, an MOU could be signed between the MoUD and the MoHFW to outline the specific areas of convergence between NUHM and the MoHFW's programs and initiatives.

2. State Level

The State Health Society, under the Chief Secretary with representations from Urban Departments and ACS/ PS/ Secretaries of various departments, would continue providing overall guidance and making policy-level decisions. Besides these, inter-departmental committees can be formed to oversee the implementation of health-related activities that involve Urban local bodies and various other departments. MOUs can be signed between the health and urban local bodies to outline the specific areas of convergence and the roles and responsibilities of each ministry.

To improve programme management under NUHM, the existing State Programme Management Unit (SPMU) under NHM will continue to function for NUHM under the overall supervision and guidance of the State Mission Director for NHM. If required, depending upon the size and need of the urban population in the State/ UT, an additional workforce in existing SPMU can be hired to strengthen urban health programme implementation and monitoring.

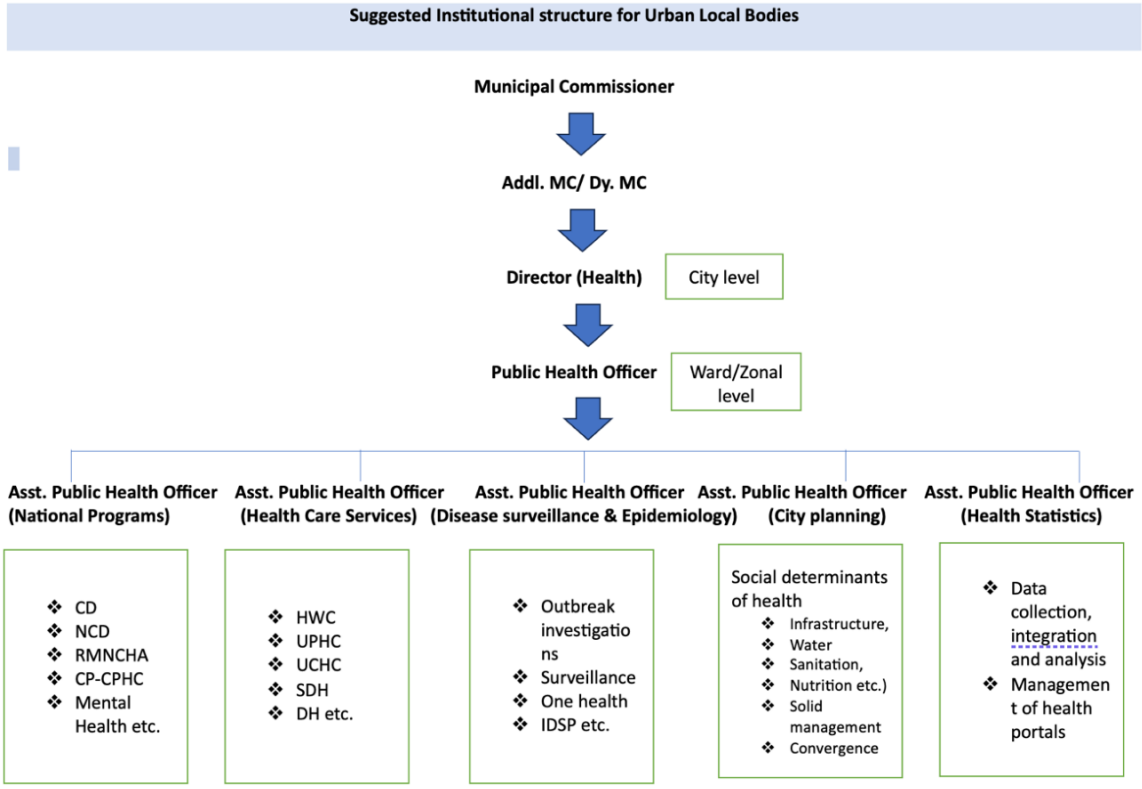
The State Programme Management Unit (SPMU), State Health System Resource Centres (SHSRC) and the State Institutes of Health and Family Welfare (SIHFW) will continue to play similar roles for the State as do their national counterparts for the Centre.

3. District/City Level

Figure 14 shows three suggested implementation models: Model 1, Model 2 and Model 3. Suppose a State chooses to adopt these models. In that case, the current District-level structure under NHM will persist, and it will receive augmented representation from Urban Local Bodies (ULBs) such as Municipal Corporations, Municipalities, Municipal Councils, Nagar Palika, Notified Area Committee, Cantonment Boards, and similar entities. Institutional structures will be enhanced at all Urban Local Bodies to address urban health needs, promoting improved governance mechanisms effectively.

In Model 3, the recommendation proposes a distinct institutional structure within the Urban Local Body. This dedicated structure will streamline implementation efforts and ensure accountability in addressing urban health requirements.

Figure 13: A suggestive institutional structure



Two types of institutional mechanisms may be developed at the ULB level: City Level Structure and Ward Level Structure.

a. City Level Structure

The city-level structure is to be ensured for larger Municipal Corporations and Municipalities, if not already existing.

The suggested structure for City/district-level Committees for various categories of cities is as follows:

Table 13 : Suggested structure for City/district-level Committees

Population of city	Chair	Functions envisaged
Above 10 Lakhs	Elected representative, e.g., Mayor/Municipal Commissioner	• Situational Analysis and Planning • Joint Monitoring • Fostering partnerships • Knowledge & Communication*
1-10 Lakhs	Municipal Commissioner	
Below 1 Lakh	District Magistrate/Additional District Magistrate/DHS (CDMO)	

**The States/ULBs shall have the flexibility to broaden the scope of any existing platforms to perform these functions.*

The respective ULB/Corporations may decide the composition of such committees. It may consist of the Director, Additional Director, Joint Directors and supporting Programme Officers, which will help augment the present capacity and the concurrent monitoring and

remedial actions. The State/ULB/Corporations have flexibility in deciding the structure/ numbers of staff, etc., according to the requirements and population of those cities.

Such committees would facilitate convergent planning & implementation of health and non-health activities through coordination between the ULBs, health department, community, and other essential stakeholders.

b.Ward Level Structure

The flexibility rests with the states in creating Ward-Level Coordination Committees (WLCC) to oversee urban health problems and provide the required actions to solve them, with adequate participation from the Mahila Arogya Samiti.

