Initial Poverty and Social Analysis

Project Number: 53121-001
June 2020

India: Strengthening Comprehensive Primary Health Care in Urban Areas

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 10 June 2020)

Currency unit	–	Indian rupee/s (₹)
Re1.00	=	$0.01324
$1.00	=	₹ 75.4950

ABBREVIATIONS

ADB	=	Asian Development Bank
CPHC	=	comprehensive primary health care
HWC	=	Health and Wellness Centre
MAS	=	Mahila Arogya Samiti
NCD	=	non communicable disease
NHP	=	National Health Policy
NUHM	=	National Urban Health Mission
UPHC	=	Urban Primary Health Centre

NOTES

(i) The fiscal year (FY) of the Government of India ends on 31 March. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2020 ends on 31 March 2020.

(ii) In this report, "$" refers to United States dollars.

INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	India	Project Title:	Strengthening Comprehensive Primary Health Care (CPHC) in Urban Areas
Lending/Financing Modality:	Results-Based Lending	Department/ Division:	South Asia Department/ Human and Social Development Division

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

A. Links to the National Poverty Reduction Strategy and Country Partnership Strategy

The National Health Policy (NHP) 2017 recognizes the growing burden of non-communicable diseases, the persisting burden of infectious diseases, and the increase in catastrophic health care related expenditure as one of the major contributors to poverty and vulnerability of Indian population. The policy envisages 'to attain the highest possible level of health and well-being for all at all ages through increasing access, improving quality and lowering the cost of healthcare delivery.[a] Universality, equity, patient-centered care and decentralization, amongst others, are the principles of NHP that are crucial for improvement in health status especially of urban poor and therefore, has a direct implication on poverty reduction. Resulting from NHP, the *Ayushman Bharat* scheme of the Government launched in 2018, with the aim to address these challenges through a Comprehensive Primary Health Care (CPHC) package delivered from 150,000 Health and Wellness Centers (HWCs), along with the National Health Protection Scheme (later renamed to *Pradhan Mantri Jan Arogya Yojna*) for financing the health of the poor through an insurance scheme.[b] This program supports CPHC roll-out in urban areas in select states of India facing rapid urbanization. The program is aligned with India Country Partnership Strategy (CPS), 2018–2022 which supports ADB's ongoing urban and health sector operations, by provision of comprehensive primary health care services to the urban poor with increased focus on equitable access and improved quality of service delivery in public facilities. The program is also fully aligned to ADB Strategy 2030 for increased universal health coverage.

B. Poverty Targeting: ☒General intervention ☐Individual or household (TI-H) ☐Geographic (TI-G) ☐Non-income MDGs (TI-M1, M2, etc.)

By developing a universally accessible and affordable primary health services in urban areas, the program will directly address the target of SDG 3: achieve universal health coverage, including financial risk protection; access to quality essential health care services; and access to safe, effective, quality, and affordable essential medicines and vaccines for all in urban areas of 12 states. While the comprehensive primary health care is for all urban residents, for free, it will benefit urban poor and vulnerable groups, especially women.

C. Poverty and Social Analysis

1. Key issues and potential beneficiaries.

Rapid urbanization in India is evidenced from urban population growth from 377 million in 2011 to 460 million in 2020 (22%).[c] This rapid urbanization involves migration and expansion of India's city limits, posing further challenges to provision of quality healthcare services. In order to address the health needs of the urban population and provide equitable access to quality basic healthcare to the urban poor, National Urban Health Mission (NUHM) was launched in 2013.[d] However, the out-of-pocket expenditure continued to rise and was high as 62.4% of the total health expenditure, which underlined the glaring need for wider range of service provision in the public sector and increased financial protection of the poor.[e] A study estimates that labor households engaged in the unorganized sector in Delhi spend about 8.87% of the annual per capita income and nearly 24% of the households either borrowed money from various sources or sold their belongings in order to meet their health care costs.[f] To address these challenges, the government announced that HWCs would be created by transforming existing primary health centers to deliver CPHC and declared this as one of the two components of *Ayushman Bharat*. This CPHC program has a clear focus on the urban poor and vulnerable including slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station luggage carriers, homeless persons, street children, constructions site workers. Slums are characterized by poverty, overcrowding, poor sanitation, vulnerability to hazards and accidents, fear of demolition drives and displacement, and stress due to livelihood security. Conditions in slums make the slum dwellers highly susceptible to communicable diseases and the lifestyle make them prone to noncommunicable diseases (NCDs) such as cardiovascular diseases, diabetes, cancer, respiratory, and other chronic diseases.[g] The program with focus on 12 selected states in India covering the urban cities with populations over 50,000. The target population covered under the program scope include 313 million urban population, which is 69% of total urban population in India. Of these over 14% are poor and vulnerable.

