

PROGRAM SOUNDNESS ASSESSMENT

A. Program Description

1. The Government of India launched the National Urban Health Mission (NUHM), as a sub-mission of the National Health Mission (NHM), under the Twelfth Five-Year Plan (2012–2017).¹ The NUHM's broad principles and strategic directions are laid out in its implementation framework. It aims to improve the health status of the urban population, especially the poor and other disadvantaged people, by facilitating equitable access to quality health care.² The Supporting National Urban Health Mission will support NUHM implementation, following the implementation framework for NUHM (footnote 2) and the overarching NHM implementation framework.³ The program's impact will be the improved health status of the urban population, particularly the poor and the vulnerable, across India. The outcome will be increased access to an equitable and quality urban health system. The program will have three broad outputs: (i) Output 1: Urban primary health care delivery system strengthened; (ii) Output 2: Quality of urban health services improved; and (iii) Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened. Further details are provided in the main text of the Report and Recommendation of the President.

B. Program Soundness

1. Relevance and Justification

2. Urbanization is critical to India's development. It is estimated that cities could generate 70% of new jobs created by 2030.⁴ As a result of surging urban growth and employment, the urban population grew from 286 million in 2001 to 377 million in 2011. At the current rate, by 2030 about 590 million people (46% of the total population) will live in urban areas. Despite the thriving urban economy, however, some 75% of urban citizens are in the bottom income segments, earning an average of Rs80 (\$1.80) a day (footnote 4). Urban poverty and slum populations are also rising rapidly.⁵ The urban poor are among the fastest growing and most vulnerable sub-populations. A substantial portion of the urban poor lives in overcrowded, hazardous, and unhygienic conditions, with limited access to clean water, sanitation, and health care, which negatively impacts their health and well-being. Poor health adversely affects the quality of life, employability, and productivity of city dwellers and migrants. Health-related spending could also have catastrophic consequences on family incomes, and lead to further impoverishment.

3. While many comparisons have been made of health-related deprivation between rural and urban areas, less attention has been given to rising health disparities within urban areas, especially between the poor and non-poor. For example, the under-five mortality rate (U5MR) among the urban poor was 72.7 per 1,000 live births, compared to the urban average of 51.9.⁶

¹ Government of India, Planning Commission. 2013. *Twelfth Five-Year Plan, 2012–2017*. New Delhi.

² Government of India, Ministry of Health and Family Welfare. 2013. *NUHM Framework for Implementation*. New Delhi.

³ Government of India, Ministry of Health and Family Welfare. 2012. *Framework for Implementation of the National Health Mission, 2012–2017*. New Delhi.

⁴ McKinsey Global Institute. 2010. *India's urban awakening: Building inclusive cities, sustaining economic growth*. Chennai.

⁵ India's population is growing at 2%, the urban population at 2.75%, large cities at 4%, and slums at 5%–6%. Of the 370 million urban dwellers, over 100 million are estimated to live in slums.

⁶ Urban Health Resource Center. 2007–2008. *Data Analysis of National Family Health Survey 3 (2005–2006)*. New Delhi.

Almost 60% of urban poor children, below 1 year of age, missed total immunization compared to the urban average of 42.4% (footnote 6). More than 46% of urban poor children are underweight (footnote 6). Poor environmental conditions and crowded living spaces also make the urban poor vulnerable to infectious diseases, such as tuberculosis, acute respiratory infections, and diarrhea. Slums also have a high incidence of vector-borne diseases, including malaria. Addressing urban health issues, including rising health disparities, is thus critical to inclusive growth and sustainable urban development in India.