WLCC may be constituted under the chairpersonship of Ward Councillor/Corporator, with representation from ward functionaries dealing with health, health programs and social determinants of health. The members may include a designated Ward Official for Urban Health, locally elected representatives, along with an MO and Public Health Manager, Data Manager, representatives from MAS, and heterogeneous representation from community members. Choosing the number and relevant representative members of the committee shall be the state's prerogative.

4. Facility Level

At the facility level, Rogi Kalyan Samiti (RKS) at SDH/UCHC and Jan Arogya Samiti at UPHC -HWC and UHWC are responsible for meeting the service guarantee at each level. Further details on these can be accessed from (https://nhsrcindia.org/practice-areas/cpc-phc/community-processes-community-platforms).

5. Community Level

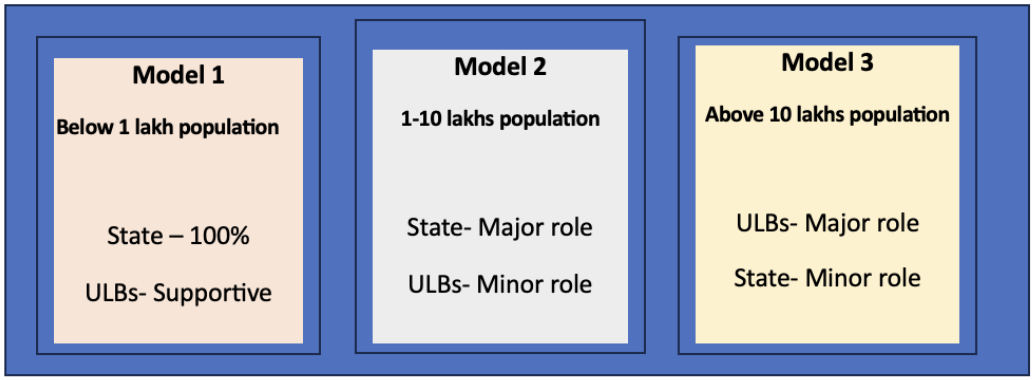
MAS would be the platform for community-level actions**.** For strengthening the primary health care systems in urban areas, a community risk pooling mechanism and enhanced community participation in health care service delivery are essential.

The urban community (both living in slums and non-slums) should participate and collaborate in deciding their health needs and implementing them. RWAs/ Mohalla Committees/ Gully Committees may be roped to implement health services in non-slum areas. This may be ensured through the existing network of community link volunteers (ASHA and Link Workers from other programs like AMRUT, ICDS, NULM, etc.) and the strengthening of existing MAS.

7.2 Models for Implementation of NUHM

It is crucial to define the extent of the role of the State Health Department/NUHM and ULBs for effective implementation and accountability of activities under the Mission.

Fig 14: Models for Implementation of NUHM



Models suggested by the Technical Resource Group for Urban Health, still hold and should be utilised across all cities to enable flexibility in implementation. NUHM allows the States to choose the model that suits their needs and capacities to best address the healthcare needs of the entire urban population. Nevertheless, empowering larger Municipal Corporations and involving smaller ULBs and Municipalities in dealing with the health of the cities is crucial.

7.3 Programme Management Unit under NUHM

The programme management unit to support the implementation of NUHM is to be organised as an extension of the existing PMU under NHM at the state and district level, wherever in urban areas. In Metros and big corporations where the Urban local bodies manage health, the PMU should act as a bridge between the Municipal Corporation and the health department for smoother coordination. The existing state, district, and city-level PMU under NUHM would coordinate with the SPMU and DPMU, not as a vertical unit. Apart from their existing role, they would be expected to perform a more significant role in planning, implementing, and monitoring the newer initiatives.

a. Key Principles:

a. The size of the team at various levels to work dedicatedly for NUHM would depend on the number and size of the NUHM facilities in the state/ UT.
b. While constituting the team, the resource envelope and overall cap under programme management are to be considered. The states must ensure that the overall programme management and M&E cost is 14% for smaller States (NE States and Union territories) and 9% of RE for the remaining States as mandated by MSG.
c. Wherever possible, the State/ UT should not increase the PM HR beyond 60% of the total PM cost under NUHM as it would not leave adequate funds for office expenses, review meetings, monitoring visits, TA/DA, etc.
d. Designations may vary from State to state, as different nomenclatures are used.
e. 1-2 posts per Big Corporation /Metro could be on deputation from the Health Department, which would be able to coordinate with the Urban Local bodies.
f. Remuneration of the PMU staff would be based on their educational qualifications, skills, experience, and workload. The remuneration should be per the existing salary structure under NHM in the state/ UT.

b.Structure of Programme Management Units (PMU)

The SPMU under NUHM may continue with the current staffing structure, but expanding the programme may require team restructuring to fully leverage the team's capabilities. States should appoint a designated state nodal officer and for NUHM-covered districts, at least one nodal officer. Depending on the workload, it could be an additional charge or a dedicated post, which should be arrived at by analysing the disease burden and the prevailing context.

Additional posts can be created based on epidemiology, disease burden, and other factors; the specialisation and skill required can be added to the PMU by the States/ ULBs. For example, an additional consultant post for managing NTEP in urban areas might be required in states with high TB prevalence in metros.

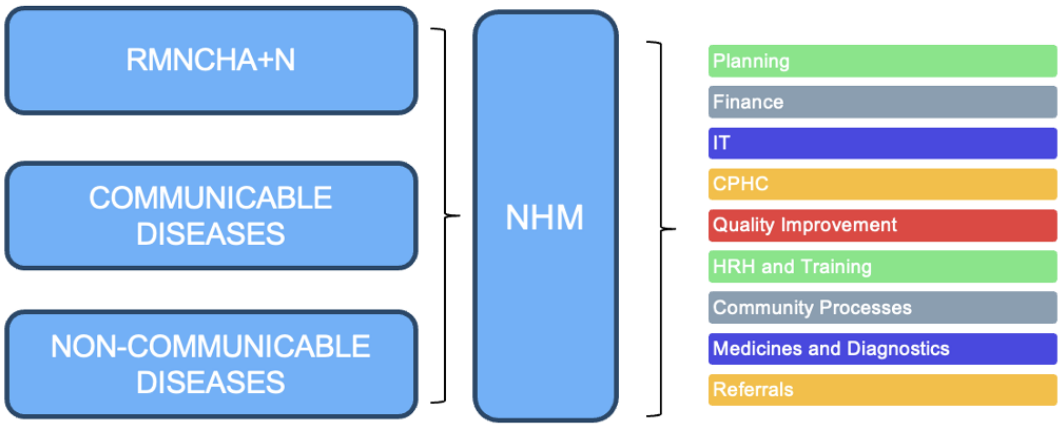
At the district/city level, the state would decide the team's institutionalisation based on available resources, gaps, and needs. In cases where a separate dedicated team is not required, the state may identify personnel from the existing DPMU to look after the urban components and provide all necessary support to the state-level team of NUHM.

