From project to programme, the story of USAID's legacy of urban health in India

2000 to 2015

Contents

Context

"The urban rich have access to healthcare facilities. But for the urban poor, medical expenses are beyond their means, as 17 per cent of them live in slums and most are migrant labourers, rag pickers and marginalised sections of society."[1]

These were words of the then Health Minister, Ghulam Nabi Azad during the launch of the National Urban Health Mission (NUHM) in January 2014. The programme has expanded across India providing free health care to about 200 million people and has subsequently been merged with NRHM into the National Health Mission.

India has the world's second largest urban population of about 400 million. Studies from early 2000s indicate that about 17-20 per cent of urban population is destitute; therefore 80 million are poor. NHM provides health services for these 80 million.

The gap in services between the general urban population and the poorest quintile is striking. In 2005-06, The U5MR and stunting rates were 42 per 1000 live births and 33 per cent, compared to 73 per 1000 live births and 54 per cent, respectively. Similarly, 54 per cent women in the poorest quintile had three antenatal check-ups, 50 per cent were attended by a skilled birth attendant and 40 children were fully immunized. This compares with 40 per cent, 83 per cent and 65 per cent for rest of population, respectively. [2]

Studies found that urban poor remained underserved by public health system, widening the rich-poor divide; the Government of India had no specific health programmes for the urban poor. There were only sporadic campaigns with no programmatic approach for health. Mr. A.R. Nanda, former Health Secretary, said the ministry assumed the population could avail services as cities had hospitals.

Gathering evidence

Dr. Sharad Pandit, former CMHO, Indore said that serving slum dwellers was a challenge compounded by regular outbreaks of diseases like malaria and cholera that claimed many lives. Dr. Massee Bateman, Chief, Maternal and Child Health, Urban Health Division, 2002-08, said one of the causes of this deprivation was lack of accurate data on size of slum population. The Indore Municipal Corporation (IMC) data had 438 slums, many of which were middle class neighbourhoods, and excluded some 100 non-notified slums with conditions worse than the listed ones.

Pravin Jha, JHPIEGO, said to overcome the lack of data on health of urban poor, the National Family Health Survey 2, (1998-1999) data was analysed again for the states of Madhya Pradesh, Uttar Pradesh, Jharkhand and Delhi. This generated evidence for the challenge.

Another issue, says Dr Basab Gupta, Deputy Commissioner, Urban Health, MoHFW, was the scattered urban health infrastructure. The existing family welfare centres, health posts, maternity homes and public/private hospitals were not mapped, and their work was limited to RCH services.

In 2003, Indore had government and private hospitals, maternity homes, medical colleges, polyclinics and 33 government dispensaries but there were only 120 government doctors for a population of 1.2 million, said Dr Pandit. There were few anganwadi centres which were used as bases by auxiliary nurse midwifes (ANM). Dispensaries were inaccessible for people in the non-notified slums as they lacked roads and public transport. Farzana, a motivator with a community-based organization (CBO) in Khajrana slum in 2003, said then most deliveries took place at home assisted by traditional birth attendants (dais). The reach of the ANM, immunization, distribution of Iron & Folic Acid (IFA) tablets to women, and use of birth control methods were negligible.

This was to change, but slowly, over several years.

