INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	India	Program Title:	Supporting National Urban Health Mission
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

Between 2001 and 2011, India's urban population grew from 286 million to 377 million (32% increase) compared to the rural population, which grew from 742 million to 833 million (12% increase). This has led to a rapid increase in the number of urban poor who are forced to live mainly in over-crowded and unhygienic slums and squatter settlements.[1] While the National Rural Health Mission, launched in 2005, has improved the access to quality public healthcare in rural India, the rapidly expanding urban areas are outside its purview. Consequently, systematic efforts have not been made so far to provide good quality and affordable healthcare services in urban areas. Public healthcare facilities in urban areas are over-burdened. In the absence of adequate primary healthcare facilities in urban areas and a good referral system, the poor are forced to rely on expensive private clinics. This results in high out-of-pocket expenses which are catastrophic for the urban poor. The 12th Five Year Plan (2012–2017) therefore, notes that India should work towards a system of universal healthcare to provide "equitable access for all Indian citizens in any part of the country, regardless of income level, social status, gender, caste, or religion to affordable, accountable, and appropriate, assured quality health services (promotive, preventive, curative, and rehabilitative); and services addressing wider determinants of health, with the government being the guarantor and enabler, and not necessarily the only provider of health and related services".[2] In order to move towards a true National Health Mission, the Government of India launched the National Urban Health Mission (NUHM) in 2013 with the goal of improving the health status of the urban population.[3] NUHM aims at facilitating equitable access to quality healthcare for the urban poor through a revamped public health system, partnerships, and community-based service delivery mechanism with the active involvement of urban local bodies (ULBs). Asian Development Bank (ADB)'s India country partnership strategy (2013–2017), which aims to support India's efforts towards inclusive growth, recognizes the importance of health as a key for overall human capital development.[4] The proposed support for NUHM is also closely aligned with the mid-term review of Strategy 2020 which emphasizes the need for ADB to expand health to 3%–5% of its annual approvals, from 2% during 2008–2012. It notes that ADB should help developing member countries to work towards attaining universal healthcare since this will support inclusiveness, reduce vulnerabilities, and improve the preparedness of developing member countries to face epidemics and infectious diseases.

B. Targeting Classification

☒General Intervention ☐Individual or Household (TI-H) ☐Geographic (TI-G) ☐Non-Income MDGs (TI-M1, M2, etc.)

The NUHM will cover all 779 cities with a population of above 50,000 and all the district and state headquarters. Urban areas with a population less than 50,000 will be covered through the health facilities established under the National Rural Health Mission. About 78 million urban poor living in these cities will be the primary beneficiaries of the scheme. The definition of "urban poor" will be defined through household surveys by community organizations/nongovernment organizations' validation under the supervision of ULBs, taking into account assets owned and state of access to basic public services.

C. Poverty and Social Analysis

1. Key issues and potential beneficiaries.

The urban poor live in overcrowded, hazardous, and unhygienic living conditions. They also lack access to affordable and quality healthcare. Poor living conditions, lack of health and hygiene awareness, and limited access to basic services leave the urban poor, especially children, vulnerable to ill health. There is also a notable disparity between health statuses of the urban poor compared to the urban average. In 2006, the under-five mortality rate among the urban poor was 72.7%, significantly higher than the urban average of 51.9%; 46% of urban poor children are underweight compared to the urban average of 33%; and almost 60% of urban poor children miss total immunization before reaching one year of age. Urban poor women also face reproductive health issues. Improved access to public health and primary healthcare services will increase the health status of urban populations, especially the poor.

2. Impact channels and expected systemic changes.

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[1] Urban slum population is growing at 5%–6% annually. Nearly 17% of the urban population lives in slums.

[2] Government of India, Planning Commission. 2013. *Twelfth Five Year Plan of India, 2012-2017*. Delhi. (para. 20, 28, Chapter 20)

[3] National Rural Health Mission and National Urban Health Mission are now the two sub-Missions under National Health Mission.

[4] ADB. 2013. *India: Country Partnership Strategy 2013–2017.* Manila.

The NUHM proposes to address healthcare needs of the urban poor through seven major channels. It intends to (i) improve access to better and more affordable services by strengthened and refurbished urban primary health centers and provide human resources, medicine, and equipment; (ii) mobilize community self-help groups of women to enhance community participation and awareness in healthcare activities; (iii) strengthen public health through preventive actions that emphasize improved water and sanitation, safe housing, and nutrition; (iv) promote information technology-enabled services and e-governance for effective monitoring and timely delivery of health services; (v) develop capacity of ULBs to support and manage public health; (vi) extend outreach services to the most vulnerable groups among the urban poor; and (vii) ensure quality health services by defining and promoting quality standards for public health services.

3. Focus of (and resources allocated in) the PPTA or due diligence.

The challenge to strengthening public health in India also requires review of institutional requirements, and creating an enabling framework for related elements to come together into a coherent operating model (e.g., institution and enforcement of public health rules and regulations, regular municipal services and urban infrastructure maintenance; community participation; availability of high-impact primary healthcare and public health services; etc.). The small-scale project preparatory technical assistance (S-PPTA) will assess (i) NUHM's program soundness, results and links with disbursement, and expenditure and financing under a potential results-based lending modality and (ii) an initial assessment of the monitoring and evaluation, fiduciary, procurement, environment, and social safeguard systems.

