

PROGRAM RESULTS ASSESSMENT

A. Program Results Framework

1. The National Urban Health Mission (NUHM) results framework covers key issues, actions, and performance targets to help the Government of India improve the health status of the urban population, particularly of the poor and vulnerable groups, by facilitating equitable access to quality health care. The program covers eight core strategies: (i) strengthening, revamping, and rationalizing existing government primary urban health structures and designated referral facilities; (ii) promoting household access to improved health care through community-based groups and processes; (iii) strengthening public health through community-level disease prevention and health promotion actions and through partnerships; (iv) addressing financial protection and high out-of-pocket expenditures by the urban poor (e.g., through community revolving funds); (v) incorporating information technology-enabled services and e-governance to improve access, monitoring, and disease surveillance; (vi) capacity building of stakeholders with respect to their management, technical, and public health competence; (vii) reaching the vulnerable through targeted outreach services; and (viii) ensuring quality health care services. The government developed these strategies based on critical assessment of key public health challenges in urban areas across India, and possible responses under the NUHM. Within the broad implementation framework, NUHM gives states flexibility to choose the model that best suits their needs and capacity in addressing the health care needs of the urban poor.

2. The results framework has been designed to capture how the following outputs will translate into the desired outcome and impact.¹ The disbursement-linked indicators (DLIs) and activities that are part of the program action plan (PAP) are identified explicitly.²

3. **Output 1: Urban primary health care delivery system strengthened.** NUHM aims to establish a system of urban primary health facilities covering cities and large towns. This output will sharpen the focus of NUHM investments on the urban poor through support for mapping of slums and vulnerable population and city-level health planning with active involvement of ULBs (DLI 3, Program Action Plan [PAP] 1.4 and 1.5). This will allow NUHM to have greater synergy with other urban services for improving health outcomes, especially for the urban poor. This output will also ensure that minimum requirements—such as clinical staff, medicine, equipment, and service package—are met at the UPHCs (DLI 3). NUHM aims at strengthening community outreach services to extend community health awareness and demand for services through the urban accredited social health activists (ASHAs) and *Mahila Arogya Samitis* (MAS) (community collectives comprising local women). This output will ensure timely recruitment and adequate training of urban ASHAs, and close monitoring of their functioning (DLI 4). It will also undertake operational research and capacity building of community-based institutions such as MAS (PAP 1.2).

4. **Output 2: Quality of urban health services improved.** NUHM will introduce a quality assurance mechanism for urban primary health facilities in a phased manner. This output will ensure that (i) state-level organizational arrangements for quality assurance and capacity to manage the quality assurance system are established, (ii) quality measurements including client-satisfaction are developed, and (iii) the NUHM monitors the progress and evaluates effectiveness of the quality assurance mechanism to guide states in making further quality

¹ Program Results Framework (accessible from the list of linked documents in Appendix 2).

² The key outputs are designated as DLIs. Those that are important for outcome achievement but difficult to link to disbursement are included in the PAP.

improvements (DLI 5 and PAP 1.7). The output will also review existing private provider regulation, accreditation practices, and incentives for improving quality, accountability, and reliability of services to promote an enabling environment for private sector engagement in health (PAP 1.3 and 1.6).

5. Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened. NUHM needs significant capacity building in program management and technical aspects of urban health to operationalize the NUHM implementation framework effectively. This output will enhance staff capacity to implement NUHM (DLI 6, [i] for prior results and 2016 and [iii] for 2015). This output will help the NUHM develop and implement a capacity development framework to plan, monitor, and provide incentives for capacity development in urban health (DLI 6, [i] for 2015).³ States with weak capacity will receive priority for capacity development support. This output will enhance existing M&E mechanisms and staff capacity to better support NUHM operations, monitor progress, and provide feedback to policy and planning. More specifically, the output will (i) improve the existing health management information system to produce urban disaggregated data (DLI 6, [ii] for 2015); (ii) strengthen existing management information systems to monitor NUHM progress; and (iii) improve data on key health outcome indicators (PAP 1.1 and PAP 5). This output will also assist MOHFW to develop and implement a framework for innovations and partnerships (DLI 7). The framework will systematically capture local innovations and lessons, adapt international best practices, promote cross learning for replication and expansion, and provide incentives for more innovative approaches and partnerships.

6. The results framework includes specific, measurable, achievable, relevant, time-bound, and transparent outcome and output indicators. The linkages between the impact, outcome, and outputs are strong, with a focus on the beneficiaries. The program soundness assessment discusses the importance given by NUHM to equitable access to health care services, quality assurance, community processes, and M&E. Using the foundation established for the NRHM, a comprehensive facility-based HMIS has been designed to collect data on various aspects of health delivery, and can be used to collect data from health facilities in urban areas under NUHM. Similarly, the NRHM MIS and its formats will be adapted to the NUHM.