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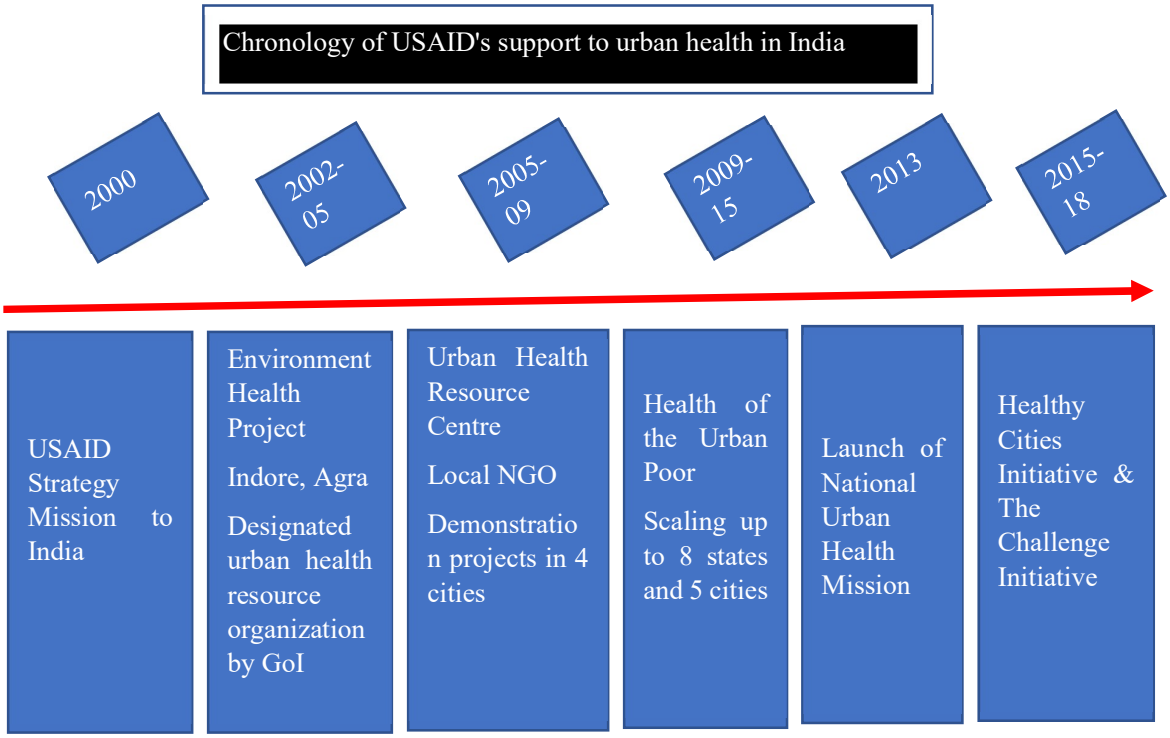
[1] http://www.thehealthsite.com/news/national-urban-health-mission-nuhm-for-urban-poor-launched-by-health-min/, accessed on 5-8-18

[2] Agarwal Siddharth, 2011. The state or urban health in India; comparing the poorest quartile to the rest of the urban population in selected states and cities

The first steps, Environment Health Project

In 2000, the US Agency for International Development's (USAID) Washington office appointed a strategy mission to India to identify areas of support to the Government. After several meetings and field visits to states, the health conditions of the urban poor was identified as a major area of concern. Rajib Dasgupta, Professor, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, said there was an assumption that there is no dearth of health facilities in cities, but the mission's findings belied this assumption.

The problems found in Indore was that most health facilities were secondary or tertiary, located far from the slums, there was little emphasis on primary care and there were few frontline workers for outreach. This created a dependency on registered medical practitioners and untrained TBAs for treatment and deliveries.



USAID set up the Environment Health Office to support urban health programs. Dr Bateman said they felt the need for orienting the government's urban health policy towards the poor at the national level. To create evidence and models on ground, two cities were selected in discussion with MoHFW, state governments, and city health functionaries.

Thus began the 10-year journey for USAID. Anand Rudra, USAID said, "From 2003 to 2013, when the NUHM was conceptualised and launched, we supported the government with evidence, models, scaling up and technical inputs to develop the mission's framework, operating guidelines, monitoring, institutional framework and roll-out."

Mr. Nanda said while the government sought support from several international development partners including UNDP and DFID, the European Commission and USAID provided technical assistance and a systematic approach to urban health program, respectively.

USAID initiated the Environment Health Project (EHP) in March 2002 under the Office of Health, Infectious Diseases and Nutrition Bureau for Global Health. Indore was selected due to the enabling political and bureaucratic environment[3]. It had a high population growth of 47 per cent in 1991-2001 with 17.7 per cent of the population living in slums as migrants, and a good health and academic infrastructure.

[3] It was the constituency of the then chief minister Digvijay Singh, had a proactive Mayor-in-Council, Dr. Uma Sharma, and CMHO, Dr Pandit

Additionally, the Indore Habitat Improvement Project (1990-97) of DFID had focussed on physical infrastructure, preventive health care, environmental health awareness and community development through creation of neighbourhood groups and vocational training (especially for women)[4].