The overall structure of the PMU under NUHM remains flexible and may differ from state to state.

c. Functions of Programme Management Units (PMU)

- Implementing the national programmes in the urban areas in coordination with the programme divisions and municipal corporations, especially in the seven states with metro cities, would be the primary function.
- NUHM would collaborate and integrate with different programme divisions to ensure smooth implementation of the National Health programmes in urban health facilities.
- Health Systems Strengthening (HSS) components such as infrastructure, HRH, quality, etc. should be managed in an integrated manner. Separate HRH for these components under NUHM should only be added based on the requirement and quantum of work.
- Similarly, the district-level team under NUHM will support the existing DPMU under NHM in implementing the urban components.

Fig 15: Overview of National Health Mission



Considering the existing challenges in the Metro Cities, a dedicated team to support implementing the national health programmes in the urban health institutions may be required in the major cities. This team will support and coordinate with the Municipal Corporations and ULBs and ensure implementation.

The data entry operations and support staff budget will be supported at different levels as needed. The bigger states may engage the services through outsourcing or under the programme.

7.4 Definitive Role of ULBs/Municipal Corporations

The Twelfth Schedule of the 74th Amendment Act (1992) of the Indian Constitution has given constitutional status to the municipalities in India to strengthen them as effective units of local government, along with defining their powers, authority, and responsibilities. After the amendment, only three categories of urban local bodies exist in India: Mahanagar Nigam (Municipal Corporation) in large cities, Nagar Palika (Municipal Council) in smaller cities, and Nagar Panchayat (Notified Area Council or City Council) in areas that are in transition from rural to urban jurisdiction.

The majority of the activities identified in the schedule have a direct or indirect role in improving the health of the urban population.

The critical areas in health where ULBs and Municipal Corporations have a crucial role in addressing health needs include:

Developing a City Action Health Plan based on mapping the area's needs

a. Providing infrastructure for urban facilities (UHWC/UPWC/Polyclinic)
b. Upgrading existing public parks or open spaces for wellness activities such as walking/cycling tracks, open gyms, yoga, and fitness programs for all age groups.
c. Comprehensive programme planning and monitoring focusing on shifting the disease burden (CD, NCD, RMNCHA including immunisation, etc.)

Coordination, Planning and Participation in the formation and functioning & monitoring of the Committees at various levels under NUHM

a. Addressing problems of mental health, domestic violence, drug addiction etc.
b. Robust reporting and analysis of health data, linked with programmatic corrections
c. Strengthening both human, animal, and environmental surveillance

Active participation in the Capacity building of the Administrative and health facility staff

a. Coordination with other departments to address other determinants of health
b. Reducing OOPEs through assured emergency, critical care, OPD/IPD services, etc.

(Note: This is a suggestive and not an exhaustive list.)

ULBs/Municipal Corporations need to develop a comprehensive **City Health Action Plan (CHAP)** on the available resources (NHM and other Ministries/Departments) and the prevailing disease burden in the city. All ULBs should have a unit of planning for preparing separate plans of cities, i.e., the City Health Action Plan. This would help address local

health needs and deal with the social determinants influencing health, thereby reducing out-of-pocket expenses (OOPE), improving the health outcomes of the urban population, and realising the goals and objectives of NUHM.

ULBs play a crucial role in the effective and efficient distribution of funds allocated to urban areas under the 15th FC health grants and PMABHIM. This includes the establishment of UHWCs and Polyclinics and the strengthening of diagnostic infrastructure.

Moreover, for the health-related activities undertaken at the ULB level to align with the guidelines and norms of the MoHFW and to facilitate capacity building, implementation, and monitoring in a structured manner, MoUD may be roped in for a uniform structure of the health department of ULBs and Municipal Corporations across the country.

Designated roles and responsibilities can be assigned to ULB officials for health system strengthening, IEC/social behaviour change communication, and addressing social determinants of health.

Health Planning by ULBs

The planning and integration of health service delivery for the urban population have faced significant challenges. Studies conducted by NITI Aayog have recommended empowering urban governance and strengthening the primary care delivery system using a multi-pronged approach. Coordination with non-health sectors to address the complex urban health scenario is needed. (Source: Urban Primary Health Strategy Paper, Women and Child Development, NITI Aayog, 2021).

The framework reiterates the importance of urban-specific planning for efficient delivery of health services in urban areas that have a highly varied population mix, health needs, infrastructure, workforce, and resource availability.

The Municipal Corporations and Municipalities need to properly plan health services through judicious and timely utilisation of the available funds. Ownership and accountability need to be ensured; for this, adequate governance mechanisms need to be developed by ULBs.

It is required that the planning committees at the city level, involved in the preparation of the city development plan, prioritise and pre-plan the health infrastructure in urban areas as part of the overall city planning, which includes spatial planning to ensure the availability of land for public health facilities, clean potable water supply, solid waste disposal, including disposal of bio-medical waste, sewerage and drainage systems, slum improvement and upgradation, etc. in their respective jurisdiction.

Every Municipal Corporation, Municipality, Notified Area Committee, and Town Panchayat can become a planning unit with its own approved broad norms for setting up health facilities. The separate plans for Notified Area Committees, Town Panchayats, and Municipalities will be part of the DHAP drawn up for NHM. Municipal Corporations can also have a separate plan of action per broad urban area norms. This would ensure that the District CMOs/CDMOs will be aware of the needs and priorities of the entire urban population.

ULB members can be part of all City/District Health Society and State Health Society meetings. Cities and Districts with Health Missions/Society should have streamlined collaboration with representatives of ULBs.