7. The NUHM MIS will collect information required for specific output indicators, e.g., status of city mapping of slums, vulnerable populations, and health facilities; and whether the UPHCs meet minimum requirements for staffing and service package (DLI 3). Similarly, the MIS captures information on human resources for ASHAs (DLI 4) and in state, district, and city project management units (DLI 6). An ASHA MIS under NRHM, which will be expanded to cover NUHM, has been adopted by select districts for monitoring ASHAs and their activities. The existing MIS collects information on a range of topics including community actions, community monitoring, functioning and staffing of health facilities, human resources, health facilities civil works, functioning of program management units, institutional deliveries, decentralized planning, computer availability, and internet connectivity in health facilities.

³ The framework will include (i) a comprehensive human resource development plan for managerial and technical personnel; (ii) strengthening of existing national and state entities to support urban health; (iii) provision of technical and management support to MOHFW and states—especially lagging ones, through a pool of experts and demand-based consulting inputs through an indefinite service delivery contract; and (iv) enhancing knowledge, training, and institutional capacity in urban health through organization of international and national forums, twinning arrangements between schools of public health in India and abroad, and a new dedicated institute for urban health research and training.

B. Disbursement-Linked Indicators

8. DLIs are key performance indicators that have been selected on the basis of extensive consultations with MOHFW. In order to focus on core outputs essential for realizing the desired outcome and impact only seven DLIs have been selected; two DLIs are outcome-level indicators, and five are output-level indicators. Together they provide adequate flexibility and scope for covering the key aspects of the overall program.

9. The outcome-level DLIs measure access to an equitable and quality urban health system, and specifically (i) increased institutional deliveries (DLI 1), and (ii) complete immunization (DLI 2). They apply in the last 2 years of the results-based lending program, because assessment is not possible at the outset of the program while the effect of NUHM will take time to be realized and the HMIS is being disaggregated to report separately on urban areas. These DLIs provide incentives for the use of country M&E systems and thereby indirectly strengthen the capacity of districts, states, and the central government to improve the coverage and quality of data collection and reporting mechanisms. Data from the third (2005–2006) and fourth (2014–2015)⁴ National Family and Health Surveys (NFHSs) could be used to compare and analyze trends in health outcomes. The NFHS provides data disaggregated by location of residence (urban and rural), sex, and wealth quintile. Although not DLIs, prevalence of communicable disease (childhood diarrhea and acute respiratory infection) could be measured by the NFHS, and out-of-pocket health expenditures by the National Sample Survey Office.

10. The program is aligned with the NUHM implementation framework impact of improved health status of the urban population, particularly the poor and the vulnerable, across India. This can be measured by measuring changes in the neonatal mortality rate, infant mortality rate (IMR), under-five mortality rate, maternal mortality ratio, total fertility rate, and child malnutrition; these are common measures of health system performance, which are also included in the NUHM Implementation Framework. Impact-level results are affected by outcome-level results, which are in turn influenced by output- or process-level results. For example, the outcome-level DLI 1 (regarding institutional delivery) influences the following impact-level results: neonatal mortality rate, maternal mortality ratio, and IMR. Although the IMR has reduced by around 30% from 2002 to 2012, the observed decrease has been largely related to neonatal deaths. Institutional delivery is also a key indicator of health inequity for the urban poor (according to 2005–2006 data from NFHS-3, 44% of the urban poor have institutional deliveries, compared to the urban average of 67.4%).

11. A strong referral system, skilled health workers, and well-equipped facilities are essential to reducing maternal and newborn deaths resulting from complications during childbirth. It is recognized that quality care is required if an increase in institutional delivery is to result in reductions in mortality.⁵ To address quality, the HMIS monitors institutional deliveries in public and *Janani Suraksha Yojana* (JSY)-accredited facilities.⁶ Improving the quality of institutional delivery, which is a key for outcome achievement but difficult to link to disbursement because of data availability, is included in the PAP. Quality of care is also covered under DLI 5 (Output 2), where NUHM's UPHCs will be required to conform to a standard set of quality criteria, self-assessment, and independent audit processes for accreditation at the national and state level

⁴ Results to be released in 2016.

⁵ Skilled-birth attendance (SBA) is not necessarily a better measurement of quality, because available data on SBA is for home deliveries, on the assumption that SBA exists across all health facilities.

