SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	INDIA	Program Title:	Supporting National Urban Health Mission
Lending Modality:	Results-based lending for programs	Department/ Division:	South Asia Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Targeting classification: targeted intervention—MDGs

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

India's Twelfth Five−Year Plan (2012−2017) emphasized moving towards universal health coverage and providing access to good quality health care for all citizens.[a] The National Urban Health Mission (NUHM) was launched in 2013 to improve the delivery of basic health services to the urban population, especially the poor and other vulnerable groups. The urban poor are one of the fastest growing and most vulnerable population segments in India. They face harsh living conditions and have limited access to basic health care, resulting in a disproportionate burden of ill health. By improving access by India's rapidly growing urban population, especially the poor, to quality public health services, NUHM will reinforce the government's efforts to support inclusive growth and alleviate poverty. It is in line with Asian Development Bank's India country partnership strategy (2013–2017), which aims to support India's efforts towards inclusive growth, and recognizes the importance of health in overall human capital development.[b]

B. Results from the Poverty and Social Analysis during Assessments of the Program and its Systems

1. **Key poverty and social issues.** Health services and basic infrastructure facilities—water supply, sewage, sanitation, and housing—in most Indian cities and towns are unable to cope with the rapid population growth and increased rural–urban migration. The urban slum population grew by 25.1% during 2001–2011. It is estimated that around 66 million persons (17.4% of the urban population) live in slums. The poor health of the urban poor results from limited access to affordable and quality health care services, a lack of health and hygiene awareness, and overcrowding and unhygienic living conditions. In 2006, the under-five mortality rate among urban poor was 72.7 per 1,000 live births, compared to an urban average of 51.9. Nearly 46% of urban poor children were underweight compared to the urban average of 33%, and 60% of urban poor children were not fully immunized before their first birthday. The urban poor are prone to recurring episodes of ill health. In the absence of a good primary health care network, they incur high and often catastrophic out-of-pocket health expenses.

2. **Beneficiaries.** NUHM will cover over 1,000 cities and towns, across India. It will benefit around 78 million urban poor living in these cities. The NUHM will focus on the urban poor living in slums, and vulnerable populations including the homeless, migrant laborers, beggars, and rag-pickers. It will reinforce the focus on sanitation, clean water, and vector control, which important determinants of public health.

3. **Impact channels.** NUHM aims to address the health care needs of the urban poor by: (i) improving access to better and more affordable services by expanding and refurbishing urban primary health centers, providing medicine and equipment, and building the capacity of public health staff; (ii) mobilizing community groups to enhance community participation and awareness of health care activities; (iii) strengthening public health through preventive actions focusing on improved water and sanitation, safe housing, and nutrition; (iv) promoting information technology-enabled services and e-governance for effective monitoring and timely delivery of health services; (v) developing the capacity of urban local bodies to manage public health functions; (vi) extending outreach services to the most vulnerable groups among the urban poor; and (vii) defining and promoting quality standards for public health services.

4. **Other social and poverty issues.** Urban poverty differs from rural poverty in several respects. Many slums and squatter settlements are not legally recognized, and thus lack access to basic health, education, and urban facilities. A high incidence of communicable and respiratory diseases results from congested living conditions; lack of basic facilities; and exposure to high levels of water, air, and other pollution. Rural migrants also suffer because of breakdowns in their social networks. Substance abuse, domestic violence, and other gender-related problems are therefore very common among slum dwellers. Given their limited access to public primary health care centers, and the absence of a functional referral system, people often go to secondary or tertiary hospitals for relatively minor ailments or health checkups. Access and financial protection for the poor or near-poor are key concerns, given that a major portion of total urban health expenditures takes the form of out-of-pocket payments to private providers, which can lead to further impoverishment. The urban poor are also often forced to use poorly qualified private providers.