ULBs/Municipal Corporations are crucial in city-level health planning and integration of health service delivery, addressing various health needs and social determinants. Critical areas of ULBs' involvement include developing City Action Health Plans, providing infrastructure, and coordinating with different departments to address health-related issues. Involvement of ULBs is vital in mapping and population enumeration, ensuring comprehensive coverage of urban/peri-urban areas without overlap.

Chapter 8

Convergence in Urban Areas

Urban areas are undergoing rapid transformations, accompanied by evolving health challenges. Tackling the fundamental causes of poor health demands a paradigm shift in our approach to public health. This chapter emphasises the pivotal role of convergence among broader health determinants and the necessity to enhance the health-supportive environment. The National Health Policy 2017 encapsulates this shift, focusing on critical aspects like ensuring access to safe water, sanitation, sustainable livelihoods, and a conducive health-promoting environment. Convergence, a central theme, aims to optimise healthcare system utilisation by providing services through a unified platform.

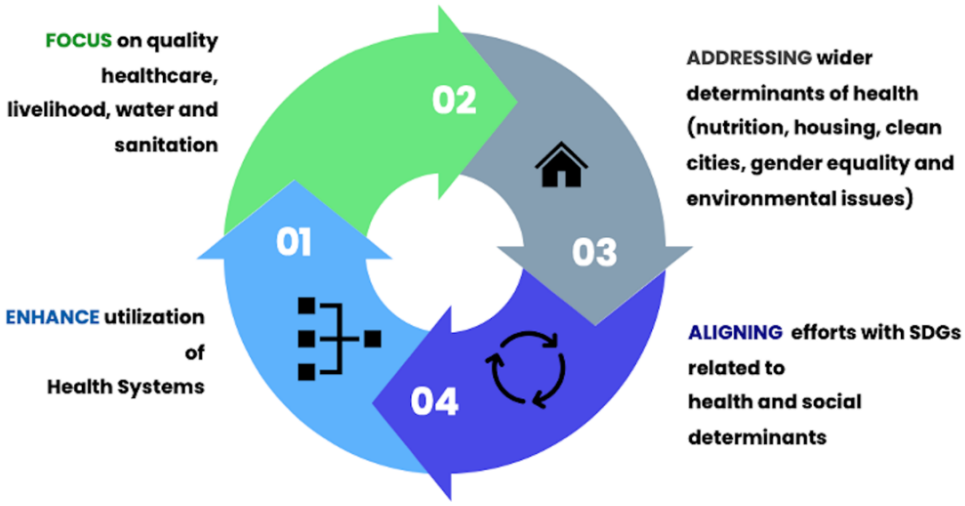
The National Urban Health Mission (NUHM) was introduced as the primary initiative of the Ministry of Health and Family Welfare (MoHFW) to enhance urban health outcomes across the nation. It relies heavily on both inter-sectoral and intra-sectoral convergence. Urban Local Bodies (ULBs) are endowed with additional healthcare funds, with larger Municipal Corporations even having dedicated funds for public health and related activities. Notably, recent allocations of funds for the urban areas encompass infrastructure and health grants under the PM-ABHIM and XV Finance Commission. Under the Government of India, the Ministry of Urban and Housing Affairs (MoHUA) spearheads various programs to enhance the urban environment and provide fundamental services to the urban populace. There exists substantial potential for convergence between NUHM and MoHUA programs, promising to elevate the health and well-being of the urban population.

8.1 Objectives of Convergence

The convergence approach to urban health has several core objectives:

- Enhancing utilisation of the health systems
- Focus on providing good quality healthcare, emphasising safe water, sanitation, and sustainable livelihoods.
- Addressing various determinants of health such as nutrition, housing, clean cities, gender equality, and environmental issues.
- Aligning efforts with Sustainable Development Goals (SDGs) related to health and social determinants.

Fig 16: Approach for convergence



The framework emphasises involving all the stakeholders from policy to implementation. Inter-sectoral convergence aims to guide health policy and ensure efficient health initiatives in urban areas. Key elements include political commitment, coordinated efforts, capacity building, funding, and civil society engagement. Fulfilling these enables achieving health-related SDGs and addressing critical social determinants: nutrition, water, sanitation, housing, safe cities, road safety, gender equality, environment, and green energy.

8.2 Scope of convergence in urban areas

The framework suggests the following priority areas that need focus through convergence:

I. **Communicable Diseases**
   a. Surveillance: Collaborating through the Integrated Disease Surveillance Programme (IDSP).
   b. Disease Control Programs: Collaborating with the National Tuberculosis Control Programme (NTEP), National Vector Borne Diseases Control Programme (NVBDCP), and other programs.

II. **Non-Communicable Diseases,** including mental health, trauma, emergency and critical care, disaster management
   a. Collaborative Efforts: Integrating efforts with the National NCD Programme and other ministries to combat the burden of NCDs.
   b. PM-ABHIM Initiatives: Integration with PM-ABHIM initiatives for critical care, and surveillance, and establishment of health institutions.

III. **Reproductive and Child Health,** including nutrition
   a. Child Health and Gender Equality: Synergising efforts between the "Beti Bachao Beti Padhao" campaign of the Ministry of Women and Child Development and the RMNCHA programme of MoHFW to enhance child health and gender equality.

IV. **Determinants of Health**

- Housing: Collaborating with the Pradhan Mantri Awas Yojana (PMAY-U) to ensure access to basic healthcare services in new housing units.
- Urban Planning and Design: Converging with urban planning and design initiatives to promote healthy and sustainable urban living.
- Basic City Infrastructure: Collaborating with the Smart City Mission to support basic infrastructure and promote health priorities.
- Urban livelihoods: NUHM can collaborate with NULM to improve healthcare access and promote safe livelihoods for urban poor and migrants, enhancing their quality of life.
- Water and sanitation: NUHM can align with SBM to encourage healthy hygiene practices and prevent waterborne diseases by ensuring clean water and sanitation in urban areas.
- Including health in all aspects of urban planning

8.3 Areas/ Programs for Convergence

Initiatives from other Ministries/Department that offer the scope of convergence with MoHFW to improve health outcomes may be included in the table

Table 14: Areas/ Programs for Convergence

Areas/programs for convergence	Suggestive areas for convergence
MoHUA	
DAY- NULM	• MAS or States/UTs may decide the appropriate mechanism. • Awareness of health issues may be taken up in ALF/SHG meetings & trainings. • Role of mobilisation for outreach programs, e.g. Urban Health & Nutrition day, immunisation. • Monitoring of health services by MAS. • Providing inputs in the Programme Implementation Plan (PIP). Data sharing with NULM (a vulnerability survey conducted by NUHM) & developing a common consensus. • The utilisation of NULM infrastructure like night shelters and City Livelihood Centers and community SBM infrastructure to provide community-level health care like outreach services and the utilisation of NUHM-SBM combined triggering platforms for sustained behavioural change counselling.
Ministry of Women and Child Development	
POSHAN Abhiyan SAG RMNCHA programs RBSK programme	Improve services through AWCs Outreach sessions/ POSHAN Pakhwada Screening for malnourished children and pregnant women empowers women to live with dignity and contribute as equal partners in development in an environment free from violence and discrimination.

