Report and Recommendation of the President to the Board of Directors

Project Number: 47354-003
April 2015

Proposed Results-Based Loan and Administration of Technical Assistance Grant
India: Supporting National Urban Health Mission

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 1 April 2015)

Currency unit	–	Indian rupee/s (Re/Rs)
Re1.00	=	$0.01605
$1.00	=	Rs62.3100

ABBREVIATIONS

ADB	–	Asian Development Bank
DLI	–	disbursement-linked indicator
M&E	–	monitoring and evaluation
MIS	–	management information system
MOHFW	–	Ministry of Health and Family Welfare
NHM	–	National Health Mission
NRHM	–	National Rural Health Mission
NUHM	–	National Urban Health Mission
PAP	–	program action plan
PPP	–	public–private partnership
TA	–	technical assistance
UHC	–	universal health coverage
ULB	–	urban local body
UPHC	–	urban primary health center

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 starts, e.g., FY2014 begins on 1 April 2014 and ends on 31 March 2015.

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

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RESULTS BASED PROGRAM AT A GLANCE

1. Basic Data — **Project Number:** 47354-003

Project Name	Supporting National Urban Health Mission	**Department /Division**	SARD/SAHS
Country	India	**Executing Agency**	Ministry of Health and Family Welfare
Borrower	India		

2. Sector	**Subsector(s)**	**ADB Financing ($ million)**
✓ **Health**	Health system development	300.00
	Total	**300.00**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	Climate Change impact on the Project	Low

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Civil society participation Institutional development Organizational development	Gender equity (GEN)	✓
Knowledge solutions (KNS)	Knowledge sharing activities Pilot-testing innovation and learning		
Partnerships (PAR)	Civil society organizations Implementation Private Sector		
Private sector development (PSD)	Public sector goods and services essential for private sector development		

5. Poverty Targeting		**Location Impact**	
Project directly targets poverty	Yes	Urban	High
MDG-targeting (TI-M)	MDG4, MDG5, MDG6		

6. Risk Categorization: Low

7. Safeguard Categorization **Environment:** B **Involuntary Resettlement:** C **Indigenous Peoples:** C

8. Financing

Modality and Sources	**Amount ($ million)**
ADB	**300.00**
Sovereign Results Based Lending: Ordinary capital resources	300.00
Cofinancing	**2.00**
Japan Fund for Poverty Reduction	2.00
Counterpart	**1,654.90**
Government	1,654.90
Total	**1,956.90**

9. Effective Development Cooperation

Use of country procurement systems	Yes
Use of country public financial management systems	Yes

Source: Asian Development Bank

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed loan to India for the Supporting National Urban Health Mission program, and (ii) the proposed administration of technical assistance (TA) to be provided by the Japan Fund for Poverty Reduction for Strengthening Capacity of the National Urban Health Mission (NUHM).[1]

2. The program will support the Government of India to implement the NUHM, which aims to improve the health status of the urban population, particularly of the poor and vulnerable, by facilitating equitable access to quality health services.[2]

II. THE PROGRAM

A. Strategic Context

3. India has made good progress in achieving health outcomes over the last decades, especially in the rural areas, but the urban poor have generally not benefitted. India is urbanizing rapidly, and the urban poor, estimated to number around 77.5 million, are one of the country's fastest-growing and most vulnerable population segments. They face harsh living conditions and have limited access to basic health care, resulting in a disproportionate burden of ill health.[3] For example, the majority of urban poor women delivered their babies at home. Almost 60% of urban poor children below 1 year of age missed total immunization compared to the urban average of 42.4%. The under-five mortality rate among urban poor was 72.7 per 1,000 live births compared to the urban average of 51.9. Many are also migrant workers with informal status, which limits their access to basic public services and welfare programs.

4. The delivery of health services in urban areas is sub-optimal and fragmented. Past interventions have tended to be in the form of vertical programs focusing on particular diseases, rather than investments made to strengthen broader urban health systems. Urban primary health facilities are limited in number with weak referral linkages, underutilized, vary in norms and quality, and have limited scope of services, such as in community outreach and health promotion. Most of the curative primary care occurs at secondary and tertiary levels, leading to inefficiencies and overcrowding of these centers. Financial protection and prevention of further impoverishment of the poor is a key concern, given that a major part of total health expenditures is paid out-of-pocket to private providers.

5. Private health providers dominate in urban areas. However, the large number of urban poor cannot afford these services, and the private health sector's contribution to primary health care has been limited. Regulatory mechanisms and management capacity need to be improved to strengthen the enabling environment for private sector engagement in the health sector. Moreover, health in the urban context is affected by multiple physical and social environmental factors and access to health services. For example, diarrhea—a leading cause of death among children in India—is correlated with poor water, sanitation, and hygiene practices. More attention is therefore required to promote integrated urban planning and convergence across key sectors that affect urban health.

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[1] The design and monitoring framework is in Appendix 1.

[2] ADB provided a program preparatory TA. ADB. 2013. *Technical Assistance to India for Supporting National Urban Health Mission.* Manila.

[3] Government of India, Ministry of Health and Family Welfare. 2007. *National Family Health Survey (NFHS-3), 2005–2006*. New Delhi. The next survey, NFHS-4, 2014–2015 is due in 2016.

6. As a policy response, in May 2013, the Government of India launched the NUHM to strengthen health service delivery in urban areas. The NUHM builds on extensive stakeholder consultations and the successful experience of the National Rural Health Mission (NRHM), which started in 2005. The NUHM and the NRHM are sub-missions of the National Health Mission (NHM) under the Government's Twelfth Five–Year Plan.[4] As a core strategy, the NUHM will enhance the public health system infrastructure by establishing a network of urban primary health centers (UPHCs) covering all cities with a population above 50,000. The UPHCs, linked with community outreach and referral services, will expand the access of the urban population to health services and strengthen primary health care in urban areas. Given that urban health is a new priority for the Government of India, the NUHM requires strong support at all levels to gain critical momentum and to effectively tackle evolving challenges unique to the urban context. In October 2014, the Government of India also introduced the Swachh Bharat Mission (Clean India Initiative) to provide universal access to sanitation facilities in urban areas. Ensuring coherence and convergence of the NUHM and Swachh Bharat Mission will be crucial to attain the desired health outcomes. Building on the health sector gains, the Government of India plans to progressively move towards universal health coverage (UHC) under the Twelfth Five–Year Plan. Success of the NUHM will be critical to the UHC agenda in urban areas, as UPHCs are expected to facilitate referrals and insurance coverage for the urban poor.

B. Program Rationale

7. The program is in line with the priorities of the India country partnership strategy, 2013–2017, which seeks to reinforce India's efforts towards inclusive growth.[5] The program is also aligned with the Midterm Review of Strategy 2020, which includes an increased focus on health sector operations and moving towards UHC.[6] The results-based lending modality is appropriate for the program because the NUHM has (i) strong government interest and ownership; (ii) a well-defined implementation framework; and (iii) reasonable systems in fiduciary management, safeguards, and monitoring and evaluation (M&E). The results-based approach will help improve the NUHM's systems and institutional capacity further and reduce the transaction costs associated with monitoring and coordinating the large and diverse range of activities and stakeholders.

8. The program will build on Asian Development Bank (ADB)'s extensive experience in the urban sector and in providing public–private partnership (PPP) advisory services in India.[7] It has the following key features and will add value by: (i) strengthening management, M&E, and implementation processes through significant capacity building; (ii) facilitating convergence between health and urban sector interventions, emphasizing integrated city-level planning with active involvement of urban local bodies (ULBs); (iii) developing partnerships and mechanisms to engage the private health sector, including not-for-profit entities; (iv) enhancing community participation to improve governance and delivery of health services; and (v) fostering learning and knowledge sharing, good practices, and innovations in urban health.

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[4] Government of India, Planning Commission. 2013. *Twelfth Five–Year Plan of India, 2012–2017*. New Delhi. http://planningcommission.gov.in/plans/planrel/12thplan/welcome.html.

[5] ADB. 2013. *India: Country Partnership Strategy, 2013−2017*. Manila.

[6] ADB. 2014. *Midterm Review of Strategy 2020: Meeting the Challenges of a Transforming Asia and Pacific.* Manila.

[7] ADB has engaged in the urban sector in India since 1995 covering 14 states. ADB urban interventions focus on strengthening urban governance and developing sustainable urban infrastructure such as water, sanitation, and waste management. ADB also supported the Department of Economic Affairs in mainstreaming PPPs in India through several TA projects since 2006.

C. Program Scope

9. The NUHM aims to improve the health status of the urban poor by facilitating equitable access to quality, essential health services. The program will reinforce the NUHM's efforts by prioritizing results and sequencing outputs and targets critical to achievement of the NUHM's outcome. More specifically, the program results emphasize quality assurance, reaching the poor and the vulnerable, enhancing private sector participation and intersectoral convergence, knowledge and innovation, and improved management capacity and business processes. The program scope is summarized in Table 1.