4. The program is highly relevant and justified. It will support the NUHM in improving the health and well-being of the urban population, focusing on the poor, and providing them with equitable access to essential quality health services, including preventive care and disease treatment. NUHM is also expected to play an integral role in India's move towards universal health coverage (UHC) under Twelfth Five-Year Plan.

a. National Urban Health Mission Core Strategies and Program Interventions

5. NUHM's core strategies are (i) strengthening, revamping, and rationalizing the government's existing urban primary health care structure and designated referral facilities; (ii) promoting household access to improved health care through community-based groups and processes; (iii) strengthening public health through disease prevention and health promotion actions at the community level and through partnerships; (iv) addressing financial protection for 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) stakeholder capacity building with regard to managerial, technical, and public health competence; (vii) reaching the vulnerable through targeted outreach services; and (viii) ensuring quality health care services. As detailed below, the core NUHM strategies are based on sound justifications and compelling needs and draw on extensive consultations and field experience; program interventions and alignment with the core strategies are also outlined.⁷

6. **Strengthening urban health facilities and community outreach, and reaching vulnerable populations.** NUHM aims to strengthen urban health systems, with primary health care as the backbone. It will establish a system of city-specific urban primary health centers (UPHCs) covering all cities with a population of above fifty thousand. The UPHCs will also provide referral services—linked to the community health centers to be newly established under NUHM, or other existing public health facilities identified through geographic information system mapping—and community outreach targeting the poor. This effort will address current gaps and inefficiencies in the delivery of urban health care services, which include weak primary health care and lack of critical links to community and referral services to ensure a continuum of care. To date, unlike in the case of rural health, central or state government interventions to develop an organized health care delivery system in urban areas have been limited, varying from state to state. As a result, delivery of health care services in urban areas is sub-optimal and fragmented with weak referral linkages. The primary health care system is largely non-functional in the urban context, with most curative primary care occurring at the secondary and tertiary

⁷ Government of India, Ministry of Health and Family Welfare, Technical Resource Group (TRG), Urban Health Mission. 2014. *Reaching Health Care to the Unreached: Making the Urban Health Mission Work for the Urban Poor*. New Delhi. The program assessment used the report and recommendations of the TRG for NUHM; TRG members include representatives from central and state governments, ULBs, and civil society, as well as health experts.

levels, leading to overcrowding of these centers. Where public primary health care centers do exist, they tend to be underutilized and have varying norms and limited scope of services; this serves to encourage patients to seek care at higher-level hospitals.⁸ Vertical health programs (e.g., that target malaria and tuberculosis) do not converge at the primary health care level. Outreach services and community-level health promotion are limited, undermining community access to disease prevention and health promotion information.

7. The NUHM also focuses on poor and vulnerable populations through targeted outreach services. In urban settings, the poor bear a disproportionate burden of ill-health that is correlated with living conditions and exposure to hazardous environmental conditions, such as solid waste and roadside pollution. Many of the urban poor are migrants from rural areas, with insecure tenure and informal status that often bars access to government social services and welfare programs. Their access to health services is also limited by a lack of appropriate public service provisions, and their inability to afford reliable private care. Thus, efforts to improve the health of the urban population in India require a focus on the poor, along with effective strategies to reach the most vulnerable.

8. In support of the NUHM strategies, the program, through a results-based lending modality, will emphasize effective delivery of services to reinforce NUHM's investments in strengthened primary health delivery infrastructure. Specifically, the program will increase NUHM attention on optimal functioning of the UPHCs by monitoring and improving systems to ensure availability of key inputs (such as staff, equipment, and medicines) in health facilities; adoption of a quality assurance mechanism; strengthened community processes through accredited social health activists (ASHAs) and Mahila Arogya Samitis (MAS) (community collectives comprising local women); and a sharpened focus on the urban poor and vulnerable, including through support for mapping of slums and vulnerable populations, with active involvement of urban local bodies (ULBs).