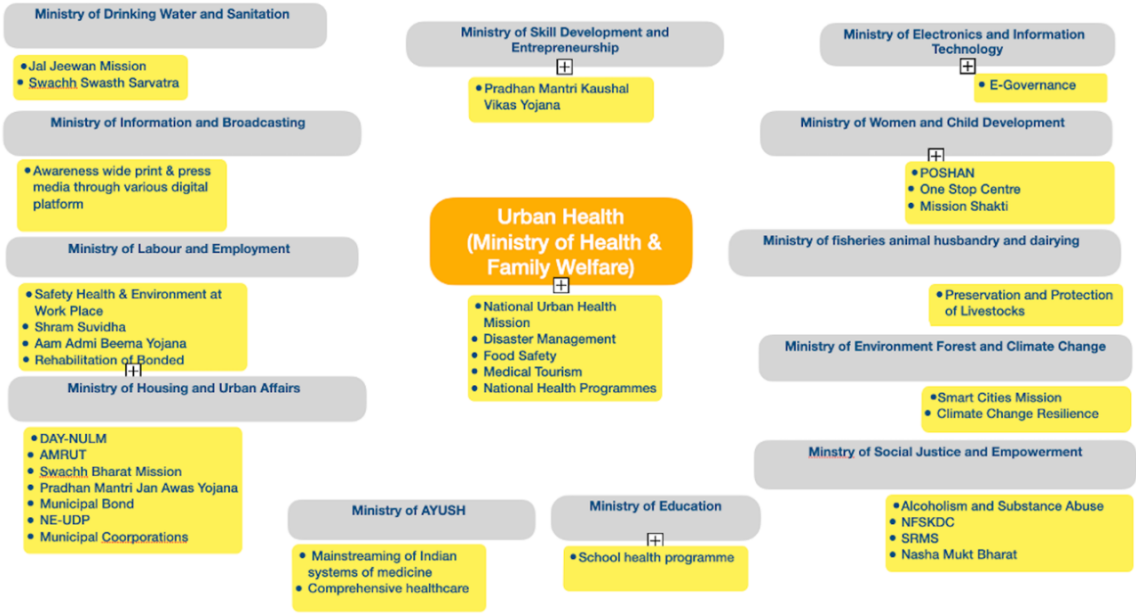
Ministry of Drinking Water and Sanitation	
Health for all WASH	Routine local water quality testing Co-ordinating with the health department in case of waterborne outbreak Co-ordinating with Swachh Bharat Mission, Access to clean drinking water and environmental sanitation
Ministry of Environment, Forest and Climate Change	
Environment-friendly health infrastructure BMW management **Climate Change**	Provision/allocation of suitable land for common bio-medical waste treatment facilities *(As per Central Pollution Control Board guidelines)* Furthering the environment and climate agenda, especially for the National Programme on Climate Change and Human Health (NPCCHH).
Ministry of AYUSH	
Comprehensive healthcare	Availability of AYUSH services at HWCs Specialised services like Panchakarma, Ksharsutra, etc., in higher health centres like DH Availability of drugs with assured supply chain
Ministry of Education	
School Health Program Ayushman Bharat RBSK programme	Health education & creating awareness about hygiene, safe drinking water nutrition, balanced diet, prevention of vector-borne disease, basic emergency handling, etc. Medical examination of primary school children for eye ailments and nutritional deficiencies. School health ambassador
Ministry of Information and Broadcasting	
Promotion of public health facilities and services	Generating awareness through various mass media
NIC	
Hospital MIS e-governance	Digitisation of health records Performing supportive supervision Monitoring of health indicators
Other Areas	
	Involvement of all the community level workers like Mahila Arogya Samiti, Self Help Groups, Area Level Federation, City Level Federation, etc., through christening them as *"Swachhagrahis"* through adequate capacity development

	and training (MEPMA Model). Leveraging self-help groups through social entrepreneurship mode incentivises them to participate actively in improving sanitation in the area and resultant health indicators.

Over and above the list, there may be other important ministries/departments where convergence is needed, e.g., fire safety licencing authorities

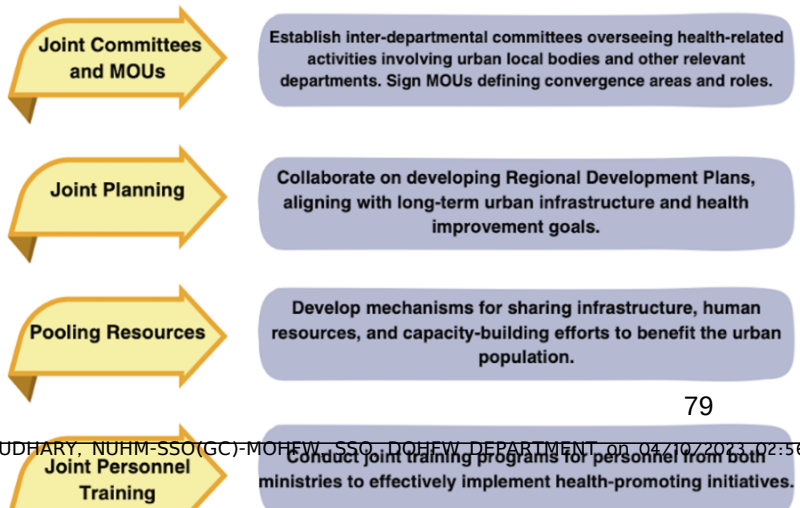
8.4 Mechanism for convergence

Figure 17: Mechanism for convergence



A consultative approach is proposed, emphasising sustained dialogue among key stakeholder Ministries, Departments, and other involved parties. Enhancing the roles of various stakeholders in convergent activities within urban areas is crucial.