Table 1: Program Scope

Item	National Urban Health Mission[a]	Results-Based Lending Program
Outcome	Equitable access to quality health care	Increased access to equitable and quality urban health system
Key outputs (NUHM core strategies)	(i) Improve efficiency of public health systems in cities (ii) Promote access to improved health care at the household level (iii) Strengthen public health thrust (iv) Increase access to health care and address out-of-pocket expenditures (v) Improve health access, surveillance, and monitoring through ITES and e-governance (vi) Build stakeholder capacity (vii) Prioritize most vulnerable among poor (viii) Ensure quality of health care services	Same as NUHM, organized into three outputs: (i) Urban primary health care delivery system strengthened; (ii) Quality of urban health services improved; and (iii) Capacity for planning, management, and innovation and knowledge sharing strengthened
Program expenditure	$3,751.2 million	$1,954.9 million[b]
Main financiers and the respective financing amounts	Government of India[c]	Government of India (84.7%) ADB (15.3%)
Geographic coverage	Nationwide	Same as NUHM
Implementation period	FY2012–2016[d]	FY2014–2017[e]

ADB = Asian Development Bank, FY = fiscal year, ITES = information technology-enabled services, NUHM = National Urban Health Mission.

[a] Government of India, Ministry of Health and Family Welfare. 2013. *National Urban Health Mission, Framework for Implementation.* New Delhi.

[b] Sum of FY2015 and FY2016 projections approved by the Expenditure Finance Committee and the revised budget for FY2014.

[c] Including shares of state governments.

[d] The cabinet approved the NUHM in May 2013, and implementation commenced in 2014.

[e] An additional year after the NUHM implementation period is allowed for results verification and disbursement.

Sources: Ministry of Health and Family Welfare of the Government of India and Asian Development Bank.

D. Program Results

10. The program will support the NUHM's goal to improve the 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, as evidenced by increased institutional deliveries (disbursement-linked indicator [DLI] 1) and complete childhood immunization (DLI 2). Increased institutional deliveries, with their quality assured, will help reduce deaths among mothers and newborns. Improved immunization coverage will also help avert infant and child mortality. These indicators were chosen as they reflect high levels of inequity between urban poor and non-poor. The outcome will be achieved through the following outputs, which focus on strengthening key building blocks of the urban health system:

11. **Output 1: Urban primary health care delivery system strengthened.** The NUHM aims to establish a system of urban primary health facilities covering cities and large towns. This output will sharpen the focus of the NUHM's 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 the 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). The NUHM aims to strengthen community outreach services to extend community health awareness and demand for services through urban accredited social health activists and community collectives comprising local women (Mahila Arogya Samitis). This output will ensure timely recruitment and adequate training of urban accredited social health activists, and close monitoring of their functioning (DLI 4). It will also study and undertake capacity building of community-based institutions such as Mahila Arogya Samitis (PAP 1.2).

12. **Output 2: Quality of urban health services improved.** The 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 improvements (DLI 5 and PAP 1.7). The output will also review existing private provider regulations, 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).

13. **Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened.** The NUHM needs significant capacity building in program management and technical aspects of urban health to operationalize the NUHM's implementation framework effectively. This output will enhance staff capacity to implement the NUHM (DLI 6). It 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).[8] States with weak capacity will receive priority for capacity development support. Existing M&E mechanisms and staff capacity will be enhanced 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 (MIS) to produce urban disaggregated data (DLI 6); (ii) strengthen existing MIS to monitor the NUHM's progress; and (iii) improve data on key health outcome indicators (PAP 1.1 and PAP 5). This output will also assist the Ministry of Health and Family Welfare (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.

[8] The capacity development 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.

14. **Convergence and public–private partnership.** The program will promote convergence and PPPs across the three outputs. Convergence will be strengthened at three levels: (i) policy and planning at the state level, where state health societies include representatives from health and urban departments; (ii) integrated planning for urban health at the city level, with active involvement of ULBs, including in planning and mapping of slums and vulnerable populations; and (iii) community processes and participation for better urban services (e.g., water, sanitation, and health services) and improved health and hygiene practices. The program will also strengthen the enabling environment and capacity for private sector engagement by (i) conducting a detailed assessment of the experience, challenges, and opportunities for PPPs in India's health sector; and (ii) developing policy guidelines and a menu of models and options for PPPs in urban health, including with the nonprofit sector.

15. ADB financing will be disbursed as per the allocation table summarized in Table 2.

Table 2: Disbursement-Linked Indicators

Indicator	Disbursement Allocated ($ million)	Share of ADB Financing (%)
Outcome: Increased access to equitable and quality urban health system		
DLI 1. Increased institutional deliveries	30	10
DLI 2. Increased complete immunization among children	30	10
Output 1: Urban primary health care delivery system strengthened		
DLI 3. City-specific primary health care delivery system established	65	22
DLI 4. Community processes improved	55	18
Output 2: Quality of urban health services improved		
DLI 5. Effective quality assurance system implemented	55	18
Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened		
DLI 6. Planning, management, and monitoring capacity strengthened	45	15
DLI 7. Innovations and partnerships in urban health developed, tested, and shared	20	7
Total	**300**	**100**

ADB = Asian Development Bank, DLI = disbursement-linked indicator.
Source: Asian Development Bank.

16. A rigorous verification protocol, including independent, third-party validation, has been established. Verification of outcome DLIs will rely on the Health Management Information System, validated by independent consultants for data quality and triangulated with population-based survey data to verify overall trends. Output DLIs will be verified through (i) joint reviews by MOHFW and ADB after reports from the states are received to gain better insights from implementation of program activities at the state level, and (ii) the use of existing reporting mechanisms, such as NUHM quarterly progress reports, and comparing the information with expenditure reports. Independent evaluation of effectiveness and progress in quality assurance and implementation of the capacity development framework will be used for DLI verification, as well as target setting for subsequent years. The verification process is designed to strengthen MOHFW's capacity in overseeing and supporting the state-level implementation of NUHM activities.

E. Expenditure Framework and Financing Plan

17. **Program expenditures.** The program will support NUHM expenditures, which are estimated to be $1,954.9 million during FY2014–2016 (Table 3).

Table 3: Summary of Program Expenditure Framework, FY2014–2016
(in 2014 prices)

Item	**Amount** ($ million)	**Share of Total** (%)
Recurrent	**1,535.4**	**78.5**
Strengthening health services (operations)	1,049.9	53.7
Community processes	135.1	6.9
Regulation and quality assurance	20.0	1.0
Training and capacity building	74.8	3.8
Innovative actions and PPPs	91.9	4.7
Program management, planning and mapping, M&E	163.7	8.4
Capital	**419.5**	**21.5**
Strengthening health services (civil work and equipment)	419.5	21.5
Total	**1,954.9**	**100.0**

M&E = monitoring and evaluation, PPP = public–private partnership.
Sources: Asian Development Bank estimates based on the Government of India, Ministry of Health and Family Welfare. 2012. *National Urban Health Mission–Expenditure Finance Committee Note with Annexures.* New Delhi; Government of India, Ministry of Finance. 2014. *Union Budget – Notes on Demands for Grants, 2014–2015, No. 46/Department of Health and Family Welfare.* New Delhi.

18. **Program financing.** Total NUHM financing needs for FY2014–2016 are estimated at $1,954.9 million, of which the government has requested a loan of $300 million from ADB's ordinary capital resources to finance the program. The loan terms and conditions are in para. 32. Subject to a review of implementation progress, the government may request additional financing of $200 million in 2017 to support the NUHM's transition and continuation into the next five-year plan. The financing plan for the program is summarized in Table 4.

Table 4: Program Financing Plan

	Amount ($ million)	**Share of Total** (%)
Government of India	1,654.9	84.7
Asian Development Bank		
Ordinary capital resources (loan)	300.0	15.3
Total	**1,954.9**	**100.0**

Source: Asian Development Bank estimates.

19. **Disbursement arrangements.** The loan will be disbursed over 3 years, subject to the achievement and verification of the DLIs. An initial disbursement of up to $40 million will take place after loan effectiveness and upon verification of achievement of prior results (completed within 12 months prior to loan effectiveness). These prior results include: (i) state-level NUHM program implementation plans approved in FY2014; (ii) urban-specific guidelines for community health workers and quality assurance; and (iii) increased staffing in program management for states, districts, and cities. All prior results have been met as of March 2015. Subsequent disbursements will be made annually after the corresponding DLIs are met. ADB will field periodic review missions, whose tasks will include validating DLI achievements prior to the submission of withdrawal applications. Once DLI achievements are validated, MOHFW will submit withdrawal applications, together with the DLI achievement report to ADB. Any amount not disbursed for unmet DLIs will be disbursed once the DLIs are achieved. The loan proceeds will be disbursed to the government's consolidated fund.