2. Impact channels and expected systemic changes.

In order to ensure delivery of CPHC services, existing urban primary health centers (UPHCs) would be converted to HWCs. CPHC will strengthen the existing institutional and service delivery mechanisms through nine channels including continuum of care; expanded services; expanded list of diagnostics; multiskilling of staff; community mobilization and health promotion; infrastructure upgradation; provider payment reform; robust IT system; and partnership for knowledge & implementation through coordinated action (endnote b). The program aims at improving the system capacity and staff to deliver expanded range of services and diagnostics to prevent, manage and treat

NCDs along with the communicable diseases and RMNCH+A services. In addition, interventions would also help strengthen continuum of care and referral mechanisms in place.

3. The due diligence will identify the health concerns, needs, and priorities of urban area communities including persisting gaps. It will provide a basis for determining the scope of intervention for expanded range of services required in primary care facilities in India. The due diligence will also assess program design features including systems and processes and will identify key areas which need strengthening to increase the use of public sector facilities for primary health care delivery in urban India.

II. GENDER AND DEVELOPMENT

1. What are the key gender issues in the sector and/or subsector that are likely to be relevant to this project or program? Women's health is compromised because of patriarchal, cultural and socioeconomic constraints. Several studies across the globe have shown how health seeking behavior of poor women and girls is particularly constrained, impacting their health and wellbeing. A 2015 Lancet study reported that fewer female patients than male visited a doctor in urban areas despite the popular belief that the health services are mainly focused on maternal care and adolescent girls' health program. [h] National Family Health Survey-4 data shows the low levels of autonomy women have in critical matters related to health: (i) 63% of the married women do not have decision making powers in matters related to their own health; and (ii) only 57% of women in urban areas have the freedom to visit a health facility alone. There is also a high level of acceptance of gender-based violence, 46.7% women in urban areas agree that husbands are justified in beating their wives for 'specific reasons'. Among NCDs, breast cancer (30%) followed by cervical cancer (12%) are two major constituents for cancer deaths for women in India. [i]

2. Does the proposed project or program have the potential to contribute to the promotion of gender equity and/or empowerment of women by providing women's access to and use of opportunities, services, resources, assets, and participation in decision making? ☒ Yes ☐ No

CPHC will empower women by improving health seeking behavior among urban women especially the poor and vulnerable through improved outreach and wider range of services. Especially it will (i) provide RMNCH+A services; (ii) NCD-related services including screening women above 30 years for cervical and breast cancer; (ii) identifying action against gender violence as a priority area for a coordinated action; (iii) engaging with existing women groups through *Mahila Aarogya Samitis* (MAS, community collectives comprising local women); (iv) incorporating management of gender-based violence related injuries, management of survivors of sexual violence as per medico-legal protocols and facilitating linkage to legal support center; in service delivery framework for UPHC-HWC; and (v) educating and mobilizing community for action on violence against women. Actions will be identified for program action plan with specific focus on gender inclusiveness.

3. Could the proposed project have an adverse impact on women and/or girls or widen gender inequality?
☐ Yes ☒ No

4. Indicate the intended gender mainstreaming category: ☒ GEN (gender equity) ☐ EGM (effective gender mainstreaming) ☐ SGE (some gender elements) ☐ NGE (no gender elements)

III. PARTICIPATION AND EMPOWERMENT

1. Who are the main stakeholders of the project, including beneficiaries and negatively affected people? Identify how they will participate in the project design.

The main beneficiaries targeted by urban CPHC are the urban poor especially women, children, elderly, and the vulnerable. For CPHC design, MOHFW constituted a task force to identify challenges in roll out, finalize components of service delivery, institutional mechanisms and service organization. The program envisages to deliver health care regardless of accessibility and quality regardless of gender, race, ethnicity, geographical location, or socioeconomic status. The operational guidelines, released in 2018, were developed through consultative process involving policy makers, practitioners, technical experts; and experiences drawn from implementation of NHM. Communities through MAS and community action for health will continue to provide relevant inputs for decentralized health planning.

2. How can the project contribute (in a systemic way) to engaging and empowering stakeholders and beneficiaries, particularly, the poor, vulnerable, and excluded groups? What issues in the project design require participation of the poor and excluded? CPHC proposes following key strategies: (i) empower MAS to facilitate intersectoral convergence, local planning and action for access and quality of care; (ii) engage with existing women groups and ensure greater participation of women from community; (iii) MAS to closely work with the representatives of Urban Local Bodies and existing community based groups to build capacities for community level planning, action and monitoring to address social determinants of health; (iv) women collectives and MAS to undertake large-scale community level information, education and communication activities for health promotion; and (v) the MAS and *Rogi Kalyan Samitis* (Patient Welfare Committee) would monitor the performance of HWCs.

3. What are the key, active, and relevant civil society organizations (CSOs) in the project area? What is the level of civil society organization participation in the project design?