To achieve integration in annual planning, financial planning, and implementation, key principles for convergence between NUHM and MoHUA could include:



The convergence of NUHM and MoHUA holds great potential to enhance the health and well-being of the urban population. Through collaborative efforts, both ministries can ensure that urban residents can access quality healthcare services and reside in a healthy, sustainable environment.

For more details, please refer to the specific mechanisms for convergence at the national, state, and city/district levels, as detailed in the Institutional Mechanisms chapter.

8.5 Networking for further collaborations

Engagement with Medical Colleges is vital for bolstering the public health system in India. These institutions possess the expertise and capacity to enhance primary and secondary care under NHM, reinforce AB-HWCs by broadening access to specialised services, and strengthen referral connections in urban and rural settings. Establishing mechanisms to utilise NHM platforms as centres for education, training, public health capacity building, and evidence generation through operational research is essential. The insights gained from this can significantly aid states in addressing their unique public health challenges. The recently launched Ayushman Bhav initiative aims to activate medical camps at CHC-level hospitals, offering specialised care and facilitating referrals to tertiary care setups and diagnostic services. Also, medical colleges can streamline secondary and tertiary care referrals, including critical situations like RTAs and emergency care.

Regarding NGOs, Civil Society, and Development Partners, their involvement is crucial in advancing the public health agenda. These organisations, dedicated to public health, can provide valuable support, including situational analysis, capacity building, research, evidence generation, innovative approaches, external monitoring, and evaluation in alignment with existing guidelines and frameworks.

Chapter 9

Financing under NUHM

The major financial goals under National Health Policy 2017 are:

1. Increasing the health expenditure by the government as a percentage of GDP from an existing 1.35% to 2.5% by 2025 in a time-bound manner
2. Increase in health sector spending to >8% of their budget by 2020

3. Decrease in the proportion of households facing catastrophic health expenditure from the current levels by 25% by 2025.

The Centre-State funding pattern (under NHM) is 60:40 for all the states w.e.f. FY 2015-16, except all North-Eastern states and other hilly States/UTs, for which the Centre-State funding pattern is 90:10. In the case of UTs, from FY 2017-18, the funding pattern of UT of Delhi and Puducherry has been revised to 60:40 and rest of the UTs without legislature are fully funded by the Central Government.

9.1 Sources of funds

The primary source of funding for the Urban Health Mission is the NHM Common Pool. The financial resources for the urban areas have increased manifold after the launch of PM-ABHIM and the 15th Finance Commission. Additional funds to the tune of Rs. 19955 crores are available for strengthening the health systems in the urban areas from FY 2021-22 to 2025-26 besides the existing fund allocation under the NHM.

9.2 Fund allocation and Flexible Financing

NUHM Flexible Pool has been merged under the National Health Mission from FY 2022-23 onwards. Therefore, the allocation of funds is done for the overall NHM including NUHM. Flexible funding mechanisms and performance-based incentives are being implemented and shall be further strengthened. The different financing components, i.e., sub-pools under NHM including NUHM, RCH, communicable diseases, and non-communicable diseases are merged to provide greater flexibility to the States in the implementation of the activities. Funding to States/UTs shall be based on the approved PIPs under overarching the umbrella of NHM, PM-ABHIM and XV FC grants.

9.3 Norms for fund release to the State Governments

The actual release of funds to the states would be based on their annual allocation of funds, and the financial expenditures at the district, city, and below level would be based on the State/ District level PIPs prepared on the basis of approved state ROPs from the central level. Further, the central share will be released based on the fulfilment of necessary conditions, such as submission of UCs and expenditure reports as per extant Rules and instructions of the Central Government in this regard. The conditions for the release of funds are applicable under the National Health Mission as a whole and are applicable for all the CSS urban components including PM-ABHIM unless otherwise indicated.

9.4 Financing under the NHM framework

NUHM can leverage the institutional structures of NHM at the National, State and District levels, both for planning and expenditure under NUHM. Besides, additional structures at the ULB level, such as City Programme Management Units, are functional and linked with the State/ District structures.

a. Participatory Planning

The process of developing PIP should involve all the stakeholders, including the urban local bodies. 15thFC envisages the greater role of Urban local bodies (ULBs) in planning and

implementation of urban activities. The States/UTs should plan for Urban-HWCs duly factoring in the resources available under the PM Ayushman Bharat Health Infrastructure Mission and FC-XV Health Grants for the UHWC component, as resources of FC-XV Health Grants for this component have been factored in or included under PM Ayushman Bharat Health Infrastructure Mission.

b.Untied funds for urban health facilities

An annual untied grant for urban health facilities would be a merger of operational costs and untied funds, as maintaining/providing such expenses under too many verticals is difficult. All urban health facilities, viz., SDH/UCHC, UPHC, Polyclinic, and UHWC would be entitled to a one-time annual untied grant, as mentioned in the table below:

Table 17: Untied funds

SN	Type of Urban Facility	Annual Untied Grant (Rs.)
1	SDH	Rs. 5,00,000
2	UCHC	Rs. 5,00,000
3	Polyclinic	**Rs. 50,000 (In addition to the untied grant of UPHC)**
4	UPHC	Rs. 2,50,000
5	UHWC	Rs. 50,000

The State needs to ensure that allocation for primary care in urban areas is increased in line with the recommendations of NHP 2017 to meet the growing trends of urbanization.

- Requirements of the Urban Local Bodies/ Municipal Corporations should be built in the State PIP/ District PIPs.
- All urban health facilities would comply with the IPHS 2022 norms for infrastructure, human resources, beds, services, medicines, and diagnostics and continue to be supported under NHM within the permissible resource envelopes of states and UTs.
- In view of the merging of the pools and budget lines, states have flexibility to utilize the funds under the approved activities.
- ULBs may be advised to create a budget line for health with the provision of funds from their municipal resources.
- Ward Level Coordination Committee: A funding provision for each ward level committee may be made available to the tune of INR 30,000 annually. The amount of the untied grant for MAS will remain the same as that for MAS i.e., INR 5000 annually.
- Fund requirements to address the health needs of the urban population have been factored in and built under different programmes of NHM, PM-ABHIM and the 15th Finance Commission.