F. Capacity Development and Program Action Plan

20. The program will strengthen capacity of NUHM institutions at various levels. The NUHM has adopted NRHM's implementation arrangements, which have been tested and refined over time, but urban-specific challenges require dedicated capacity-strengthening efforts, including:

(i) strengthening existing technical agencies at the national and state levels, (ii) technical support to states through a pool of experts located at the central level, (iii) establishing dedicated institutes for urban health research and training, and (iv) creating knowledge-sharing platforms. The PAP complements the DLIs and includes actions in specific technical areas, fiduciary management, M&E, safeguards, and gender and social equity. The PAP focuses capacity building on key areas of identified gaps pertaining to strengthening systems and institutions at the national level, which in turn will strengthen the capacity of the states to implement the NUHM.

G. Technical Assistance

21. The attached capacity development TA will help strengthen NUHM implementation. The TA is estimated to cost $2.2 million, of which $2 million will be financed on a grant basis by the Japan Fund for Poverty Reduction. The government will support the TA in the form of counterpart staff, office and meeting space, and coordination support. The TA will support (i) state-level institutional capacity assessments; (ii) monitoring, verification, and reporting of program results; and (iii) developing and learning from innovations in urban health. The TA activities will focus on states with weaker capacity and where ADB's urban sector presence can be leveraged to enhance synergy and convergence. The TA will be implemented over a period of 36 months from July 2015.

H. Implementation Arrangements

22. Program implementation will follow the NUHM Implementation Framework. MOHFW will be the executing agency. The NHM Steering Group under the Union Health Minister, the Empowered Program Committee under the Secretary of MOHFW, and the National Program Coordination Committee under the Mission Director will guide and oversee NUHM implementation, including the program. The Urban Health Division of MOHFW will be the implementing agency, coordinating program activities, and supporting state-level activities. The states will implement NUHM activities based on the annually approved state program implementation plans. The states will prepare periodic reports on progress in meeting DLIs and PAP as part of their regular reporting on overall NUHM implementation. MOHFW will consolidate state-level reports and submit periodic progress reports on achievement of DLIs and PAP and other NUHM key performance indicators, and prepare DLI achievement reports for disbursement.

III. SUMMARY OF ASSESSMENTS

A. Program Technical Assessments

23. The program's soundness was assessed according to its relevance, justification, and adequacy.[9] The program is highly relevant to India's sustainable and inclusive urban development. It will improve the health and well-being of the urban population, focusing on the poor and the vulnerable, and provide them with equitable access to quality health services. Program interventions are well justified, focusing on key results that are prioritized and sequenced to improve NUHM implementation performance in accordance with its core strategies. The program addresses current inefficiencies in the delivery of urban health care by strengthening overall health systems and focusing resources on comprehensive primary health

[9] Program Soundness Assessment (accessible from the list of linked documents in Appendix 2).

care. While the program reinforces public provisioning of essential health services, it also facilitates partnerships with the private health sector to improve health services coverage and the continuum of care. The program promotes cross-sectoral convergence to address key determinants of urban health both within and beyond the health sector. The program has a strong gender focus. Sustainability of results will be ensured through the program's focus on strengthening institutions and significant capacity building.

24. The economic analysis weighed the program's benefits relative to its costs. The economic benefits are from (i) reduced mortality rates, (ii) increased health facility utilization, (iii) increased productivity and out-of-pocket health care cost savings, and (iv) productivity gains in terms of decreased disability-adjusted life years.[10] The economic analysis yielded an economic internal rate of return of 13%. The economic internal rate of return is sensitive to changes in population coverage. Thus, reaching more beneficiaries would ensure the program's economic viability.

25. The program is categorized as gender equity. It has a strong gender and pro-poor focus. Health interventions directly target the poor while also allocating greater resources to the needs of women and girls, especially their reproductive health. Health service providers will be trained to be responsive to specific needs and concerns of women and girls and to improve their interactions with poor and marginalized communities. Through community outreach and counselling services, women and girls will be empowered to realize their health rights and address issues of gender-based violence. The program will also help improve the working conditions and career trajectories of female health workers.

B. Program System Assessments

26. **Monitoring and evaluation systems.** The M&E system assessment found that the NUHM's monitoring framework, comprising oversight and steering committees, MIS, and annual common review missions, is robust for tracking the program's outputs and outcome.[11] Common review missions consist of officials from MOHFW, state health departments, and technical experts; development partners can be invited to participate. The areas for further strengthening include: (i) enhancing existing systems to track information specific to the NUHM's progress and main program beneficiaries (the urban poor and vulnerable groups), (ii) building the capacity of data entry operators and MIS officers at all levels, (iii) harmonizing the operability of multiple systems, and (iv) providing adequate resources to improve coverage and accuracy of reporting and availability of quality and timely data. MOHFW will be responsible for performance monitoring against a set of key performance indicators that are defined within the NUHM's implementation and results frameworks, including DLIs and PAP targets. MOHFW will also draw on interagency information systems to obtain urban health-related indicators in preparing annual performance reports.

27. **Fiduciary systems.** Rigorous financial management, procurement, and anticorruption systems assessments confirm that the program systems are adequate for results-based lending with some risk mitigation measures.[12] The overall financial management risk is moderate. Areas for improvement include: (i) timely release of funds from state treasuries to state health

[10] Economic Analysis (accessible from the list of linked documents in Appendix 2).
[11] Common review missions will cover results, technical, and fiduciary aspects of the program. Program Monitoring and Evaluation System Assessment (accessible from the list of linked documents in Appendix 2).
[12] Program Fiduciary Systems Assessment (accessible from the list of linked documents in Appendix 2).

societies, and (ii) timely financial reporting and auditing. The PAP includes the following risk mitigation measures: (i) enhancing fiduciary performance monitoring, (ii) supporting staff capacity development, (iii) ADB participation in annual common review missions of MOHFW's financial management group, and (iv) provision of program financial statements following a Statement of Audit Needs.

28. The program will entail procurement of civil works, drugs, and consumables; furniture and equipment at health facilities; and consulting services, all of which will be sourced domestically. Overall procurement risk is substantial mainly due to (i) lack of adequately trained staff in some states, and (ii) inadequate quality assurance mechanisms and supply management, especially for drugs in some states. The risks will be mitigated by ensuring adequate number of qualified procurement staff (DLI 6) and implementing pre- and post-delivery quality checks of drugs and annual post-procurement reviews in at least three states (PAP). The program will strengthen the implementation of the NHM Governance and Accountability Framework, grievance redressal mechanism, and community processes in service delivery monitoring. The Guidelines to Prevent or Mitigate Fraud, Corruption, and Other Prohibited Activities in Results-Based Lending for Programs were explained to, and discussed with, the government and MOHFW.[13]

29. **Safeguard systems.** This program is categorized as B for environment, C for involuntary resettlement, and C for indigenous peoples. Potential environmental impacts include those from construction and refurbishing of urban primary health facilities and generation of biomedical waste and infection risks during operation. The program safeguard system assessment examined environmental safeguard management and compliance aspects of NHM relative to ADB's Safeguard Policy Statement (2009). The assessment found that a wide range of policies, laws, and regulations related to environmental issues are in place. The existing guidelines related to environmental management will be strengthened to guide central and state institutions and health facilities in urban areas. Environment and social safeguard elements will be incorporated in the quality assurance tools to ensure proper monitoring and compliance. For potential impacts of involuntary resettlement associated with the program's civil works, a screening procedure has been developed to ensure that the program excludes any activities that may trigger category A or B. The PAP includes raising awareness, training of staff on safeguards, and enforcement of specific environmental regulations.

C. Integrated Risk Assessment and Mitigating Measures

30. Major risks and mitigating measures are summarized in Table 5.[14] Overall program risk is assessed as substantial, but appropriate risk mitigation measures have been incorporated in the DLIs and PAP to ensure further strengthening of systems and achievement of program outcome. The overall benefits and impacts are expected to outweigh the costs.

[13] ADB. 2013. *Piloting Results-Based Lending for Programs.* Manila.
[14] Integrated Risk Assessment and Mitigating Measures (accessible from the list of linked documents in Appendix 2).