⁶ Only about 13% of institutional births do not occur under JSY. B. Randive et al. 2013. *India's Conditional Cash Transfer Programme (the JSY) to Promote Institutional Birth: Is There an Association between Institutional Birth Proportion and Maternal Mortality?* PLoS ONE 8(6): e67452.

over the program period. A few PAP or DLI actions to be taken include: (i) review the JSY accreditation mechanism and availability of emergency obstetric care and neonatal services in facilities; (ii) conduct and pilot perinatal and maternal death audit (committees as part of facility-based quality assurance at public and JSY facilities); and (iii) focus on quality assurance indicators related to institutional delivery and antenatal care services (screening complicated and high-risk pregnancies, and appropriate referral linkages) at UPHC and urban community health center levels.

12. Outcome-level DLI 2 measures complete immunization among children below 1 year old (measles is used as a proxy for complete immunization). Vaccines are important to avert preventable childhood deaths. Studies indicate outbreaks of vaccine-preventable diseases are higher in urban slums because of the population density and continual influx of infective agents, yet immunization coverage is low in slums; in 2005–2006 NFHS-3 found that 60% of urban poor children do not achieve total immunization before completing 1 year, compared to the urban average of 42%. Thus, DLI 2 emphasizes immunization coverage, especially among the urban poor, to reduce IMR and under-five mortality, and decrease inequity.

13. Five output-level DLIs are included covering the three outputs (paras. 3–5). Output-level indicators that are not DLIs have also been included in the results framework as follows. The following will be monitored under Output 1 (urban primary health care delivery system strengthened): (i) number of new and refurbished UPHCs and urban community health centers, (ii) the status of their referral systems, and (iii) coverage of slums and settlements by ASHAs and *Mahila Arogya Samitis*, and (iv) effective outreach as evidenced by (a) percentage of urban poor children who had diarrhea in the past two weeks who received ORS, and (b) percentage urban poor households using a sanitary facility for the disposal of excreta (flush/ pit toilet). For Output 2 (quality assurance), (i) number of facilities registered under the Clinical Establishments Act (MOHFW 2010) and (ii) percentage maternal health delivery points introducing standard treatment protocols for child birth delivery.

14. For Output 3 (planning, management, and innovation and knowledge sharing capacity), four indicators that are not DLIs are included in the results framework and have sufficient flexibility to enable the government to adopt activities as required. These could include: (i) strengthening existing technical support agencies at national, state, and ULB levels through increased staff capacity in urban health and supporting MOHFW in monitoring and states and ULBs in NUHM implementation; (ii) establishing a dedicated institute for urban health research and training (center of excellence in urban health); (iii) establishing twinning arrangements between schools of public health in India and abroad, with government officials trained in public health management and health systems through these arrangements; and (iv) establishing knowledge-sharing platforms such as an international forum on urban health for global research and training in urban health, and an interstate solution exchange.

C. Managing Risks and Improving Capacity

15. Two risks related to results have been identified and risk-mitigating measures and actions defined and agreed upon with the government. They include (i) timely achievement of results and (ii) proper implementation of data collection mechanisms. The NUHM is a decentralized national program where states have responsibility to deliver the program through the Program Implementation Plans that they submit to and are subsequently approved by MOHFW. Given the wide variation in states' institutional arrangements and implementation capacity for urban health, the risk lies in possible delayed achievement of results. The mitigating measure for this risk is a capacity development framework that will be developed to enhance

implementation capacity, especially in the lagging states. The attached capacity development technical assistance will assess and monitor state-level institutional arrangements and capacity for urban health.

16. The NUHM implementation framework describes strategies to be used to achieve the impact, outcomes, and outputs. Although the DLIs and the PAP are designed to enhance the focus on significant outputs that are focused on beneficiaries, the identified risks are in coordinating the collection of results indicators across multiple information systems, divisions, and agencies, and implementing capacity-building activities to improve data completeness and quality, which may undermine proper measurement of results. Mitigating these risks will require an increased focus on NUHM and dedicated staff in the MOHFW Statistics Division. The NUHM results framework, DLIs, and PAP already identify appropriate data (and data sources) to capture results. Still, there appears to be weak institutional coordination to collect data across various divisions and ministries regarding other results indicators, which are identified in the implementation (but not the results) framework. Also, the availability of NUHM results indicators from a single consolidated source may also pose a challenge in sharing results with the wider public. To address this, MOHFW may consider a one-stop resource such as annual publications focusing on urban health statistics (similar to rural health statistics reports under the NRHM).

17. Based on the lessons of NRHM, NUHM's design and results framework is balanced and provides a good foundation to establish a results-oriented program. The Asian Development Bank has capacity development technical assistance to support technical inputs required by NUHM to ensure achievement of the annual DLIs and PAP. The technical assistance will also provide inputs for Asian Development Bank's independent verification activities along with capacity development support. MOHFW will provide technical and implementation support at state and sub-state levels to align M&E systems and improve quality and timely availability of necessary data. The multipronged approach and combined efforts will make it possible to track the outputs and outcomes of the proposed loan.