9.5 Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)

It is a paradigm shift from a sectorial, segmented, and fragmented approach to service delivery through various national and state schemes to a bigger, more comprehensive, and better converged and need-based service delivery of secondary and tertiary care.

The scheme aims to provide health protection coverage to poor and vulnerable families for secondary and tertiary care. It will further reduce out-of-pocket hospitalisation expenses, fulfil unmet needs and improve access of identified families to quality inpatient care and daycare surgeries, and ensure the continuum of care through a network of Empanelled Health Care Providers (EHCP).

Chapter 10

Monitoring Evaluation and Reporting Systems

10.1 Monitoring & Evaluation

Monitoring and Evaluation (M&E) is an integral part of any public health programme to ensure the attainment of objectives. Monitoring is a core function under NUHM for the time-bound implementation of activities envisaged in the framework. It is an essential mechanism that adds accountability criteria to the system for delivering quality services to the urban population. Both conventional and participatory approaches for M&E be adopted for NUHM.

a. Monitoring

- Routine monitoring is required at all levels- policy makers at national and state levels, managers at city/district levels and at the operational levels. It needs to be ensured that monitoring is a participatory process involving all the key stakeholders, programme implementers and the community. Periodic evaluation of results through systematic data collection and analysis is desirable to understand if any mid-course corrections or re-designing is required.

- A logical framework approach is recommended for the monitoring and evaluation of NUHM. The identification of urban population issues, involving key stakeholders, and

analysing strategies and objectives will serve as the base for the log frame. The log frame for NUHM needs to have a Project Planning Matrix (PPM) with clearly defined objectively verifiable indicators (OVI) and means of verification, based on the overall objectives and interventions.

b. Evaluation

- Internal and external evaluation of the National Urban Health Mission at periodic intervals to be undertaken.
- The baseline evaluation and timelines for mid-term and final evaluations need to be established. A specific mechanism for evaluation with thorough planning, effective methodology, reliable data collection and analysis needs to be defined, followed by timely reporting of findings.

c.Participatory M&E

- Incorporating a participatory process for M&E involving the beneficiaries in urban areas, through the community level platforms such as MAS would further entrust the mechanism. Core monitoring teams can be established with defined objectives and indicators. This would enable transparency, accountability, and effectiveness of interventions, enhance collaboration and develop trust within the community.
- The infrastructure, service delivery and community process under NUHM shall be monitored periodically/regularly. The IPHS assessment checklist tailored for every level of the facility may also be used for monitoring purposes. Further, it is paramount to monitor the quality and coverage of health services among the urban population. Besides activities undertaken by ASHAs and MAS, many outreach services like UHNDs, population-based screening for NCDs (for populations above 30 years and above), vulnerability mapping of slums and migrants etc., need continuous monitoring.

10.2 Institutional mechanisms for monitoring and evaluation

- A mechanism for robust internal and external monitoring is vital to maintain standards, identify gaps and address deficiencies in service delivery at public health facilities. Internal systematic assessments using checklist mechanisms like record keeping and timely reporting etc. should be set up for regular monitoring of the facility. External evaluation by the Managers at ward/district/state level on a periodic basis is essential and can be done or by using the data reported on various portals.
- Service delivery data of the health facilities are being regularly uploaded on various Health portals such as HWC, NCD, HMIS and RCH etc. Currently, there is provision of mapping and reporting of Urban Health Facilities on the HMIS portal. Adequate provisions need to be made for mapping and reporting of UHWCs (under PM-ABHIM and 15th FC) in the HMIS portal and other related portals. Also, there is a need to have standard indicators for Urban areas or make provisions in National/State specific portals to collect information on urban-specific requirements. These indicators may be aligned with the SDGs. Further, all programme divisions may segregate data (information) as urban and rural.

a. To monitor the progress of the new initiatives under NUHM as well as the delivery of services, comprehensive indicators in terms of process, output, and outcome/impact will be defined, a few indicators are mentioned below:

10.3 Monitoring and Evaluation Indicators

Process level indicators (not exhaustive)

1. Number of UHWCs operational
2. Number of MAS formed and functional
3. Number of JAS formed and functional at UPHC-HWC
4. Number of ASHAs trained
5. Number of drugs and diagnostics available

Output level indicators (not exhaustive):

1. Increase in OPD attendance
2. Increase in ANC check-ups of pregnant women
3. Increase in complete immunization among children < 12 months
4. Increase in case detection for malaria through blood examination
5. Increase in case detection of TB
6. Number of UHNDs held against target
7. Number of 30 years and above population screened for 5 NCDs
8. Number of UPHC-HWCs providing specialist services
9. Number of citizens allotted ABHA IDs

Outcome/Impact Indicators

1. % Increase in utilization of urban health facilities
2. Reduction in OOPE of the urban poor
3. **All program-specific impact indicators**

10.4 Training and Orientation

Data flow from the facility level to the top level should be done in the prescribed formats. All health personnel appointed in the urban health facilities and programme managers should be trained, orienting them to utilize this data for monitoring and analysis. Based on the analysis, mid-course corrections should be planned.

10.5 Reporting Systems

Reporting is an integral part of the health facilities in public health to keep the system updated about the functioning of the health facility. There are various portals for health-related programmes developed by GoI for ease of reporting various indicators to monitor the programme performance and gauge the health situation in urban areas. State to ensure that there is one Urban-HWC per 15,000-20,000 population. This will be linked to the UPHC-HWC's population of 50,000. All the HWC-UPHCs are required to have a NIN-ID and register

on the AB-HWC portal, on par with the Urban-HWCs, duly mapping the hierarchy (source: as per the operational guidelines of PMABHIM page 27, para 4.3.1)

A specific online format for collecting information of Outreach Services may be developed and linked to the UPHC.