Table 5: Summary of Integrated Risk Assessment and Mitigating Measures

Risks	Ratings	Key Mitigating Measures
Results Gaps among states in institutional arrangements and implementation capacity for urban health, which may delay achievement of results	Substantial	A capacity development framework will be developed to enhance implementation capacity, especially in lagging states. The attached TA will assess and monitor state-level institutional arrangements and capacity for urban health.
Fiduciary Delay in fund release from state treasuries to state health societies	Substantial	MOHFW and states to increase monitoring and follow up of timely fund releases with state authorities.
Inadequate number of trained and qualified procurement staff in some states	Moderate	The program will support states to increase qualified procurement staff. SPMUs will establish computerized program monitoring systems and undertake quarterly review meetings. NPMU will coordinate post-procurement reviews in at least three states annually by an independent agency.
Inadequate mechanisms for drug quality assurance and supply chain management in some states	Substantial	States will apply more stringent quality requirements in manufacturing facilities, strengthen quality checks at pre- and post-dispatch by independent test agencies or firms, and adopt a computerized stock management system.
Overall program risk	**Substantial**	

MOHFW = Ministry of Health and Family Welfare, NPMU = national program management unit, SPMU = state program management unit, TA = technical assistance.
Source: Asian Development Bank.

IV. ASSURANCES

31. The government and MOHFW have agreed with ADB on certain covenants for the program, which are set forth in the loan agreement and program agreement.

V. RECOMMENDATION

32. I am satisfied that the proposed loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve:

(i) the loan of $300,000,000 to India for Supporting National Urban Health Mission, from ADB's ordinary capital resources, with interest to be determined in accordance with ADB's London interbank offered rate (LIBOR)-based lending facility; for a term of 20 years, including a grace period of 5 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan and program agreements presented to the Board; and

(ii) the administration by ADB of technical assistance not exceeding the equivalent of $2,000,000 to the Government of India for Strengthening Capacity of the National Urban Health Mission to be provided by the Japan Fund for Poverty Reduction on a grant basis.

Takehiko Nakao
President

24 April 2015

DESIGN AND MONITORING FRAMEWORK

Impact

Improved health status of the urban population, particularly the poor and the vulnerable, across India (NUHM Implementation Framework, 2013[a]).

Program Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks
Outcome Increased access to equitable and quality urban health system	By 2017 (for all indicators): a. Institutional deliveries in urban areas increased to at least 80% (with poor and non-poor differential reduced to no more than 10%) (baseline in 2005–2006: urban average 67.4%; urban poor 44%; urban non-poor 78.5%). b. Complete immunization among children below 12 months of age in urban areas increased to at least 80% (with poor-non-poor, female-male differential no more than 10%) (baseline in 2005–2006: urban average 71.8%; urban poor 52.6%; urban non-poor 80.1%). c. Increase antenatal care (three or more antenatal care visits) coverage to at least 90% in urban areas (urban national was 74.7% in 2005–2006).	a-c. NFHS	Gaps among states in institutional arrangements and implementation capacity for urban health may delay achievement of results.
Outputs 1. Urban primary health care delivery system strengthened	1a. By 2016, at least 55% of cities with approved PIPs have completed mapping of slums, vulnerable populations and health facilities, and gap analysis for public health facilities. 1b. By 2017, 50% of NUHM-supported UPHCs meet the minimum requirements including RMNCH+A in the standard primary health care package. 1c. By 2017, 23,000 ASHAs trained and 85% of recruited ASHAs are functional.	1a. NUHM progress report by MOHFW 1b. NUHM progress report by MOHFW 1c. HMIS and ASHA MIS	Delay in fund release from state treasuries to state health societies may undermine timely implementation and achievement of results. Difficulty in recruiting and retaining adequate number of experienced and qualified staff for NUHM may affect program implementation. Challenges in collecting data on
2. Quality of urban health services improved	2a. By 2017, 20 states, union territories, and large ULBs have set up organizational arrangements for quality assurance of health facilities. 2b. By 2017, at least 80% of UPHCs and UCHCs in target states, union	2a-b. NUHM progress report by MOHFW	

Program Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting	Risks
	territories, and larger ULBs completed self-assessment of service quality against the set quality criteria including client satisfaction (men and women disaggregated).		results indicators across multiple systems and agencies, and in the quality and completeness of data, may undermine proper measurement of results.
3. Capacity for planning, management, and innovation and knowledge sharing strengthened	3a. By 2016, at least 55% of staff sanctioned for NUHM at SPMUs, DPMUs, and CPMUs are in position. 3b. By 2017, NUHM capacity development framework implementation achieved at least 60% of annual targets (including specific gender targets) at national level and in the 20 states and union territories in priority areas. 3c. By 2017, 50% of states, union territories, and large ULBs implement innovations and partnerships in urban health.	3a-c. NUHM progress report by MOHFW	

Key Program Actions

1. Technical Actions

1.1 Analyze new NFHS results on urban health, including outcomes related to diarrhea and ARI, equity aspects, and progress towards DLIs 1 and 2, and strengthen implementation strategies for NUHM.
1.2 Study and document structure and activities of MAS and other community institutions from at least two settlements showing effective intersectoral convergence and good community health-seeking practices.
1.3 Conduct private health sector assessment in selected states; develop a framework, guidelines, and contract templates for implementing health PPPs in the urban context.
1.4 Facilitate policy-level intersectoral convergence through relevant NUHM guidelines and consultations with participating states.
1.5 Facilitate, through the PIP and other guidelines, active participation of ULBs in state-level planning processes, including mapping of slums, vulnerable populations, and health facilities.
1.6 Study and document experiences with the Clinical Establishments Act, 2010 and other regulatory efforts to improve the quality of private sector health services.
1.7 Ensure the quality assurance mechanism (DLI 5) addresses improving quality of institutional deliveries and antenatal care.

2. Financial Management Actions

2.1 Submit annual audited financial statements in accordance with the detailed statement of audit needs and follow-up on resolution of statutory and concurrent auditor recommendations.
2.2 Develop detailed fund flow mechanisms for cities and districts considering individual states' institutional arrangements, requirements, and capacities.
2.3 Strengthen MOHFW's financial management performance monitoring and conduct common review missions for validation of performance.
2.4 Recruit additional accountants at states and ULBs and undertake continuous training and capacity building for improved financial management.

3. Procurement Actions

3.1 Establish state-level procurement oversight and contract management framework and undertake continuous training and capacity building of procurement staff.
3.2 Conduct independent pre- and post-delivery drug quality audits and procurement and contract management audits, covering a sample of at least three states per year.

3.3 Monitor implementation of the NHM Governance and Accountability Framework in NUHM, assess and strengthen the effectiveness of community and facility-based GRMs.

4. Safeguards Actions

4.1 Engage a qualified consultant to monitor social and environmental impacts and train relevant state level staff on social and environmental safeguards.
4.2 Assess and build capacity of states, ULBs, and health facilities to ensure compliance with IMEP and/or quality assurance guidelines.
4.3 Strengthen and monitor compliance with environmental regulations through updated IMEP and/or quality assurance guidelines.
4.4 Assess and strengthen existing GRMs at the state and community levels.

5. Monitoring and Evaluation Actions

5.1 Strengthen HMIS indicators to adequately capture key processes and outcomes related to urban health and include a quality assurance module in HMIS formats.
5.2 Include substantive review of urban health issues in CRM, including recommendations and action plans to address gaps.
5.3 Develop NUHM MIS to meet NUHM program reporting requirements.

6. Gender and Social Equity Actions

6.1 Engage a qualified consultant to provide gender and social equity-related inputs to program activities and conduct regular training programs to sensitize and train health workers on the needs of women and the marginalized communities.
6.2 Incorporate care and counselling to address gender-based violence in the health service package.
6.3 Promote skill up-grading and training opportunities for career progression of community and link workers and monitor progress.
6.4 Promote equal opportunity measures in recruitment of new staff across state, city, and district PMUs; maintain sex-disaggregated data on staff dedicated for NUHM.

Inputs

Government:	$1,654.9 million
ADB:	$300.0 million
Technical Assistance (Japan Fund for Poverty Reduction):	$2.0 million

Assumptions for Partner Financing

Not applicable.

ADB = Asian Development Bank; ARI = acute respiratory infection; ASHA = accredited social health activist; CPMU = city project management unit; CRM = common review mission; DLI = disbursement-linked indicator; DPMU = district project management unit; GRM = grievance redress mechanism; HMIS = health management information system; IMEP = Infection Management and Environmental Plan; MAS = Mahila Arogya Samitis (community collectives comprising local women); MIS = management information system; MOHFW = Ministry of Health and Family Welfare; NFHS = National Family Health Survey; NHM = National Health Mission; NUHM = National Urban Health Mission; PIP = program implementation plan; PMU = project management unit; PPP = public–private partnership; RMNCH+A = Reproductive, Maternal, Newborn, Child, and Adolescent Health; SPMU = state project management unit; UCHC = urban community health center, ULB = urban local body; UPHC = urban primary health center.