EHP was also executed in Agra with a somewhat different approach. Here too, it covered vulnerable people in non-notified slums. In both cities, EHP worked with NGOs and the urban local government bodies, the municipal corporations.

EHP was designed to generate evidence and templates for various processes. It three-year objectives were:

1. Increased coverage of services and adoption of key health behaviours in neonatal survival, diarrhoea control and other child health priorities
2. Improved capacity of CBOs, NGOs, private and public sector health providers in health behaviour promotion, use of child health data and building partnerships
3. Improved mechanism of linkages between communities and service providers
4. Better targeted policies and increased allocation of resources for urban slum health
5. Development of replicable models for urban child health programmes.

Building local expertise

In November 2005, with the progress of EHP, Urban Health Resource Centre (UHRC) was set up to take forward the urban health mandate and to provide technical support to GoI. The demonstration projects in Indore, Agra, Delhi and Meerut tested and developed context-specific strategies to improve the health of urban poor. “This was the crystallisation of EHP into a legally-registered Indian entity to scale up the work,” says Benazir Patil, formerly with Save the Children.

Scaling up: From demonstration to mission

To prove that urban health models developed in Indore and Agra could work in diverse situations, USAID initiated the four-year Health of the Urban Program (HUP) in 2009. As in the EHP model, it selected Population Foundation of India (PFI) as Lead NGO, with Plan India, the Institute of Health and Management Research, Jaipur (IIHMR), Bhoruka Charitable Trust (BCT), the Centre for Development and Population Activities (CEDPA), the International Institute for Population Sciences (IIPS) and the Micro Insurance Academy (MIA) as NGO partners. The program had one or more community-based organizations in each project city which mapped vulnerable areas and provided services.

HUP covered nearly half a million people across eight states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, and Uttar Pradesh and five cities of Bhubaneswar, Jaipur, Pune, Agra and Delhi. In addition to demonstration at scale, HUP provided support to the (then) proposed NUHM by including Reproductive Maternal Neonatal Child Health plus Adolescents (RMNCH+A), promotion of water supply, sanitation and hygiene in the scope of urban health. “From 2008, series of inter-ministerial meetings were conducted with Ministry of Housing and Urban Poverty Alleviation and Women and Child Development on NUHM and to discuss issues of education, health and WASH,” says Patil.

HUP’s objectives were to:

1) Provide quality technical assistance to the government of India, states and cites for effective implementation of NUHM
2) Expand partnerships in urban health, including engaging the commercial sector in public-private partnerships (PPP)
3) Promote the convergence of different GOI urban health and development efforts
4) Strengthen the evidence-based rigor of city-level demonstration and learning efforts in order to improve program learning.

HUP’s achievements included the preparation of urban health plans (Odisha and Chhattisgarh); reorganization of state health society to include stakeholders from other relevant departments (Uttarakhand); evidence generation through facility assessments and studies, emphasis on health determinant issues under urban health

[4] Dewan Verma, Gita. "Indore's Habitat Improvement Project: success or failure?" Habitat International: a Journal for the Study of Human Settlements 24 (2000): 91-117.

(all states); including health determinant approaches in state Project Implementation Plans (PIP) for 2013-14 (Rajasthan); orientation of urban health functionaries on comprehensive public health issues and needs assessments; and influencing policy inclusion of water and sanitation activities in scope of urban health (Chhattisgarh, Uttarakhand and Rajasthan).[5]

HUP supported drafting PIP guidelines and setting financial norms for NUHM with the Government of India. It facilitated the formation and orientation of state and city program management units and developing 359 city PIPs in the eight states. In these states, HUP was a part of the NUHM steering committees. Memorandums of Understanding (MOUs) for training functionaries through state technical agencies were signed with governments in UP and Rajasthan.

Senior decision makers in the eight states, interviewed as part of HUP's final evaluation in 2015 said, "urban health started with HUP," and "HUP has advocated for and created an inclination for urban health activities."[6] It was included in the Technical Advisory Group (TAG) of the Government of India and the Technical Resource Groups (TRG) of NUHM at the Central and state levels.