9. **Strengthening public health through preventive and promotive actions.** The design and delivery of public health needs to be strengthened in India. Effectively addressing key determinants of public health requires a convergence between medical health issues and essential non-medical public health functions, such as water and sanitation. Currently, typical investments in water and sanitation and other basic urban infrastructure tend to fall short of delivering the intended public health benefits. Institutional mechanisms for ensuring convergence between urban primary health services and other agencies and schemes that address health determinants (e.g., sanitation, water, housing, and vector control) need to be strengthened. In urban areas, unlike in the rural context, the institutional arrangement as per the 74th Constitutional Amendment calls for complete integration of primary health care and other public health functions under a municipal health officer. In many states, however, health care services are taken up by the state health department, and public health activities are not under the leadership of the municipal health officer. Funding, functions, and functionaries are fragmented under existing institutional structures, undermining convergence around public health goals and effective response to disease outbreaks. Consequently, the public health capacity of ULBs needs to be revived, supported, and strengthened.

⁸ Some assistance has been provided by the central government to enhance urban primary health infrastructure and services through the NRHM's urban reproductive and child health component. Some states have also received support to enhance urban health service delivery under the India Population Projects and Integrated Child Development Services, supported by the World Bank.

10. As a key feature, the program will promote convergence between health and urban sector interventions by emphasizing active participation of ULBs and community-based institutions (such as MAS)—with requisite capacity building—in key aspects of urban health planning, implementation, and monitoring at the city level. This is supported by creation of an enabling environment through policy directives and necessary guidance at the state and national levels. Significant capacity building is also planned to develop the public health capacity of ULBs, such as through twinning arrangements between Indian institutions and notable foreign schools of public health to deliver customized public health curriculum. Detailed institutional assessments will be carried out in selected states to inform institutional capacity requirements for convergence.⁹ Effective institutional convergence models will be studied and documented for sharing and possible replication across states.

11. **Financial protection for the urban poor.** Access and financial protection for the poor and near-poor are key concerns, given that out-of-pocket expenditures to private providers make up nearly 70% of overall health spending in India, which can lead to further impoverishment. Studies by the National Sample Survey Organization indicate that 5% of urban households dropped below the poverty line as a result of health expenditures; of this, 3.8% was due to expenditure on outpatient care. The impact of health care-related expenses is greatest in the second-poorest quintile in urban areas. To help eliminate out-of-pocket expenditures and enhance financial protection, the program will support NUHM in extending access to quality primary health care, delivered free of user fees and in facilities located close to slums and vulnerable populations. The program will also support operations research and capacity building of community-based institutions, such as MAS; this includes exploring the experiences of community-based risk pooling mechanisms or revolving funds, which can be used for health care or other community priorities that promote public health.

12. **Ensuring quality health care services.** Ensuring actual and perceived quality of care is important if NUHM investments in the urban public health care system are to be used by the intended beneficiaries. In India, even those patients with limited incomes often choose to visit private facilities because they perceive the quality of care to be higher compared to that available at public facilities, which also have long waiting times. The quality of services at public facilities remains an issue even under the National Rural Health Mission (NRHM). A focus on quality is especially important given the experience of the *Janani Suraksha Yojana* (safe motherhood intervention) under the NRHM, which increased the proportion of institutional deliveries, but without an apparent corresponding reduction in mortality.¹⁰ Improved coverage and access to health services are not sufficient to achieve health improved outcomes in the absence of concurrent effort to ensure clinical quality and client satisfaction. There is a need to institutionalize a sustainable and effective quality assurance system—covering both technical quality and client satisfaction—at public health facilities, with appropriate organizational structures and in-built incentives.

13. **Incorporating information technology-enabled services and e-governance for improving access, monitoring, and disease surveillance.** The NUHM plans to leverage information technology-enabled services and health technologies to improve service delivery, community participation, and health outcomes. Marshalling health technologies has been proven globally to improve health outcomes. Health information technology and telemedicine can enhance productivity, cost-efficiency, and quality of care. Partnerships with the private

⁹ This will be supported under the capacity development technical assistance attached to the program.

¹⁰ 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.

sector should be leveraged to enhance this core NUHM strategy, as India is emerging as an innovation hub for low-cost, high-volume products.¹¹ The program will support learning and sharing of knowledge, good practices, and innovations to improve urban health, including through a focus on health technologies to enhance health care access, quality, and efficiency.