[a] Government of India, Ministry of Health and Family Welfare. 2013. *National Urban Health Mission, Framework for Implementation.* New Delhi.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://adb.org/Documents/RRPs/?id=47354-003-3

1. Loan Agreement
2. Program Agreement
3. Country Economic Indicators
4. Summary Sector Assessment: Urban Health
5. Program Soundness Assessment
6. Program Results Assessment
7. Program Results Framework
8. Program Expenditure and Financing Assessment
9. Program Monitoring and Evaluation System Assessment
10. Program Fiduciary Systems Assessment
11. Program Safeguard Systems Assessment
12. Integrated Risk Assessment and Mitigating Measures
13. Program Action Plan
14. Attached Technical Assistance
15. Contribution to the ADB Results Framework
16. Development Coordination
17. Summary Poverty Reduction and Social Strategy
18. Program Implementation Document

Supplementary Documents

19. Economic Analysis
20. Program Initial Environmental Examination, and Environmental Management Plan

DISBURSEMENT-LINKED INDICATORS, VERIFICATION PROTOCOLS, AND DISBURSEMENT SCHEDULE

Table 1: Disbursement-Linked Indicators[1]

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
Outcome: Increased access to equitable and quality urban health system							
DLI 1 Increased institutional deliveries in urban areas	Nationally 85.3% in FY2013.[2]	—	—	2% point increase with respect to FY2014.[3]	2% point increase with respect to FY2015.	2% point increase with respect to FY2016.	2% point increase with respect to FY2017.
DLI 2 Increased complete immunization among children below 12 months of age in urban areas	Nationally 88.4% in FY2013.[2]	—	—	2% point increase with respect to FY2014.[3]	2% point increase with respect to FY2015.	2% point increase with respect to FY2016.	2% point increase with respect to FY2017.
Output 1: Urban primary health care delivery system strengthened							
DLI 3 City-specific primary health care delivery system established	As of 2014, urban health facilities are limited in number, service package, and quality to address urban	(i) At least 90% of cities included for support under NUHM have their respective state PIPs approved by	At least 25% of cities with approved PIPs have initiated mapping of slums and vulnerable population and health facilities.	(i) At least 55% of cities with approved PIPs have completed mapping of slums and vulnerable population and	50% of UPHCs meet the minimum requirements for staffing and service package.	60% of UPHCs meet the minimum requirements for staffing and service package.	70% of UPHCs meet the minimum requirements for staffing and service package.

[1] The grey shaded areas are indicative results for additional financing from 2018 to 2019. The indicative targets will be critically reviewed based on the performance during the current program period and revised as required.

[2] These baselines are national averages (including both rural and urban) from the current Health Management Information System. The Health Management Information System is being strengthened to report urban-rural disaggregated data, and urban-specific baselines will be established by May 2015 based on the data collected by March 2015.

[3] Target value (2% points from the previous year level) is based on assessment of historical trends and consideration of accelerated progress under the National Urban Health Mission.

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
	health issues.	FY2014. (ii) Norms for identification of vulnerable populations established.		health facilities. (ii) 30% of UPHCs meet NUHM minimum requirements for staffing and service package.			
DLI 4 Community processes improved	ASHAs are active in rural areas, and those with adequate skills and roles in urban context is not yet available in 2014.	*Guidelines for ASHA and MAS in the Urban Context* are issued and disseminated at state level.	Training modules based on the *Guidelines for ASHA and MAS in the Urban Context* are issued in Hindi and some regional languages.	(i) 15,000 of recruited ASHAs are trained. (ii) 80% of recruited ASHAs are functional.	(i) 23,000 of recruited ASHAs are trained. (ii) 85% of recruited ASHAs are functional.	(i) 31,000 of recruited ASHAs are trained. (ii) 90% of recruited ASHAs are functional.	(i) 35,000 of recruited ASHAs are trained. (ii) At least 90% of recruited ASHAs are functional.
Output 2 : Quality of urban health services improved							
DLI 5 Effective system of quality assurance for urban health services implemented	QA mechanism for NRHM exists in 2014 but it needs to be adapted and adopted by NUHM to guide sub-national entities to address urban specific issues.	*MOHFW Operational Guidelines for Quality Assurance (QA) in Public Health Facilities* issued and disseminated.	QA Assessor Guidebook and tools are developed for UPHCs, reflecting *MOHFW Operational Guidelines for Quality Assurance (QA) in Public Health Facilities.*	(i) 15 states/ UTs/ large ULBs have set up organizational arrangements for QA of health facilities that include UPHCs and UCHCs. (ii) 50% of UPHCs and	(i) 20 cumulative states/ UTs/ large ULBs have set up organizational arrangements for QA of health facilities that include UPHCs and UCHCs. (ii) 80% of UPHCs and	(i) 40% of UPHCs and UCHCs in the 20 states/ UTs/ ULBs received national or state-level quality certification. (ii) MOHFW conducted a	Based on the review MOHFW prepared and approved a time-bound action plan to further improve: (i) quality of urban primary healthcare services; and (ii) quality assurance

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
				UCHCs in those states/UTs/ ULBs are assessing the quality of their services, including patient satisfaction.	UCHCs in those states/UTs/ ULBs are assessing the quality of their services, including patient satisfaction.	comprehensive independent review of the QA program with states focusing on (a) the quality of urban primary health care services, and (b) effectiveness of quality assurance mechanism.	mechanism
Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened							
DLI 6 Planning, management and monitoring capacity to deliver urban health services strengthened	NUHM is a new program, and requires a comprehensive capacity development to deliver the mission.	At least 30% of staff sanctioned for NUHM at SPMUs, DPMUs and CPMUs are in position.	(i) NUHM capacity development framework is developed, specifying priority areas for capacity development and implementation support; outputs and targets; modalities; and progress reporting mechanism. (ii) HMIS is enhanced to include urban-disaggregated data and has	(i) At least 55% of staff sanctioned for NUHM at SPMUs, DPMUs and CPMUs are in position. (ii) NUHM capacity development framework implementation achieved at least 50% of annual targets at national level and in 15 states/UTs in priority areas	NUHM capacity development framework implementation achieved at least 60% of annual targets at national level and in 20 states/UTs in priority areas.	Based on recommendations of the independent evaluation, MOHFW has updated the NUHM capacity development framework, including outputs and modalities.	NUHM capacity development framework (updated) implementation achieved at least 75% of annual targets at national level and in 25 states/UTs in priority areas.

Disbursement Linked Indicators	Baseline Year and Value	Target Values					
		Prior results	2015	2016	2017	2018	2019
			functionality to identify urban health facilities near poor and vulnerable populations. (iii) The National PMU established a pool of experts for technical and implementation support at national and states/UTs/ ULB level.				
DLI 7 Innovations and partnerships in urban health developed, tested, and shared	Innovative approaches exist, but not well-evaluated, documented, and disseminated; incentive mechanism for encouraging innovations is weak.	—	—	A framework for innovations and partnerships, including examples of good practices, is developed, approved, and implemented.	50% of states/UTs/ large ULBs implement innovations and partnerships aiming at improving equity, access, or quality of urban health services.	20 good practices in innovations and partnerships in at least 10 states/UTs/ large ULBs are demonstrated and disseminated.	Incentive mechanisms for more innovation for equitable access to, and improved quality of, urban health services including performance based financing.

ASHA = accredited social health activist, CPMU = city program management unit, DLI = disbursement-linked indicator, DPMU = district program management unit, HMIS = health management information system, MAS = Mahila Arogya Samitis (community collectives comprising local women), MOHFW = Ministry of Health and Family Welfare, NRHM = National Rural Health Mission, NUHM = National Urban Health Mission, PIP = program implementation plan, PMU = project management unit, QA = quality assurance, SPMU = state program management unit, ULB = urban local body, UCHC = urban community health center, UPHC = urban primary health center, UT = union territory.
Source: Asian Development Bank.

Table 2: Verification Protocols

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
Outcome: Increased access to equitable and quality urban health system			
DLI 1 Increased institutional deliveries in urban areas	**Definition** Number of institutional deliveries in urban health facilities as a percentage of total number of reported deliveries, described as $\frac{\text{\# of institutional deliveries}}{\text{\# of institutional deliveries + \# of home deliveries}} \times 100.$ Urban health facility includes public facilities and private facilities accredited under JSY (but not limited to these facilities).[4] **March 2016** Institutional delivery has increased by 2% point or more from the FY2014 level, based on the HMIS data. **March 2017** Institutional delivery has increased by 2% point or more from the FY2015 level, based on the HMIS data.	HMIS, annual	1. MOHFW Statistics Division will provide quarterly data on institutional deliveries to the program division. The report will facilitate regular assessment of performance and gaps towards this target. 2. MOHFW Statistics Division will prepare HMIS data as of 31 March of each year or later date when the target is met. An independent entity (firm) engaged by ADB under the attached TA will conduct spot reviews of HMIS in selected cities/states to ensure data quality and strengthen HMIS for initial 2 years. 3. MOHFW will provide ADB with a report certifying the percentage change in the institutional deliveries in urban health facilities based on the HMIS data. The report will include supporting tables of state-wise and all-India data including numerator and denominator.[5] 4. Within 1 month from receipt of MOHFW report, ADB will review the report and confirm if the DLI target is met.