Evolution of project structures

The Indore Diocese Social Service Society (IDSSS) works in the city and rural parts of neighbouring districts. Sister Arokiamary, IDSSS Joint Director, was the field project manager for IDSSS under EHP. She said IDSSS, Bal Niketan Sangh (BNS), Pushpkunj Family Helper Project Trust (PFHPT), Bhartiya Grameen Mahila Sangh (BGMS) and the Centre for Development Economics and Development Consultants Society (CECOEDECON) were the five NGOs selected out of the 15 that applied as project implementers in 2003.

The five NGOs formed a forum to coordinate amongst themselves. They generated demand from the community and increased reach of government health services. The forum had a project manager and coordinator from each NGO. The project structure had nine lead CBOs (LCBOs), 87 basti community based organizations (BCBOs) and about 800 women in 100 slums were created or selected for community outreach.

The slums were divided amongst NGOs based on experience and logistical considerations. The reason, says Rita Lahiri who was the project manager for BGMS, was to foster local ownership and capacity that would outlast the project.

Dr. Bachawat, then District Immunisation officer, suggested ward coordination committees (WCCs) be set up for interface with the government to improve reach and access of public and private primary health services in slums. Ward No. 5 was selected as it was one of largest. The WCC had the municipal councillor, staff of different government departments, the NGO and LCBO as members.

The HUP structure was similar to EHP's. PFI as lead NGO worked with six implementing NGOs. In turn, these appointed local NGOs in the states and project cities. The local NGOs trained CBOs to map vulnerable areas, raise awareness about health and ensure services reached the 'last mile'.

The NUHM implementation framework recognises that NGOs also run health facilities but assigns them a supporting rather than core implementation role. NGOs have a role in identifying the most vulnerable. NUHM acknowledges that despite government and private institutions in cities, issues such as unqualified private practitioners, weak public health system, poor WASH conditions, congested tertiary hospitals and low access and demand of health facilities are common.

To rationalise the unwieldy urban health structure, says Sachin Gupta, USAID's advisor on MCH, NUHM planned to develop Urban Primary Health Centres (UPHCs). Depending on the spatial distribution of the slum population, a UPHC would cover between 25,000-50,000 people providing preventive, promotive and non-domiciliary curative care.

[5] USAID/India Health of the Urban Poor Program Mid-Term Evaluation Report, 2012
[6] USAID/India Health of the Urban Poor Program Final Evaluation Report, 2015

Identifying most vulnerable areas

The first step in EHP's execution was to identify the most vulnerable areas in slums. For this, the NGOs conducted health vulnerability assessments over 3-5 months. These resulted in socio-economic service maps including the age of slum, physical infrastructure, geographic location, and community institutions, within non-notified slums and poor pockets within. Meetings with communities were held to understand urban poverty, access to health centres, nutrition, WASH and institutions. Involvement of the city health officials in the exercise sensitised and inculcated a sense of responsibility in them but prompted the people to take the exercise seriously.

Anjali Bijoy Kumar, who was IDSSS' project manager, says, "We conducted transect walks, participatory appraisals, focus-group discussions to ascertain the status of slums. We used EHPs tools and our own experience of working in the slums."

The survey identified 101 unlisted slums. These were ranked on vulnerability on basis of criteria such as socioeconomic conditions, environment, land tenancy, public health services access and use, health status and morbidity and community confidence and negotiating capacity. As many as 157 slums were ranked as less, moderately, and highly vulnerable, and finally 75 slums were selected for EHP.

The EHP baseline survey found about one-third of the intervention and one-fourth of the non-intervention slums had no health facility. About 46 per cent had a private facility. The average distance to private clinics was 2 km compared to 5 km for a government facility. Just 41 per cent had an anganwadi center. Piped water and handpumps were the main sources of water, but piped water supply was erratic. About 34 per cent had toilets and 60 per cent had ever used contraception[7].