a.Public Sector Reporting

- Urban health facilities under NHM will continue to report their data through the existing reporting mechanisms, i.e., Health Management Information System (HMIS), Integrated Health Information Platform (IHIP), Reproductive and Child Health (RCH) Portal, Health & Wellness (HWC) Portal, Comprehensive Primary Health Care-NCD portal, Nikusth, Nikshay, and Electronic Health Records DVDMS. The PM-Ayushman Bharat Digital Mission envisions the creation of the Ayushman Bharat Health Account (ABHA) Number and the development of a Unified Health Interface (UHI) for the integration of various digital health services, teleconsultation, and portals, into one). Apart from the online data reporting systems, necessary programmatic data reporting must per the specific programme guidelines and formats. All urban facilities shall be mapped under various portals. All types of Urban Health Facilities i.e., UPHC-HWC, UHWCs (PMABHIM & 15FC), UCHCs, and other state-specific urban health facilities like civil dispensaries etc. need to be mapped. Further, there should be provision for mapping, and reporting of all facilities falling in urban areas.
- The reporting structure for UHWCs would be through the UPHCs-HWC, and in stand-alone U-HWCs in cities/towns where UPHC is not available, reporting would be through the nearest existing government health facility.

b. Health Management Information System 2.0

- The management information system of NHM efficiently captures the progress of various components under NUHM viz., a number of operational facilities, human resources, ownership of buildings, outreach activities, referral transport, etc. Data on the HMIS portal is specifically designed to support planning, management, and decision-making based on the grading of facilities' various indicators at the Block, District, State, and National Levels. This also enables periodic monitoring of the performance indicators.

- Apart from this, to periodically monitor the progress under new initiatives like XV FC, PM- ABHIM, and ECRP, the NHM PMS Portal has also been launched.

c. Engaging Private Sectors

- All potential private players in urban areas should be mapped, identified and tapped optimally to provide the urban population data enforced under the Clinical Establishment Act. Adequate, timely reporting and notification of disease are undertaken by these health facilities. This is particularly important for notifiable diseases like TB, malaria, leprosy, diseases under IDSP surveillance through S, P, and L forms, and any other emerging and re-emerging infectious diseases like COVID -19, Influenza, and other notifiable diseases, etc.

- Appropriate mechanisms for partnering (or entering into an agreement) with the private sector need to be considered for reporting and monitoring systems, coupled with routine follow-up through meetings. The private health facilities' implementation of various regulatory provisions like the PCPNDT Act, MTP Act, Private Medical Establishment Acts, etc. by should be ensured. Therefore, the mapping of facilities is an important step for urban facilities. Private players/sectors may be defined specifically, which will help in mapping, and reporting of the data in the existing portals.

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Annexure

Revised Structure and Composition of Jan Arogya Samiti (JAS) for the Urban Health Wellness Centre(UHWC) in Guidelines for JAS

The Proposed composition of JAS to be formed in Primary Health Centres in Urban Areas (will be applicable to both, AB-HWCs at Urban (PHC) as well Urban HWC)

I. Chairperson - The Ward Member of the Urban Local Body, representing the AB-HWC area shall be the Chairperson of the JAS. If there is no Ward Member, an Equivalent representative from the elected local body can be designated. In the absence of an elected body, the administrator nominated by the State Govt for the urban local body shall be the chair.

II. Co- Chair - Medical Officer In-charge of the facility to which the HWC is linked (Urban CHC of the area or the other linked higher facility in case of UPHC-HWC and Medical Officer i/c UPHC-HWC in case of UHWC), shall be designated the Co-Chairperson of JAS. If there is no facility linked to the AB-HWC, City / District Urban Nodal Officer can be designated the Co-chair.

III. Member Secretary- Medical Officer In-charge of the AB-HWC (UHWC/UPHC)

IV. Ex-Officio-members (maximum 10 members from the list below)

i. Chairperson of the Health Sub-committee of Urban Local Body.

ii. Sector Supervisor of Dept. of Women and Child (DWCD) of the area.

iii. A representative of Public Health Engineering Dept. (PHED) / Department responsible for Sanitation under Swachh Bharat Mission.

iv. A representative of Public Health Engineering Dept. (PHED) / Department responsible for Water under Swachh Bharat Mission.

v. A representative of the Health / Public health Department of the ULB.

vi. A representative of School Department / Principal of the school of the local area (if there is no government school in the area, representation from private school of the area can be taken)

vii. A representative from department / agency managing Nehru Yuva Kendra (NYK) / Youth volunteers programmes.

viii. A representative from department / agency managing the Deendayal Antyodaya Yojana – National Urban Livelihood Mission (DAY-NULM)/ Urban Poverty Reduction programme.

ix. One other Medical Officer / AYUSH Medical Officer of the AB-HWC.

x. Senior Staff nurse / LHV, of the AB-HWC.

xi. Chairpersons of MAS: Chairpersons of the two MAS from the AB-HWC area. This shall be on rotation of 2 years to allow greater participation.

xii. ASHAs – ASHA / Member Secretary of MAS under the AB-HWC area (up to a maximum of 5).

xiii. All Multi-Purpose Health Workers (Male and Female) of AB- HWC.

xiv. A representative from Resident Welfare Associations (Registered) of the area – If the area has federation of Resident Welfare Associations, they should be represented.

xv. Any other representatives from States/UTs from similar department/agency/organisation.

V. General Members –

1. Women Self Help Groups - Presidents of two SHGs from the AB-HWC area (to be chosen from among functional and active SHGs).

2. Livelihood Groups (Urban Poverty Reduction programme) - Presidents of 2 community level Livelihood Groups from the AB-HWC area.

3. School Health Ambassadors: One representative from among the Ayushman Bharat School Health & Wellness Ambassadors of the AB-HWC area (representative from the school with highest enrolment).

4. Representatives from 2 civil society organisations in the area.

5. 2 representatives from other departments / programmes which have close linkages with health or its determinants, as per the local context.

VI. Special invitees-

One Tuberculosis Champion, one cancer survivor one transgender, one differently-abled person, and one youth representative, and ‘any male’ who has undergone sterilization after one / two children

General considerations

• All General Members shall have a tenure of two years. This is to enable greater participation of community representatives in the JAS.

• An ex-officio member of JAS, like, the Ward Member of the Urban Local Body, will cease to be member of JAS, when she/he, ceases to be the ward member of ULB. The representative will be selected subsequently from the newly elected ULB.

• Formation of JAS and its role should be widely publicized in the area. The process of selection of members should include community level consultations, with involvement of all ULB members of the area. The list of JAS members, along with phone numbers should be displayed in the AB-HWC.

• In the selection of JAS members, efforts should be made, to ensure that all habitations, and all communities especially the minority communities like SC/ST of the AB-HWC area are well represented (should be minimum 1/3 rd of the total composition).

• At least 50% JAS members should be women