[4] JSY or the Janani Suraksha Yojana is a central government scheme providing cash assistance for delivery and post-delivery care.
[5] While the focus of DLI 1 is on improving institutional delivery as measured by a percentage, attention will be paid on improving coverage and effectiveness of HMIS to capture increased total reported deliveries (both institutional as well as in the home), which forms the denominator of DLI 1.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
DLI 2 Increased complete immunization among children below 12 months of age in urban areas	**Definition** Complete immunization rate is measured by number of infants below 12 months (up to 1 year of age) who received measles vaccination[6] in urban public facilities, including through outreach services, as a percentage of estimated annual number of infants described as $\frac{\text{\# of measles vaccinations given}}{\text{annual estimated \# of infants}} \times 100.$ "Annual estimated number of infants" in urban areas from HMIS is based on SRS data. **March 2016** Complete immunization rate has increased by 2% point or more from the FY2014 level, based on HMIS. **March 2017** Complete immunization rate has increased by 2% point or more from the FY2015 level, based on HMIS.	HMIS, annual	1. MOHFW Statistics Division will provide quarterly data on immunization rate to the program division. The report will facilitate regular assessment of performance and gaps towards this target. 2. MOHFW Statistics Division will prepare HMIS data as of 31 March of each year or later date when the target is met. An independent entity (firm) engaged by ADB under the attached TA will conduct spot reviews of HMIS in selected cities/states to ensure data quality and strengthen HMIS for initial 2 years. 3. MOHFW will provide ADB with a report certifying the annual percentage change in the complete immunization in urban health facilities based on the HMIS data. The report will include supporting tables of state-wise and all-India data including numerator and denominator. 4. Within 1 month from receipt of MOHFW report, ADB will review the report and confirm if the DLI target is met.
Output 1: Urban primary health care delivery system strengthened			
DLI 3 City-specific primary health care delivery system established	**Prior Result** (i) At least 90% of cities included for support under NUHM have their respective state PIPs approved by FY2014.	FY2014 record of proceedings from MOHFW	1. (i) Upon loan effectiveness, MOHFW will certify that at least 90% of cities targeted for support under NUHM have their respective state PIPs approved by FY2014. The certification will attach an enumerated list of these cities; (ii) Upon loan effectiveness,

[6] Measles vaccination, one of the last vaccinations provided for infants (up to 1 year of age), is used as a proxy for complete immunization.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	(ii) Norms for identification of vulnerable populations established.		MOHFW will provide ADB with a copy of approved checklist of vulnerable populations. 2. (i) ADB will verify if the number of cities with approved PIPs is at least 90% of cities targeted for support under NUHM; (ii) ADB will verify if the checklist of vulnerable populations is published on NUHM or NHSRC website.
	March 2015 At least 25% of cities with approved PIPs have initiated mapping of slums, vulnerable populations, and health facilities. [Mapping includes (i) Listed and Unlisted Slums and vulnerable populations; and (ii) Existing Public and Private Health Facilities.] [Mapping is initiated when cities have mapped listed and unlisted slums and health facilities, using available sources of data, including GIS, from other departments.]	NUHM MIS (Progress Report), annual	1. By 1 July 2015, MOHFW will certify that at least 25% of cities with approved PIPs have initiated mapping of slums and vulnerable populations and health facilities. MOHFW certification will also include: (a) list of cities with approved PIPs; and (b) list of cities that have mapped listed and unlisted slums and health facilities, using available data, including GIS, from other departments. 2. By September 2015, ADB will review and verify MOHFW certification report and data.
	March 2016 (i) At least 55% of cities with approved PIPs have completed mapping of slums, vulnerable populations and health facilities. [Mapping is completed when cities have mapped with listed and unlisted slums and health facilities and information on vulnerable populations, using available sources of data, including GIS, from other departments.]	NUHM MIS (Progress Report), annual	1. By 1 July 2016, MOHFW will certify that at least 55% of cities with approved PIPs have completed mapping of slums and vulnerable populations and health facilities. MOHFW certification will also include: (a) list of cities with approved PIPs; and (b) list of cities that have completed the mapping. 2. By September 2016, ADB will review and verify MOHFW report and data.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	(ii) 30% of UPHCs meet the minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing. [**Minimum requirements** will be defined by MOHFW based on the existing norms of NUHM, and be agreed by ADB in 2015. To assess progress towards this target, by end of 2015, MOHFW will develop and submit to ADB an assessment or evaluation process, including the assessment form that would be used by states, in determining compliance with staffing and services requirements. The minimum requirements may include the following elements: <u>Staffing</u> (i) At least one medical officer (full-time) who can be a civil servant or a contractual /contracted MD; (ii) At least two staff nurses (full time civil servants); (iii) At least two ANMs; (iv) A staff designated as the pharmacist or dispenser of medicines (this staff can be a licensed pharmacist or a concurrent designation of the medical officer); (v) A staff designated as the lab technician (a staff nurse can be trained and assigned the additional task of lab technician); (vi) A staff designated as public health manager (the MD or a staff nurse can be given this function as a concurrent designation); and (vii) One or two staff designated for account keeping and M&E (a staff can be designated to do both account keeping and M&E). <u>Service Package</u> (i) OPD medical care (at least 6 hours, these services include consultations and basic diagnostics);	NUHM MIS (Progress Report), annual	For verification of this DLI from 2016 to 2019: 1. By 1 May every year from 2016 to 2019, state missions will submit to MOHFW, facility-wise assessment of UPHCs against minimum requirements. 2. By 1 July every year from 2016 to 2019, MOHFW will provide ADB with a report certifying the percentage of UPHCs that meet the agreed minimum requirements. The report will include: (a) an enumerated list showing number of UPHCs that have been approved as of 31 March of the relevant fiscal year; and (b) a certified list of UPHCs that meet minimum requirements, at the end of each fiscal year. 3. By September of each year, MOHFW and ADB will jointly conduct a validation of selected UPHCs out of the certified list.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	(ii) Services as prescribed under RMNCH+A (RMNCH+A is a new approach of the government to address the health problems of mother, newborn, child & adolescence simultaneously at different stages of life through 'continuum of care'); (iii) Collection and reporting of vital events and IDSP; (iv) Referral services (There should be referral paper forms or an electronic or mobile system as evidence of the presence of a referral system); and (v) Basic laboratory services (including national vector-borne disease programs), in-house or out-sourced (The presence of diagnostic equipment {including microscope and centrifuge} and diagnostic supplies and reagents. If claimed to outsourced, a copy of the outsourcing agreement including payment or fee schedule).] **March 2017** 50% of UPHCs meet NUHM minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing. **March 2018** 60% of UPHCs meet NUHM minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing. **March 2019** 70% of UPHCs meet NUHM minimum requirements for staffing and service package as a percentage of UPHCs approved for NUHM financing.		
DLI 4 Community processes	**Prior Result** *Guidelines for ASHA and MAS in the Urban Context* are disseminated at the state level and oriented on to	MOHFW, once	1. Upon loan effectiveness, MOHFW will provide ADB with the copy of the *Guidelines for ASHA and MAS in the Urban Context*

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
improved	the state nodal officers.		and evidence of its dissemination to the state nodal officers (e.g. the dissemination workshop held in August 2014). 2. ADB will verify publication of the guidelines on NUHM or NHSRC website and evidence of its dissemination to state nodal officers.
	March 2015 Training modules based on the *Guidelines for ASHA and MAS in the Urban Context* are issued by MOHFW and translated into Hindi and some local languages for use in training-of-trainers at state levels. These training modules will be: (i) ASHA induction module with urban-specific training on health vulnerability assessment, household mapping and listing; and (ii) MAS training modules.	MOHFW, one-time, until further modifications are envisaged.	1. By 1 May 2015, MOHFW will provide ADB with the copy of the training modules based on the *Guidelines for ASHA and MAS in the Urban Context* in at least one local language to be used in training of trainers. 2. By September 2015, ADB will verify if the training modules are available in at least one local language to be used in training-of-trainers.
	March 2016 (i) 15,000 of recruited ASHAs trained in the induction module. (Approximately 40% of the targeted number of ASHAs i.e. 38,720, as per the NUHM Implementation Framework). (ii) 80% of recruited ASHAs are functional. **March 2017** (i) 23,000 of recruited ASHAs trained in induction module. (Approximately 60% of the targeted number of ASHAs i.e., 38,720, as per the NUHM Implementation Framework). (ii) 85% of recruited ASHAs are functional.	NUHM MIS and ASHA MIS, annual	For verification of this DLI from 2016 to 2019: 1. By 1 May of each year, state missions will report ASHA statistics (selected, trained, drop out status, as well as sex-disaggregation) as of 31 March of the same year to MOHFW in a compiled form. (In case male workers have been assigned the role of ASHAs, as per needs of the states, the NUHM MIS will be updated to collect yearly information on them). 2. By 1 July of each year, MOHFW will provide ADB with a report certifying: (i) the number of recruited ASHAs who completed