14. **Capacity building of stakeholders.** The program further supports the NUHM core strategy of building stakeholder competence with respect to the management, technical, and public health aspects of health care. Significant program management and technical capacity strengthening is needed to operationalize the NUHM implementation framework. The program support targets strengthening business processes and management capacities to deliver urban health. The program's framework for capacity building support to NUHM includes (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 the Ministry of Health and Family Welfare and states—especially those that are lagging—through a pool of experts and demand-based consulting inputs; and (iv) enhancing knowledge, training, and institutional capacity in urban health through organization of international and national forums, institutional twinning arrangements, and a dedicated institute for urban health research and training.

b. Engaging the Private Health Sector

15. NUHM considers that strong public provisioning of essential health care, based on adequate and appropriate public financing, is the most promising approach to improving health access and financial protection. The private sector provides about 80% of patient care in urban areas, but there are good arguments in India to support development of public health infrastructure and staff. First, comprehensive primary health care has largely been neglected, with private investments focusing on more costly secondary and tertiary care; this gap calls for public intervention. Private health providers also generally do not provide disease preventive and health promotion services, which have low profit margins. Second, it is difficult to organize the vastly diverse private providers around public health goals, such as programs for vaccinations and communicable disease control, which need to be systematically applied at a large scale to realize public health impacts. Third, regulatory challenges and complexities raise issues of accountability and reliability when relying on the private sector.¹² There are also documented problems associated with the use of public–private partnerships (PPPs) for primary health care.¹³ Strengthening public health care facilities, with requisite focus on quality and accountability, would also expand the choice of providers, especially for the poor, who are currently often forced to visit poorly qualified private providers, and incur out-of-pocket payments.

16. The dominance of the private sector in urban areas provides challenges, but also unique opportunities to leverage their capabilities and improve urban health. While NUHM has opted to

¹¹ India's fast developing medical technology industry can be leveraged to enhance production of affordable, quality medical equipment for the poor. The domestic production of medical devices is growing rapidly, with estimated revenues of \$3 billion in 2011. National Institute of Pharmaceutical Education and Research. 2009. *Ahmedabad Medica Devices Sector Analysis*. New Delhi.

¹² Oxfam India Policy Brief, No. 3. 2012. http://www.oxfamindia.org/sites/default/files/Policy%20Brief%20No3-final%20December%202013_0.pdf

¹³ Partnerships with for-profit private providers in India have resulted in problems such as low quality, high cost, and rent-seeking. However, the governments of Tamil Nadu, Gujarat, Karnataka and Andhra Pradesh have demonstrated that PPPs with non-profit providers, such as private voluntary or nongovernmental organizations, can contribute to expansion of health care coverage.

strengthen public provisioning of essential health services, it also recognizes opportunities for private sector engagement and government purchasing of services, and leaves the door open for states—depending on needs, capacities, and context—to explore PPPs to improve health service coverage and referral linkages. UHC, which is a government priority, will require that all resources be harnessed to expand access to health care to all citizens and to effectively engage the private health sector to contribute to common public health goals. An integrated service provision network would need to be carefully designed so that both public and private primary care providers are linked to secondary and tertiary care providers to provide a continuity of care, and to enable primary care to serve as a responsible gatekeeper role for referral services. Given the diversity of urban settings—from small cities to large metropolises—a menu of models and approaches for engaging with the private sector to increase equity, access, and quality in delivery of health care will be explored for NUHM under the program. PPP models that enhance private sector quality, accountability, and cost control will be assessed and facilitated.

c. Gender Equity

17. Females suffer disproportionately from poor health outcomes. For example, in the National Family Health Survey-3, the proportion of male children who were fully immunized was 9% higher than the corresponding proportion of female children. Trend analysis across National Family Health Surveys reflects that the gender gap in full immunization is growing.¹⁴ Gender-based discrimination is also reflected in the urban infant mortality rate of 29 females per 1,000 live births, compared to 26 for males.¹⁵ Women also face challenges in terms of inadequate living conditions. The 2011 Census indicates that only 66% of slum households have latrine facilities, and only 57% have water connections within the premises. Other issues such as gender-based violence in the urban setting also shape gender-based disadvantages. In recognition of gender disadvantages, the program has a strong gender focus in its inclusive approach to health.