5. **Design features.** The proposed loan will benefit the urban poor by (i) expanding the network of good quality urban primary health centers to slums and poor neighborhoods, (ii) establishing a good referral system, (iii)

encouraging community participation and engaging women's groups in health and social outreach, and (iv) improving coordination between health and urban departments in towns and cities. At the outcome level, changes in the institutional delivery rate and immunization uptake in urban areas will measure the overall efficacy of the program. At the output level, the community processes will contribute directly to equitable access by identifying the most disadvantaged groups through community outreach services and creating awareness and demand for these services. The program will also address issues of convergence, especially with water and sanitation and women and child development departments.

II. PARTICIPATION AND EMPOWERING THE POOR

1. **Participatory approaches and proposed program activities.** During the design of the NUHM the Ministry of Health and Family Welfare (MOHFW) has conducted several national and state-level workshops involving technical agencies, nongovernment organizations, and other relevant stakeholders, and conducted surveys of the urban poor. Additional consultations were held by the Asian Development Bank while designing the proposed program. Field visits were undertaken to the states of West Bengal, Tamil Nadu, and Madhya Pradesh. Meetings were held with MOHFW, municipal corporations, doctors, health center staff, outreach workers, community members, nongovernment organizations, and other development partners.

2. **Civil Society**. Community outreach, engagement of *Mahila Arogya Samiti* (MAS) (community collectives comprising local women) women's groups and involvement of civil society are integral aspects of the NUHM, and will raise their awareness about health and hygiene, and their ability to help the urban poor in accessing good quality healthcare.

3. **Civil society organizations.** Accredited social health activists (ASHAs) and MAS will conduct outreach services.

4. **Forms of civil society organization participation envisaged during program implementation**
☒ Information gathering and sharing ☒ Consultation ☒ Collaboration ☒ Partnership

5. **Participation plan** ☐ Yes ☒ No
The MAS will be the basic unit of planning and community action. The planning process will involve identification, mapping, and vulnerability assessment of slums; assessment and mapping of the existing health care services; stakeholder consultations; mapping of referrals in each area; rationalization of manpower; and ensuring effective convergence with departments such as Women and Child Development and Urban Development.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: gender equity as a theme (GEN)

1. **Key issues.** Females suffer disproportionately from poor health outcomes. For example, the National Family Health Survey (NFHS-3) found the proportion of male children who are fully immunized to be 9% higher than the corresponding proportion of female children. Trend analysis across NFHS reflects that the gender gap in full immunization is growing.[c] In addition, the sex ratio is skewed: the 2011 Census for slums reported a sex ratio of 928 girls (per 1,000 boys), and 922 for ages 0–6 years. Gender-based discrimination is also reflected in the urban infant mortality rate of 29 females (per 1,000 live births) as compared to 26 males.[d] Women face several gender-based disadvantages and barriers in accessing health care (distance to health care, need for transport, concern regarding the lack of providers). These challenges are exacerbated by other factors such as inadequacies in living conditions in urban slums. The 2011 Census indicates that only 66% of all slum households have latrine facilities, and 57% a water connection within the premises. Other issues such as gender-based violence, alcoholism, and substance use in the urban setting also contribute to gender-based disadvantages for women and girls, and vulnerable populations (e.g., the destitute; homeless; pavement dwellers; beggars; street children; construction workers; coolies; rickshaw pullers; sex workers; street vendors; migrant workers; construction workers; the elderly poor; disabled; and the lesbian, gay, bisexual, and transgender community).

2. **Key actions.** NUHM's key results indicators—a reduction in the maternal mortality ratio, under-five and infant mortality rates, total fertility rate, and universal access to reproductive health, including 100% institutional delivery—have a strong gender dimension. Likewise, the outreach and delivery mechanism envisaged under NUHM provides a key role for women (e.g., ASHAs and MAS) in improving awareness about health and nutrition issues, and facilitating preventive care. The capacity of the MASs and ASHAs will be strengthened under the proposed loan. A dedicated human resource (gender) expert will be engaged under the proposed accompanying capacity development technical assistance to monitor and report on community processes and related areas. A framework with monitorable gender-disaggregated targets will be used to guide community outreach activities. Gender-responsive innovations and partnerships in urban health care facilities in different states will be identified and replicated. Health staff capacity building will include gender sensitization training that focuses on maternal health, gender-based violence, and reproductive rights. Opportunities for skill upgrading and career progression will be provided to community health workers. The elements of the gender and social equity framework are described in the program action plan (PAP).
☒ Gender actions ☐ Other actions or measures ☐ No action or measure