An assessment of CBOs in the slums revealed the existence of many self-help groups, Bal Vikas Samitis (BVS) and mahila mandals. These collected information on pregnant women and children and counselled them for services such as immunization. They were supported by LCBOs for capacity building and counselling, but had no formal rules and regulations. Similarly, LCBOs that evolved from SHGs, NGOs and BVS had different capacities and structures; only half had bank accounts. Of nine LCBOs, six predated the project. These provided information to BCBOs and communities on pregnancy, new-born care, immunization, diarrhoea prevention and monitored vitals and hygiene practices through home visits.

In Agra, from 2005, UHRC followed the same process of mapping unidentified slums and their vulnerability assessment through three implementing NGOs, Family Planning Association of India (FPAI), Naujhil Integrated Rural Project for Health and Shri Niroti Lal Buddhist Sansthan. They categorised 183 (46 per cent) slums as most vulnerable from a total of 393 slums (215 listed and 178 unlisted)[9]. Consultations with civil society and the government were held to devise a strategy for improving access to health services.

EHP and HUP's approach to define the urban poor has been incorporated into the NUHM framework. It calls for a household surveys through CBOs and NGOs supervised by the ULBs to define the urban poor. "This has to be through a communitized process and take note of the vulnerability of the households in terms of the assets it possesses…. NUHM will use surveys of the urban poor done under various government programs. However, it will subject all listing to public disclosure of name before the Mahila Arogya Samitis (MAS) or ward level ULB unit"[8]

This is a formalisation of the participatory identification of the urban poor that started with EHP. There is a complete alignment between NUHM's approach and that of HUP, says Gupta.

Finding the people

One of EHP's cornerstones was identifying local people and fostering community leadership. For this, the NGOs carried out a series of activities.

[7] EHP Baseline study, 2004.
[8] NUHM Framework for Implementation, 2013. MoHFW, Government of India

Identifying and setting up LCBOs

LCBOs were selected from among existing local organizations, or created from scratch. They were staffed by qualified people who were trained in community mobilisation and supporting BCBOs to ensure they continued work after project ended. Shakila Khan, who started the LCBO Rahbar Mahila Mandal, said she was trained on reporting of antenatal visits, vaccination, IFA tablet distribution, hygiene practices, institutional deliveries and scheduling ANM visits. The team got a monthly honorarium of Rs 1,000, says Megha Namdeo, who worked with a LCBO of CECOEDECON.

Setting up BCBOs

NGOs set up BCBOs comprising 12-15 local women from slums. Some were from a common self-help group. They were trained on health issues. The women were responsible for reaching out to households in their neighborhood. Each woman managed about 50 households, focussing on pregnancies and children aged 0-1 for vaccinations and monitoring diarrhoea cases.

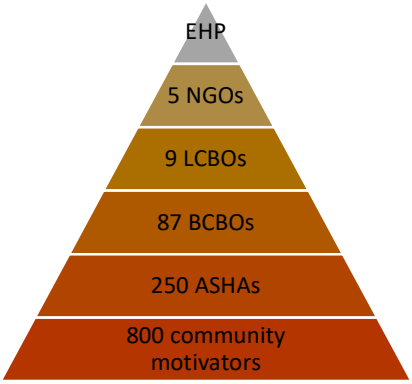


Figure 1: EHP's project structure

In Agra, the model was somewhat different. EHP set up mahila Arogya samitis (MAS) or women's health groups similar to BCBOs in Indore. MAS conducted monthly meetings to build a link between communities and existing government health service providers. NGOs also recruited and trained community link volunteers (CLVs) to provide health information and counselling, mobilize the community and provide support during outreach camps. FPAI and SNBS reached out to 100,000 people in Agra.

Several MAS had impact beyond health services. Indra Devi, President, Mehtab MAS, Kachpura slum said, "In 2003, there was so much filth and garbage in our area that you had to cover your nose. After our group was formed in October 2005, we realized the importance of sanitation and hygiene." Within two years, they instituted an emergency health fund, improved their slum's lanes and approached the corporator to assign a municipal sweeper to collect garbage and clean drains.[11]

In 2009, HUP developed operational guidelines for MAS by defining their roles and responsibilities from the experience in EHP. Many MAS members were trained on health needs in their communities. In 2013, when HUP helped formulate NUHM guidelines, the roles and responsibilities of MAS were further refined and detailed.