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	March 2018 (i) 31,000 of recruited ASHAs trained in induction module. (Approximately 80% of the targeted number of ASHAs i.e., 38,720, as per the NUHM Implementation Framework). (ii) 90% of recruited ASHAs are functional. **March 2019** (i) 35,000 of recruited ASHAs trained in induction module. (Approximately 90% of the targeted number of ASHAs i.e., 38,720, as per the NUHM Implementation Framework). (ii) At least 90% of recruited ASHAs are functional. **[Definition of being functional**, (as per drop out criteria in *Guidelines for ASHA and MAS in the Urban Context*, page 8) ASHAs who have not been declared as "drop-outs". Drop-out is defined as: (i) She has submitted a letter of resignation to the city/district Urban ASHA Selection Committee and to the designated ASHA facilitator/community organizer for her [designated][allocated] area; **or** (ii) She has not attended three consecutive Urban Health and Nutrition Days or outreach sessions and has not given reasons for the same; **or** (iii) She has not been active in most of the activities and the ASHA facilitator/community organizer has visited the slum cluster of ASHA and ascertained through discussions with all MAS members that she is indeed not active.]		training using the induction module; and (ii) percentage of total ASHAs functional. 3. By September of each year, ADB will review the MOHFW certified reports and confirm if the targets are met.
Output 2: Quality of urban health services improved			
DLI 5 Effective system of quality	**Prior Results** *MOHFW Operational Guidelines on Quality Assurance in Public Health Facilities* are issued and disseminated.	MOHFW, once	1. Upon loan effectiveness, MOHFW will provide ADB with copy of approved operational guidelines and a record of

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
assurance for urban health services implemented			proceedings of the National Convention on Quality in Public Health in November 2014, when the Guidelines were officially disseminated. 2. ADB will verify publishing of the guidelines on NUHM or NHSRC website and the record of meeting proceedings.
	May 2015 QA Assessor Guidebook and tools for UPHCs developed, reflecting MOHFW operational guidelines. [**Quality assurance tool** would include (these criteria are in line with the guidelines on quality of public health facilities issued by the Ministry): (a) areas of concern, standards, and measurable elements applicable to UPHCs and UCHCs including outreach; (b) protocols for internal assessment, independent assessment, state and national level certification, periodic surveillance and re-validation for certification; and (c) Patient/Client Satisfaction Survey, with sex-disaggregated analysis to inform men or women specific issues for further improvement.]	MOHFW, once	1. By 1 July 2015, MOHFW will provide the copy of the UPHC QA Assessor Guidebook approved by MOHFW for consultation with stakeholders. 2. By September 2015, ADB will verify the finalized assessor guidebook published on NUHM or NHSRC website.
	March 2016 (i) 15 states/UTs/large ULBs have set up organizational arrangements for QA of health facilities, that include UPHCs and UCHCs organizational arrangements for QA include monitoring and reporting mechanisms. (ii) 50% of UPHCs and UCHCs in those states/UTs /ULBs are assessing the quality of services including client/patient satisfaction.	MOHFW, annual	1. By 1 May 2016, MOHFW will provide ADB with a report certifying: (i) that 15 states/UTs/ULBs have set up organizational arrangements for QA of health facilities that include UPHCs and UCHCs; and (ii) that at least 50% of UPHCS and UCHCs in those locations are assessing the quality of services against set benchmarks that

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	[**Large ULBs** are defined as those which have a direct responsibility for implementing NUHM and have a dedicated CPMU.]		includes client satisfaction. MOHFW report will include: (i) state/UT/ULB specific details of organizational arrangements; and (ii) total number of UPHCs and UCHCs and the percentage in these areas which have been assessed. 2. By July 2016, MOHFW and ADB will conduct a joint field validation of the state/UT/ULB specific reports (sample based). 3. By September 2016, ADB will verify if the DLI targets are met.
	March 2017 (i) 20 cumulative states/UTs/large ULBs have set up organizational arrangements for QA of health facilities that include UPHCs and UCHCs. (ii) 80% of UPHCs and UCHCs in those states/UTs /ULBs are assessing the quality of services including client/patient satisfaction.	MOHFW, annual	1. By 1 May 2017, MOHFW will provide ADB with a report certifying: (i) that 20 states/UTs/ULBs have set up organizational arrangements for QA of health facilities that include UPHCs and UCHCs; and (ii) that at least 50% of UPHCS and UCHCs in those locations are assessing the quality of services against set benchmarks that includes patient/client satisfaction. MOHFW report will include: (i) state/UT/ULB specific details of organizational arrangements; and (ii) total number of UPHCs and UCHCs and the percentage in these areas which have been assessed. 2. By July 2017, MOHFW and ADB will conduct a joint field validation of the state/UT/ULB specific reports (sample based).

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
			3. By September 2017, ADB will verify if the DLI targets are met.
	March 2018 (i) 40% of UPHCs and UCHCs in the 20 states/UTs/ULBs received national or state-level quality certification.	MOHFW, once	1. (i) By 1 May 2018, MOHFW will certify the total and percentage of UPHCs and UCHCs in the 20 states/UTs/ULBs having received national- or State-level certifications. MOHFW will include an enumerated list of the certified facilities and their details and (ii) by 1 July 2018, MOHFW will provide ADB with the report of the QA program review.
	(ii) MOHFW conducted a comprehensive, independent review of the QA program with states focusing on (a) the quality of urban primary health care services, and (b) effectiveness of quality assurance mechanism.	Independent evaluation report, once	2. By September 2018, ADB will verify if the DLI targets are met.
	March 2019 Based on the review, MOHFW prepared and approved a time-bound action plan to further improve: (a) quality of urban primary healthcare services; and (b) quality assurance mechanism.	Time-bound action plan, once	1. By 1 March 2019, MOHFW will submit the action plan to ADB, and ADB will verify the adequateness of the action plan in addressing issues and recommendations identified by the independent evaluation report.
Output 3: Capacity for planning, management, and innovation and knowledge sharing strengthened			
DLI 6 Planning, management, and monitoring capacity to deliver urban health services strengthened	*a. Program Management Capacity* **Prior Result** At least 30% of staff sanctioned for NUHM at SPMUs, DPMUs, and CPMUs are in position. [SPMUs, DPMUs, and CPMUs will include, but not be limited to, program management, accounting/finance, M&E/HMIS/MIS, and procurement functions.]	NUHM MIS, once NUHM MIS	1. Upon loan effectiveness, MOHFW to provide the following information from NUHM MIS before submitting the first withdrawal application for disbursement against prior results: (a) Number of the staff sanctioned for NUHM SPMUs, DPMUs, and CPMUs approved as of 31 March 2014; and (b) Number of the sanctioned staff that are in position by loan effectiveness