☒ Information generation and sharing (M) ☒ Consultation (M) ☐ Collaboration ☐ Partnership

MAS and *Rogi Kalyan Samitis* are consulted by the government in designing the HWC guidelines. ADB consulted with some of them during the NUHM annual common review missions and ADB's own review missions to gain insights on the effectiveness of community process, outreach and operation of UPHCs.

4. Are there issues during project design for which participation of the poor and excluded is important? What are

they and how should they be addressed? ☐ Yes ☒ No

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C ☐ FI

1. Does the project have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☐ Yes ☒ No

The HWCs would be converted from existing UPHCs and hence no land acquisition will be involved. Even for Urban Community Health Centers, mostly existing government facilities would be upgraded.

2. What action plan is required to address involuntary resettlement as part of the transaction TA or due diligence process? ☐ Resettlement plan ☐ Resettlement framework ☐ Social impact matrix
☐ Environmental and social management system arrangement ☒ None

B. Indigenous Peoples Category ☐ A ☐ B ☒ C ☐ FI

1. Does the proposed project have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☐ Yes ☒ No
2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No

The urban poor are mostly migrated individuals moving to urban areas for employment and staying in slums.

3. Will the project require broad community support of affected indigenous communities? ☐ Yes ☒ No
4. What action plan is required to address risks to indigenous peoples as part of the transaction TA or due diligence process? ☐ Indigenous peoples plan ☐ Indigenous peoples planning framework
☐ Social impact matrix ☐ Environmental and social management system arrangement ☒ None

Implementation of program components will not affect the dignity, human rights, livelihood systems, ancestral domains or cultural systems of indigenous peoples, either directly or indirectly. Therefore, indigenous peoples safeguard issues are unlikely to be triggered.

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the project design?
☐ Creating decent jobs and employment ☐ Adhering to core labor standards ☐ Labor retrenchment
☐ Spread of communicable diseases, including HIV/AIDS ☐ Increase in human trafficking
☒ Affordability (L) ☐ Increase in unplanned migration ☐ Increase in vulnerability to natural disasters
☐ Creating political instability ☐ Creating internal social conflicts ☐ Others, please specify _____

The program aims to improve access to quality primary health care for the urban poor and reduce their out-of-pocket health expenses.

2. How are these additional social issues and risks going to be addressed in the project design?

The CPHC together with *Pradhan Mantri Jan Arogya Yojana*, which is a national health protection scheme to cover the poor through government-funded insurance policies, constitute the *Ayushman Bharat* scheme. Hence, apart from free service delivery that would be provided to the poor through the HWCs, they would also be covered against financial burden for secondary and tertiary ailments, though CPHC's referral services.

VI. TRANSACTION TA OR DUE DILIGENCE RESOURCE REQUIREMENT

1. Do the terms of reference for the transaction TA (or other due diligence) contain key information needed to be gathered during transaction TA or due diligence process to better analyze (i) poverty and social impact, (ii) gender impact, (iii) participation dimensions, (iv) social safeguards, and (v) other social risks. Are the relevant specialists identified? ☒ Yes ☐ No

2. What resources (e.g., consultants, survey budget, and workshop) are allocated for conducting poverty, social, and/or gender analysis, and participation plan during the transaction TA or due diligence? During due diligence an experienced social and gender consultant will analyze ways in which the access of women to preventive and promotive health care can be improved. Gender actions will be incorporated into the program action plan and disbursement-linked indicators, based on this analysis.

[a] MOHFW, Government of India. 2017. National Health Policy. New Delhi.
[b] MOHFW, Government of India. 2018. Operational Guidelines-Ayushman Bharat-Comprehensive Primary Health Care through Health and Wellness Centre. New Delhi.
[c] National Commission on Population, MOHFW, Government of India. 2019. Population Projections for India and States 2011-2036, Report of the Technical group on population projections. New Delhi.
[d] MOHFW, Government of India. 2013. National Urban Health Mission, Framework for Implementation. New Delhi.
[e] World Health Organization. 2017. Out-of-pocket expenditure. Geneva.
[f] Nair, K.S., Health and Population, Perspectives and Issues, 24 (2): 88-98, 2001 Cost of Health Care – A study of Unorganized Labor in Delhi.
[g] George, C.E., Norman, G., Wadugodapitya, A. et al. 2019. Health issues in a Bangalore slum: findings from a household survey using a mobile screening toolkit in Devarajeevanahalli. BMC Public Health 19:456.
[h] Krishna D Rao, David H Peters. 2015. Urban health in India: many challenges, few solutions. Lancet. 3.
[i] Ramnath Takiar. 2018. Status of Breast and Cervix Cancer in Selected Registries of India. Annals of Women's Health.
[j] ADB. 2015. Report and Recommendation of the President to the Board of Directors: Proposed Results-Based Loan and Administration of Technical Assistance Grant to India for the Supporting National Urban Health Mission. Manila.