d. Consultations with Beneficiaries

18. The main beneficiaries targeted by NUHM and the program are the urban poor. The NUHM and its strategies were developed through a highly consultative process, and based on an extensive knowledge base and experience drawn from 8 years of implementation experience with NRHM. The report and recommendations of the technical resource group (TRG) for NUHM provide guidance on key issues, including reaching vulnerable groups, the main strategies and institutional design of NUHM, and organization of urban health service delivery and its governance to guide and strengthen implementation strategies. The TRG report is based on a series of consultations with experts and a range of vulnerable urban poor groups, and field visits to 30 cities across the country.

2. Adequacy

19. **Outcome.** The foregoing NUHM core strategies and cross-cutting features are broadly supported under program outputs, emphasizing specific results and elements needed to ensure NUHM achieves its stated outcome. NUHM aims to achieve equitable access to quality health care, which is critical to improving urban health status. Although the current program implementation period is limited, the program design assumes a phased, long-term approach to

¹⁴ S. Kishor and K. Gupta. 2009. *Gender Equality and Women's Empowerment in India*. National Family Health Survey, India, 2005–2006. Mumbai: International Institute for Population Sciences; Calverton, Maryland, USA: ICF Macro.

¹⁵ Government of India, Registrar General of India. 2014. *Sample Registration System Bulletin*. New Delhi.

strengthening the urban health system, focusing on key building blocks towards results and creating a development impact.

20. **Equity.** Equity would be increased through strengthened access to health services, especially among the urban poor and the vulnerable. To ensure that health services are used by the poor (and health outcomes thus improve), the program strategy addresses both supply (by providing a package of services that is relevant and essential to the needs of the urban poor) and demand (by increasing the range of beneficiaries that seek these services through community outreach and community processes). Equitable access is further facilitated through (i) expanded physical availability of services that are appropriately mapped and located in proximity to the urban poor; and (ii) by understanding and addressing other non-physical barriers to health seeking by the poor, such as payment of user fees, limited service hours, long waiting times, poor staff attitudes, and quality perceptions.

21. **Quality.** The program will further help to ensure that quality health services are delivered by incrementally introducing a system for quality assurance at public urban health facilities.¹⁶ The system and accompanying tools address quality dimensions both on the clinical side (providing appropriate care) and on the service side (client satisfaction). Incentives for quality measurement and improvement (e.g., certification) are also included in the framework for quality assurance. These incentives will be assessed and incrementally improved on. The program's focus on quality learns from the experience from NRHM, where service quality failed to keep pace with increased demand for and coverage of services and key interventions; as a result, corresponding level of impact on health outcomes (e.g., reduction in the maternal mortality ratio [MMR]) was not seen. The program addresses the need to provide quality assurance incentives—including dealing with issues such as workers absenteeism and safety of services—concurrently with increased expansion of services to realize health outcomes. The program also supports a defined minimum package of services at the primary level that addresses the health needs of urban slum dwellers and other urban poor.

22. **Efficiency.** The program is also expected to improve resource use efficiency by improving urban health care service delivery organization, strengthening urban health systems, and focusing on effective service delivery. An organized health care delivery structure with a focus on primary health care and preventive care with effective referral linkages is expected to substantially improve allocative efficiency (increase the cost-effective allocation of resources). With regard to technical efficiency (delivery of services in a way that improves efficiency and lowers costs), however, the program recognizes that a sole reliance on public provision of services may not be optimal, given the role and dominance of private providers in urban areas, and will seek opportunities for partnering with the private sector in urban areas.¹⁷ The program thus also supports exploring successful PPP models for more efficient delivery of health services.¹⁸

¹⁶ Documented issues of poor accountability in India's public health care system, include doctor absenteeism, embezzlement of drugs, and undue charges. There are also issues regarding lack of essential quality inputs such as shortage or lack of staff, drugs and equipment.