Increasing demand for health services

The community organizations and NGOs created a demand for urban health services, which was one of the EHP's objectives. BCBO motivators conducted house visits to enumerate pregnant women, new-borns and children and inform them about vaccinations and other health practices. Community motivators were trained intensively by the EHP team and NGOs. Sunita Rai from the NGO Mahila Sandesh Vikas Sangh, said, "When we heard a child had only got one vaccination for DPT, we convinced the mother to take it for boosters and the other vaccines."

Shakila Khan, an ASHA who started with a BCBO, said she sought support from NGO staff to overcome taboos associated with immunizations and birth control among Muslims and Parsis. Through persistent counselling, the demand for these services improved. Bharti Neena, who worked with a LCBO, said individual and group meetings were held to sensitize women about health issues.

To achieve this, EHP worked with ANMs for immunization and IFA. ANMs were initially reluctant as they anticipated an increase in workload. But they soon realised BCBO community motivators were helping them achieve targets. BCBOs and ANMs developed a symbiotic relationship where ANMs promoted the former and BCBOs helped ANMs in immunization drives. This, says Anjali, helped increase awareness and access services.

BCBO women became credible sources of information as many members were themselves early adopters of immunization services and preventive care. Through HUP and later, NUHM, the links between ASHAs and

ANMs were formalised. ASHAs and MAS created a demand for health services that doctors and ANMs fulfilled.

Extending and ensuring health services

To ensure the community received services at a fixed location and time, teams from BCBOs and LCBOs planned health camps in each locality on a fixed date, usually a Sunday, in consultation with the ANM. The local health centre staff were present, making these camps a one-stop shop for basic reproductive and child health services and treating minor ailments.

The community motivators knew which families had new-borns and expectant mothers in their neighborhood. They visited the families and gave each mother a schedule for health check-ups and health camps. Farzana said they would identify children needing immunization and write the child's name and immunization date on a pink slip. They ensured the mother attended next health camp with the slip. This improved accessibility and quality of health services and helped decongest tertiary health facilities.

The EHP team then identified the local, 'trusted' and accessible RMPs and dais to upgrade their skills. RMPs were trained to treat common ailments and refer serious cases to hospitals, while dais were trained in good hygiene practices such as handwashing, identifying high risk pregnancies and cutting umbilical cords.

Urban ASHAs

Of the 800-odd BCBO members, 250 women were trained as Urban ASHAs. They were given ID cards signed by IDSSS and IMC, a nameplate for their home and a medicine kit. They became an integral part of the government health system, generating demand for services. Sarita Malhotra, a motivator, said her training, motivation and identity cards helped her to ensure Jaimala from Solanki Nagar safely delivered triplets at a hospital despite complications.

In Agra, EHP adopted different strategy. FPAI and NIRPHAD opened two UPHCs under at locations jointly identified with government. These provided conventional PHC services and community outreach services and covered about 100,000 people.

The urban ASHAs were tasked to raise awareness on health and entitlements.

- Community mobilisation for increased utilisation of public health facilities at PHCs and referral to tertiary facilities for MCH services
- Providing information of WASH, nutrition, health facilities, services, and immunisation
- Counselling services to women and families and adolescents such as birth preparedness, safe delivery, breastfeeding and complementary feeding, contraception, substance abuse, prevention of domestic violence and sexual violence
- Treatment for diarrhoea, fevers, new-born children, childhood illnesses and first aid and providing IFA pills and condoms
- Screening for anaemia and basti surveillance of vectors such as mosquitos

Each ASHA was linked to a BCBO and ensured it met regularly and conducted household visits to give health messages. Uma Manaware, a former BCBO motivator from Gangaru Nagar said she organised and trained CBOs comprising outspoken women in bastis to prepare due lists of services from the basti.

The NUHM guidelines for ASHAs took the same path. It has also incorporated MAS. Their roles were clearly defined. Each ASHA is responsible for 1000-2500 people and manages 2-5 MAS. The eligibility qualification for ASHAs has been raised from EHP; she must have passed Class X (this can be relaxed if no candidate is available). She should live in the slum and is selected by committee comprising city officials and NGOs. ASHAs visit homes, facilitate urban health and nutrition days (UHNDs), accompany sick people or pregnant women to health centres, promote MAS and maintain a record of its work.