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement **Safeguard Category:** ☐ A ☐ B ☒ C

1. **Key impacts.** The program will not involve large-scale civil works and is unlikely to trigger any resettlement impacts. Small-scale civil works will be conducted for renovation or upgrading of existing health service premises or new urban primary health or urban community health centers on government-owned land, where there are no encroachers or squatters. Vendors in the vicinity of health facilities may need to temporarily move a few yards during the construction phase.

2. **Strategy to address the impacts.** Although no resettlement impacts are envisaged, in view of the conditions in urban areas, the program will apply a two-stage screening process to exclude any activities that may result in involuntary resettlement. This will be supplemented by physical monitoring of a sample of screened facilities using risk-based, purposive sampling and NUHM's grievance redressal mechanism. Actions to improve program safeguard systems are included in the PAP.

3. **Actions** ☒ Program safeguard systems improvements ☐ No action

B. Indigenous Peoples **Safeguard Category:** ☐ A ☐ B ☒ C

1. **Key impacts.** 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 policy safeguards are unlikely to be triggered.
Is broad community support triggered? ☐ Yes ☒ No

2. **Strategy to address the impacts.** Same as section A.2.
3. Actions ☐ Program safeguard systems improvements ☒ No action

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. **Relevance of the program for the country's or region's or sector's labor market.**
unemployment = low; underemployment= low; retrenchment = low; core labor standards = low

2. **Labor market impact.** The program will positively impact the labor market by reducing the frequency of labor absenteeism resulting from recurring incidence of ill health.

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

C. Communicable Diseases and Other Social Risks
1. The impact of the following risks are rated high (H), medium (M), low (L), or not applicable (NA): Communicable diseases = NA; Human trafficking = NA; Others (please specify) = NA
2. Risks to people in program area = NA

VI. MONITORING AND EVALUATION

1. **Targets and indicators**. At the outcome level, the program aims to enhance institutional and individual capacities by providing the skills needed to establish an equitable, quality urban health system that targets the poor and vulnerable. The PAP includes a sector-wide gender and social equity framework, with dedicated human resources to assist in implementation.

2. **Required human resources**. The MOHFW Statistics Division will require staff strengthening, focused on monitoring and evaluation of NUHM results indicators. The national program management unit will include a social and environmental safeguard monitoring consultant and a gender specialist to monitor and evaluate progress in achieving key performance indicators, including PAP items.

3. **Information in program implementation document**. The program implementation document includes disbursement-linked indicators, PAP, the results framework, program systems and implementation arrangements, and integrated risks and mitigating measures.

4. **Monitoring tools**. The health management information system and the program's management information system, including periodic government surveys (NFHS, Sample Registration Survey, and National Sample Survey) will be used to monitor key performance indicators, including progress toward disbursement-linked indicators and PAP items.

[a] Government of India, Planning Commission. 2013. *Twelfth Five–Year Plan of India, 2012–2017*. http://planningcommission.gov.in/plans/planrel/12thplan/welcome.html
[b] ADB. 2013. *India: Country Partnership Strategy 2013–2017*. Manila.
[c] S. Kishor and K. Gupta. 2009. *Gender Equality and Women's Empowerment in India*. NFHS-3, India, 2005−2006. Mumbai: International Institute for Population Sciences; Calverton, Maryland, USA: ICF Macro.
[d] Government of India, Ministry of Home Affairs. Office of the Registrar General & Census Commissioner. 2013. *Sample Registration Survey, 2013*. http://www.censusindia.gov.in/vital_statistics/SRS_Reports_2013.html