¹⁷ The NHM Implementation Framework provides for developing effective partnerships with nonprofit, nongovernment organizations and with the for-profit, private sector to bring additional capacity where needed to close gaps or improve service quality.

¹⁸ With regard to PPPs, a key demand that emerged during the program due diligence process was for assistance with guidelines and frameworks in the area of engaging and harnessing the capacity of the private sector. The widespread presence of non-state providers in urban areas provides a range of opportunities, but structuring partnerships is a challenge. Drawing from ADB's experience supporting the Government of India in structuring and executing PPPs, the program will provide guidance and capacity support to structure, regulate, and monitor health PPPs, including contracting guidelines with adequate checks and balances for health care outsourcing and

23. **Sustainability of results.** Program results will be sustained by focusing on the building blocks of urban health systems and related institutional capacity development. The program will focus capacity building on key areas with identified gaps that pertain to the strengthening of systems, institutions, and program management at national and state levels. Capacity development under the program will leverage Asian Development Bank (ADB) strengths to support (i) convergence between basic urban infrastructure services and health interventions to strengthen the public health thrust, and (ii) PPPs. While NUHM leverages the structures and approaches of NRHM (which was launched in 2005), it is expected to evolve based on implementation experience and develop improved processes to tackle challenges unique to urban areas. The program will support this by developing sustainable institutions and mechanisms for dedicated program research, training, knowledge sharing, and innovations focused on urban health in India.

3. Financial and Economic Analysis

24. The NUHM expenditure framework is assessed against criteria of effectiveness, efficiency and economy, and adequacy.¹⁹ Regarding effectiveness, the NUHM expenditure framework is consistent with the results and issues at hand, and is likely to achieve the program results when implemented. Regarding efficiency and economy, the NUHM aims to fill the large gap in primary health care in urban areas, thus improving the overall efficiency of the urban health system. Investment in primary health care would be the most cost-effective approach to improving overall health outcome, given limited resources. It will also strengthen the enabling environment for private sector engagement in the urban health system. Regarding adequacy, NUHM allocation across its components reflects the resources required to generate results. The challenge is expected to be more on improving fund utilization and absorptive capacity.

25. The economic viability of NUHM was analyzed by comparing projected project benefits to total project costs.²⁰ Project benefits were projected over 20 years, including the project implementation period—fiscal year (FY) 2014–FY2034. The expected economic benefits include (i) 40% decrease in U5MR; (ii) 50% decrease in MMR; (iii) institutional delivery and measles immunization increased by 2 percentage points per year over 3 years (FY2015–FY2017); (iv) increased out-of-pocket savings as a result of reduced health care expenditures; and (v) increased productivity savings because of improved health welfare. The target beneficiaries are households living in urban slum areas. The expected total project cost in achieving project outcomes is \$1.95 billion over a project period of 3 years.

26. The economic viability was gauged by examining the economic internal rate of return (EIRR), net present value (NPV), and cost per disability-adjusted life year saved through the program. A standard discount rate of 12% was used for the 20-year projection. A sensitivity analysis was conducted by changing crucial assumptions that could have adverse effects on achievement of the expected benefits. Adverse scenarios that were considered were (i) unexpected increase in project costs, (ii) reduced coverage of the beneficiary population, (iii) an overestimation of out-of-pocket savings, and (iv) reduced out-of-pocket savings.

27. The economic analysis shows that the positive effects of reduced U5MR and MMR, and increased out-of-pocket savings outweigh the economic costs of the program. The computed

provision. Several menus and models cities will be designed and documented for engaging various types of providers in various types of urban areas. A private health sector assessment will also be done to study the enabling environment for PPPs.

¹⁹ Program Expenditure and Financing Assessment (accessible from the list of linked documents in Appendix 2).

²⁰ Economic Analysis (accessible from the list of linked documents in Appendix 2).