Neetu, an ASHA, said she maintains a calendar of work including household visits, camps, meetings with SHG, women and students along with due services list that culminate in the monthly UHND at the anganwadi centre.

Under NUHM, ASHAs have been institutionalized. They are selected by a government-appointed panel at regular intervals and paid incentives according to a fixed rate chart.

Impact on women

Being an ASHA has been a life-changing experience for many. Usha Kushwaha, who has worked as an ASHA in Indore working since 2003, covers two bastis and visits households daily to assess pregnancies and immunizations. She takes people to the anganwadi for health problems. Her efforts have been recognized by people and the ANM. Neetu works in the slums of Niranjanpur, Gomatiphel and Kazi ki Chand as an ASHA. She maintains a record of all activities in triplicate and gets it vetted by ANM before submitting it to the IMC that pays her incentives for each activity. The job is cumbersome but that has not dimmed her passion.

According to Farzana, before being trained by EHP, she was just another woman living a mundane life. Echoing what other women said, after training, she felt a strong sense of purpose and importance as local people approached her for health-related issues, settling cases of domestic violence, alcoholism and drug abuse.

Outreach services

A formal mechanism to extend government health services to slums was developed in EHP and extended under HUP. By 2009, under HUP camps became formalised as UHNDs. The UHNDs were organised monthly at the anganwadi or other place jointly by the AWW, ASHA, ANM and MAS.[9] While most HUP cities exceeded their UHND targets, Rourkela, Lucknow and Kanpur lagged. HUP's operational guideline on UHNDs were included in the NUHM guidelines for Outreach Sessions in Urban Areas, 2015, and Guidelines for ASHAs and MAS in urban context.

These guidelines specify the urban poor as the target audience[10] and cover regular or special UHND sessions at a fixed date and time. There are challenges with UHNDs as were unable to provide the full range of health services even in 2013[11]. The UHND activities, that are based on EHP's experiences are:

- Early registration of pregnancies, ante-natal checkups, birth preparedness, referrals of high-risk pregnancies
- Awareness generation about government health schemes and entitlements
- Routine immunization, treatment of diarrhoea and acute respiratory infections among children
- Growth monitoring and screening, referral and counselling of malnourished children
- Counselling for infant and young child feeding, family planning and distribution of condoms and pills
- IFA supplementation and deworming for adolescents
- Awareness about WASH and distribution of chlorine tablets

As in EHP, ASHAs and MAS prepare due lists for UHNDs and inform people of date and venue ANM refers cases that need medical attention to the UPHC OPD or special clinics.

Health facilities

In view of the lack of health facilities in slums health camps (UHNDs) were held in anganwadis. Suitable schools, community centres or private halls also used. Dr Basab Gupta said the criteria to select a location was that it had to be accessible, equitable and focused on primary and preventive health care.

Urban PHCs

These are now the fulcrum of the urban health system, for which land and buildings are provided by government or ULB. Some may be co-located with AYUSH centres. Their size and scope of services varies

[9] Operational Guidelines Conducting Outreach Session in Urban Areas, 2015. MoHFW, Government of India
[10] These include slums and JJ Clusters, female-headed households, minor-headed households, those engaged in a variety of unsafe occupations, households, the aged, and people with disability from rag-picking, to begging, to helping and illness. unsanitary, head loaders, coolies, rickshaw pullers, sex workers, brick kiln workers, sanitary workers, manual scavengers, domestic workers and construction workers, street vendors, the homeless, elderly poor, single women, street children, differently abled, people living HIV/AIDS, leprosy, TB, etc.,
[11] HUP final evaluation report, 2015

from only outpatient care to the full range of care. There is a complex relationship between ULBs and district health services in many states underpinning this 'model' says Dasgupta.

States have re-designated existing facilities as PHCs or urban community health centres (UCHCs) depending on the capacity of their ULBs. The national quality assurance standards of NUHM have been designed taking in consideration these variations and it allows states to customise their approach. However, as Gupta points out, governments have been slow to set up the centres. NUHM instituted *Rogi Kalyan Samitis* to manage UPHCs and UCHCs. These get ₹ 250,000 or ₹ 500,000 each year for O&M, depending on the centre. Additionally, RKSs are responsible for community outreach and raising funds.