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
			or earlier (with a list of breakdown by SPMU, DPMU and CPMU). 2. ADB will review and confirm the achievement of results based on the provided information. ADB will visit five randomly selected states to assess program management capacity.
	March 2015 (iii) The NPMU is supported by experts in planning, management, monitoring, and other technical areas to assist (a) MOHFW in managing NUHM and overseeing implementation, and (b) states/UTs/ULBs in program implementation.	MOHFW, once	1. By 1 July 2015, MOHFW to provide ADB with a detailed report on the NPMU capacity in management of NUHM. 2. By September 2016, ADB will review the report and verify the adequacy of NPMU capacity.
	March 2016 (i) At least 55% of staff sanctioned for NUHM at SPMUs, DPMUs, and CPMUs are in position.	NUHM MIS	1. By 1 July 2016, MOHFW to provide ADB the following information from NUHM MIS: (a) Number of the staff sanctioned for NUHM SPMUs, DPMUs, and CPMUs approved as of 31 March 2014; and (b) Number of the sanctioned staff that are in position by May 2016 or earlier (with a list of breakdown by SPMU, DPMU and CPMU). 2. By September 2016, ADB will review and confirm the achievement of results based on the provided information. ADB will visit five randomly selected states to assess program management capacity.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	b. Capacity Development **March 2015** (i) MOHFW will develop and approve a costed capacity development framework. [**A capacity development framework** may include the following aspects, but not limited to: (a) Comprehensive human resource development plan for managerial and technical personnel; (b) Strengthening existing national and state entities to support urban health; (c) Provision of technical and management support to MOHFW and states, especially lagging ones, through a pool of experts and demand-based consulting inputs through indefinite service delivery; and (d) 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. The capacity development framework would specify: (a) Priority areas for capacity development, including planning, financial management, procurement, and monitoring and evaluation for improved business process; (b) NUHM financial support for capacity building at the state- and city-levels: 1. eligible areas of support and norms for funding; and 2. implementation procedures – proposal submission, appraisal, approval, and fund disbursal.	MOHFW, once	1. By 1 July 2015, MOHFW will provide ADB with the capacity development framework approved by MOHFW. 2. By September 2015, ADB will review the framework and verify the elements of the capacity development framework.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	(c) M&E – result areas, performance indicators, targets to be committed by states/ cities, and reporting mechanism.] (ii) HMIS includes urban-disaggregated data, and has the functionality to identify urban health facilities located within or in close proximity to slums, resettlement areas, and where there is concentration of vulnerable populations.	MOHFW, annual	1. By 1 July 2015, MOHFW will provide ADB with a report certifying fully disaggregated urban data, and HMIS will have functionality to identify urban health facilities located within or in close proximity to slums, resettlement areas, and where there is concentration of vulnerable populations. 2. By September 2015, ADB will review and verify the report and check the HMIS functionality to identify urban health facilities in or close to slums, resettlement areas and vulnerable populations.
	March 2016 (i) MOHFW's review of NUHM capacity development framework shows progress at national level and in 15 states/UTs: (a) (1) increased staff numbers/capacity in urban health in national and state technical agencies, and (2) conducting trainings in health service delivery and program management; (b) strengthened M&E system, including (1) adapting NRHM MIS format for NUHM, (2) expanding reporting of HMIS by facilities, (3) training data entry operators and data administrators in data quality, and (4) community process data collected under ASHA MIS; and (c) monitoring and reporting of availability and quality of essential drugs in UPHCs and UCHCs.	MOHFW, annual	1. By 1 July 2016, MOHFW will provide ADB with a report reviewing the progress achieved by NUHM in the capacity development framework implementation as defined in the verification protocol. 2. By September 2016, ADB will review and verify the review report.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
	March 2017 MOHFW's independent evaluation of NUHM capacity development framework shows progress at national level and in 20 states/UTs: (a) (1) increased staff numbers/capacity in urban health in national and state technical agencies, and (2) conducting trainings in health service delivery and program management; (b) strengthened M&E system, including (1) adapting NRHM MIS format for NUHM, (2) expanding reporting of HMIS by facilities, (3) training data entry operators and data administrators in data quality, and (4) community process data collected under ASHA MIS; and (c) monitoring and reporting of availability and quality of essential drugs in UPHCs and UCHCs.		1. By 1 July 2017, MOHFW will provide ADB with an evaluation report by an independent evaluator to assess the implementation of NUHM capacity development framework as per verification protocol. 2. By September 2017, ADB will review the report and verify if the targets (at least 60% of annual targets achieved at national level and in 20 states/UTs in priority areas) are met.
	March 2018 Based on recommendations of the independent evaluation (conducted in 2017), MOHFW has revised the NUHM capacity development framework, including outputs and modalities.	MOHFW, once	1. By 1 July 2018, MOHFW will provide ADB with a revised capacity development framework. 2. By September 2018, ADB will confirm if the revised framework is published on NUHM or NHSRC website.
	March 2019 NUHM capacity development framework (updated) implementation achieved at least 75% of annual targets at national level and in 25 states/UTs in priority areas.	MOHFW, once	1. By 1 July 2019, MOHFW will provide ADB with a report of implementation of the revised capacity development framework. 2. By September 2019, ADB will confirm if the targets are met.
DLI 7 Innovations and partnerships in urban health	**March 2016** A framework for innovations and partnerships, including examples of good practices, is developed, approved, and implemented.	MOHFW, once	1. By 1 May 2016, MOHFW will provide a copy of Framework for Innovations and Partnerships.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
developed, tested, and shared	[NUHM framework for innovations and partnerships will specify: (a) overall objectives of innovations and partnerships; (b) eligible areas of innovation and partnerships, focusing on 'processes' (such as convergence, PPP) and 'products' (such as ICT and medical technology); (c) mechanisms of knowledge sharing ; (d) financial and technical support under NUHM; and (e) guidelines for determining and documenting good practices.]		2. By 31 September 2016, ADB will review adequacy of the framework meeting the criteria described in the definition in verification protocol and verify if the framework is published on NUHM website and at least one activity in knowledge sharing is conducted.
	March 2017 50% of states/UTs/large ULBs implement innovations and partnerships aiming at improving equitable access to or quality of urban health services. [**Large ULBs** are defined as those which have a direct responsibility for implementing NUHM and have a dedicated CPMU.]	MOHFW, once	1. By 1 July 2017, MOHFW will certify the percentage of states/UTs/large ULBs implementing innovations and partnerships aiming at improving equitable access to or quality of urban health services. The MOHFW report will include a list of states/UTs/large ULBs and details of their innovations and partnerships. 2. By September 2017, MOHFW and ADB will jointly review and verify from a sample of the submitted list of innovations and partnerships. Independent review by the entity engaged by ADB under the attached TA as required.
	March 2018 20 good practices in innovations and partnerships in at least 10 states/UTs/large ULBs are demonstrated and disseminated.	MOHFW, once	1. By 1 July 2018, MOHFW will submit the list of 20 good practices in innovations and partnerships in at least 10 states/UTs/large ULBs. The MOHFW report will include details of their demonstration and dissemination.

Disbursement-Linked Indicator	Definition and Description of Achievement and Verification Timeframe	Information Source and Frequency	Verification Agency and Procedure
			2. By September 2018, MOHFW and ADB will jointly review and verify from a sample of the list of good practices. Independent review by the entity engaged by ADB under the attached TA as required.
	March 2019 Incentive mechanisms developed and approved for implementation in FY2020 for more innovation for equitable access to, and improved quality of, urban health services including performance based financing.	MOHFW, once	1. By March 2019, incentive mechanisms such as performance based financing, matching fund scheme, etc. are developed and approved by MOHFW for implementation in FY2020 to encourage innovations and replication/expansion of proven innovative approaches for better quality of and equitable access to urban health services.

ADB = Asian Development Bank, ANM = auxiliary nurse midwife, ASHA = accredited social health activist, CPMU = city program management unit, DLI = disbursement-linked indicator, DPMU = district program management unit, GIS = geographic information system, HMIS = health management information system, ICT = information and communication technology, IDSP = Integrated Disease Surveillance Project, JSY = Janani Suraksha Yojana, MAS = Mahila Arogya Samitis (community collectives comprising local women), M&E = monitoring and evaluation, MD = medical doctor, MIS = management information system, MOHFW = Ministry of Health and Family Welfare, NHSRC = National Health Systems Resource Center, NPMU = national program management unit, NRHM = National Rural Health Mission, NUHM = National Urban Health Mission, OPD = Out-Patient Department, PIP = program implementation plan, PPP = public–private partnership, RMNCH+A = Reproductive, Maternal, Newborn, Child, and Adolescent Health, SPMU = state program management unit, SRS = sample registration survey, TA = technical assistance, ULB = urban local body, UCHC = urban community health center, UPHC = urban primary health center, UT = union territory.
Source: Asian Development Bank.

Table 3: Expected Disbursement Schedule

Disbursement-Linked Indicators	Total ADB Financing Allocation ($ million)	Share of Total ADB Financing (%)	Financing for Prior Result ($ million)	2015 ($ million)	2016 ($ million)	2017 ($ million)
DLI 1 Increased institutional deliveries in urban areas	30	10	—	—	15	15
DLI 2 Increased complete immunization among children below 12 months of age in urban areas	30	10	—	—	15	15
DLI 3 City-specific primary health care delivery system established	65	22	(i) 5 (ii) 5	15	(i) 10 (ii) 10	20
DLI 4 Community processes improved	55	18	10	15	(i)10 (ii) 5	(i)10 (ii) 5
DLI 5 Effective system of quality assurance for urban health services implemented	55	18	10	15	(i)10 (ii) 5	(i)10 (ii) 5
DLI 6 Planning, management, and monitoring capacity to deliver urban health services strengthened	45	15	10	(i) 5 (ii) 5 (iii) 5	(i) 5 (ii) 5	10
DLI 7 Innovations and partnerships in urban health developed, tested, and shared	20	7	—	—	10	10
Total	**300**	**100**	**40**	**60**	**100**	**100**

ADB = Asian Development Bank, DLI = disbursement-linked indicator.
Source: Asian Development Bank.