EIRR of 13% indicate that the program is economically viable. The cost per disability-adjusted life year saved over the 20-year period is estimated to be \$43.8, which is cost effective. The sensitivity analysis indicates that the expected benefits are reasonably robust to adverse change in the assumptions. Reduced beneficiary coverage yields lowest EIRR (8.3%) among the scenarios. All other scenarios produced positive EIRRs ranging from 8.4% to 12.9%. Thus, mitigating actions focused on reaching all the targeted beneficiaries would ensure economic viability and high economic returns.

4. Implementation Arrangements

28. The NUHM leverages NRHM institutional structures at national, state, and district levels for operationalization of the NUHM. Field assessment in five states (including Madhya Pradesh, Odisha, Tamil Nadu, and West Bengal) evaluated the implementation readiness and capacity development requirements. The assessment confirms that the states are confident in their ability to implement NUHM, primarily because of their familiarity with NRHM institutional arrangements. However, the existing NRHM institutional mechanisms at various levels would need to be strengthened for NUHM implementation, in order to provide a dedicated focus on urban health issues. The program has been designed with significant institutional capacity building to address these critical elements.

C. Managing Risks and Improving Capacity

29. Implementation of NUHM's core strategies to address unique urban challenges cannot rely solely on prior experience and approaches of NRHM. There are challenges that include: (i) targeting of urban poor and vulnerable groups, (ii) improving community participation and processes through urban ASHAs and MAS, (iii) strengthening public health through actions that support disease prevention and health promotion, and (iv) increasing access to health and financial risk protection through community revolving funds. Effective implementation of these strategies will require close coordination and collaboration with ULBs, and further development and leveraging of existing ULB capacities.

30. Many ULBs have developed their capacity to reach and increased the attention given to the urban poor (e.g., targeting the poor and vulnerable and setting up community groups) as a result of various government initiatives, such as *Jawaharlal Nehru National Urban Renewal Mission* and *Rajiv Awas Yojana National Urban Livelihood Mission*. ULBs are also traditionally responsible for key public health functions such as water and sanitation. ULBs are therefore key to enhanced community participation in the urban health care delivery system and for achieving inter-sectoral convergence around public health goals. However, because NUHM is being implemented mostly by the state health departments (except in the mega cities and in a few cities selected by the state governments), there is a risk of undermining the role of ULBs during NUHM implementation.²¹ While the success of NUHM's key strategies will depend on the active involvement of ULBs during planning, monitoring, and implementation, the institutional responsibility for enhancing ULB roles and capacities and achieving convergence around public health functions needs to be further clarified. The program's design therefore targets the following to address convergence and involvement of ULBs:

- (i) **Joint planning processes at the city level.** Effective models of convergence in planning for urban health will be sought at the city level, which is the unit of

²¹ There are two main institutional models for NUHM implementation: (i) implementation by the ULB, and (ii) implementation by the state.

planning for health and allied activities under NUHM. This would include strengthening of structures and incentives for development of city health plans (under NUHM) jointly with urban development (e.g., city development or city sanitation plans, and City Health and Sanitation Planning Committees).

- (ii) **Implementation capacity at the city level and below.** To assist city-level NUHM implementation for public health outcomes, capacity of ULBs in their mandated public health functions will be strengthened under NUHM. Development of guidelines and terms of references for community-based institutions such as MAS would also be supported to serve as effective community-level platforms for convergence between health, nutrition, and municipal services during implementation. The role of urban ASHAs would also be strengthened for promoting positive health and hygiene behaviors to complement basic urban infrastructure investments, such as in sanitation.
- (iii) **Policy and planning at the state-level.** Supportive policies and structures for convergence at the state level will be supported, such as inclusion of secretaries of line departments in state health societies, issuance of joint circulars by health and urban development for joint planning and reporting, development of state public health acts, and revival of the state public health cadre.

31. Recognizing inadequate attention to convergence as a key risk in implementation, the program seeks to bring higher attention to convergence in the design of disbursement-linked indicators and program actions.