II. GENDER AND DEVELOPMENT

1. What are the key gender issues in the sector/subsector that are likely to be relevant to this project or program?

NUHM's key outcome indicators – reduction in maternal mortality rate, universal access to reproductive health including 100% institutional delivery, reduction in under-five and infant mortality rates – have a strong gender dimension. Likewise, the outreach and delivery mechanism envisaged under NUHM (see 2 below) provides a key role to women in improving awareness about health and nutrition issues, and facilitating preventive care.

2. Does the proposed program have the potential to make a contribution 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 Please explain.

Through *Mahila Arogya Samitis* (community groups), *Anganwadi,* or civil society organizations (CSOs) that raise participation and awareness in healthcare activities in the community, women will be informed about health and hygiene, and how to access appropriate health-related services. Moreover, Accredited Social Health Activists (ASHAs), who are woman residents of the slum and frontline community workers in charge of each area, will serve as an effective demand–generating link between the health facility and urban slum population. They would maintain interpersonal communication with beneficiary families and individuals to promote the desired health-seeking behavior as well as assist in delivering outreach services.

3. Could the proposed program have an adverse impact on women and/or girls or widen gender inequality?

☐ Yes ☒ No Please explain

4. Indicate the intended gender mainstreaming category:

☐ GEN (gender equity theme) ☒ EGM (effective gender mainstreaming)
☐ SGE (some gender elements) ☐ NGE (no gender elements)

III. PARTICIPATION AND EMPOWERMENT

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

The urban poor, especially women, children, elderly, and the vulnerable will be the primary stakeholders and beneficiaries of NUHM. While designing NUHM, the Ministry of Health and Family Welfare had undertaken extensive consultations with nongovernment organizations, public and private health care providers, municipalities, and ULBs. The NUHM provides flexibility to states to choose which implementation model suits their needs and capacities to best address the healthcare needs of the urban poor. Models will be decided through community-led actions.

2. How can the program contribute (in a systemic way) to engaging and empowering stakeholders and beneficiaries, particularly, the poor, vulnerable and excluded groups? What issues in the program design require participation of the poor and excluded?

For strengthening the extant primary public health systems, NUHM, based on the key characteristics of the existing urban health delivery system, proposes a broad framework that (i) rationalizes the available manpower and resources; (ii) improves access through a communities risk pooling mechanism; (iii) enhances participation of the community in planning and management of the health care service delivery by ensuring a community link volunteer (ASHAs and link workers from other programs like Jawaharlal Nehru National Urban Renewal Mission (JNNURM), Integrated Child Development Services (ICDS), etc.); (iv) ensures effective participation of ULBs and their capacity building along with key stakeholders; and (v) makes special provision for inclusion of the most vulnerable amongst the poor. Also, NUHM will improve managerial, technical, and public health competencies among ULBs/medical and paramedical staff/private providers/community level structures and functionaries of other related departments.

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

Mahila Arogya Samitis (community groups), ASHAs, *Rogi Kalyan Samitis*, and link workers from other programs like JNNURM, *Anganwadi* workers of ICDS program are the relevant CSOs.

H Information generation and sharing **H** Consultation **H** Collaboration **H** Partnership

4. Are there issues during program design for which participation of the poor and excluded is important? What are they and how will they be addressed? ☒ Yes ☐ No

The CSOs will be actively engaged in household surveys to understand the poverty of households and the challenges of public health in urban slums. The *Mahila Arogya Samiti* will be the basic unit of planning and community action. The planning process would involve identification, mapping, and vulnerability assessment of slums, assessment and mapping of the existing healthcare services, stakeholder consultations, mapping of referrals in each area, rationalization of manpower, mapping and accrediting the private sector, ensuring private sector participation and also ensure effective convergence with departments like ICDS and JNNURM.

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C

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

NUHM will mainly strengthen and revamp existing Urban Family Welfare Centers/Urban Health Posts into "Urban Primary Health Centers" and establish new Urban Primary Health Centers, as per need. The PPTA will assess the extent of the civil works involved and confirm that no adverse impact on involuntary resettlement is anticipated.

2. What actions are required to address involuntary resettlement as part of the PPTA or assessment process?
☐ Program safeguard system assessment and actions ☒ None

B. Indigenous Peoples Category ☐ A ☐ B ☒ C

1. Does the proposed program 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

Especially in urban environments, there is heterogeneity of people hailing from different backgrounds and geographic locations so there is no potential issue specifically affecting indigenous peoples. The PPTA will assess and confirm that no adverse impact on indigenous peoples is anticipated

3. Will the program require broad community support of affected indigenous communities? ☐ Yes ☒ No

4. What actions are required to address risks to Indigenous Peoples as part of the PPTA or the program assessment process?
☐ Program safeguard system assessment and actions ☒ None

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the program 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
☐ Increase in unplanned migration ☐ Increase in vulnerability to natural disasters ☐ Creating political instability
☐ Creating internal social conflicts ☐ Others, please specify _____

2. How are these additional social issues and risks going to be addressed in the program design?
Successful implementation of NUHM will help reduce the spread of communicable diseases. It will not add to any of the potential risks listed above.

VI. PPTA OR ASSESSMENT RESOURCE REQUIREMENT

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

2. What resources (e.g., consultants, survey budget, and budget for workshop(s)) are allocated for conducting poverty, social and/or gender analyses, and participation plan during the PPTA or the program assessments?

An experienced social and gender consultant will be engaged using staff consultancy budget. He/she will analyze ways in which the access of women to preventive and curative health care can be improved. Gender actions will be prepared on the basis of this analysis, and subsequently incorporated into the program action plan and disbursement-linked indicators.