NGO-CBO partnership

This was the foundation of EHP. It built local capacity and leadership in the communities. The project trained slum women to become health workers, thus empowering them. The NGO-CBO partnership ensured the project activities continued after EHP ended. Trupti Sharma said many BCBO staff were absorbed as ASHAs under NUHM and continued to use skills acquired during EHP.

EHP demonstrated that involving well-established NGOs can expand the reach of health services in a relatively short span of three years. NGOs' experience made it easy to identify CBOs and map slums for qualitative information. The critical component was involvement of both NGOs and government officials and doctors to generate demand and provide services, thus bridging gap between the urban poor and formal health system.

In Agra, EHP tried two approaches to the NGO-CBO model. One was engaging NGOs to generate demand through community level volunteers and MAS. The other was to run UPHCs. HUP built on this model. In several cities, NGOs fostered MAS. They selected and trained the women, helped open bank accounts and guided activities.

Under NUHM, while state governments can work with NGOs for vulnerability mapping, community engagement, ASHA and MAS training, behaviour change activities and outreach work, they are not central to the delivery of health services as in EHP and HUP. NUHM recognizes that NGOs run clinics and hospitals in many cities that can be included under its ambit for providing health care. As the government policy and system have evolved, the role of NGOs and CBOs has shrunk.

Some of the LCBOs that became NGOs continue to function in Indore but are only peripherally engaged with NUHM. The Rahbar Mahila Mandal, for instance, organizes SHGs under National Urban Livelihoods Mission. The other NGOs work on other development schemes with health as a small component.

USAID continues to work with NGOs in two large projects:

The Challenge Initiative for Healthy Cities, co-funded with the Bill and Melinda Gates Foundation (BMGF) that started in 2017 has Population Services International (PSI) and Save the Children. It works in 31 cities across Uttar Pradesh, Madhya Pradesh and Odisha to improve health services for the poor. It links the private sector with the government. Trupti Sharma said they train urban health officials to familiarise them with context, policy and operational issues.

In communities, the NGOs work on demand generation and through advocacy with national and state governments, they ensure sustainable funding for city health systems. A key innovation is the development of a challenge fund mechanism that provides matching funds and technical assistance to incentivize replication and leveraged scale-up of interventions that have proven to work for the urban poor.

USAID also supports the Building Healthy Cities project through a consortium of NGOs led by John Snow International. It is a partnership with the Smart Cities initiative in India, Save the Children and JHPIEGO. This project aims to create coordination structures to achieve health goals and improve metrics in infrastructure and information and communication technology (ICT) projects, enhance interoperability of data systems, and increase efficiency of multisector urban spending.

In addition, the project will give citizens a voice in the process through integration of a mobile citizen reporting system. Better and faster data can reduce time and costs of producing data that can influence policy decisions and empower citizens to demand better health-related services. "This project tries to address gaps in HUP related to systems strengthening. It provides a platform for stakeholders to contribute resources," says Benazir.

There are several elements from EHP and HUP in both projects. HUP's final evaluation suggested public private partnerships and need to focus on innovative models as two challenges. USAID therefore continues to work on new models while plugging gaps in earlier projects. Under NUHM, a few state governments including Odisha, Uttarakhand and Rajasthan, formulated policies for PPP with an emphasis on setting up the public health network infrastructure.

Impact at scale through convergence

Under EHP, in Indore's Ward 5, a ward coordination committee (WCC) was set up in May 2003 to bring all the stakeholders together – NGOs, LCBOs, officials and elected representatives. They were to work towards improving the access and reach of primary public health and private sector services to the slum community. The project team was selected after consultations with local officials and the IMC zonal officer. WCC was a model of coordinated effort of government departments, statutory and non-statutory bodies and NGOs.

From 2009, HUP helped set up convergent platforms to bring urban health decision makers into existing societies and committees. It facilitated setting up WCCs and City Coordination Committees (CCCs) that played an important role in convergence and coordination of city and ward plans. By June 2015, eight cities had CCCs; just 30 of the 234 WCCs were set up.

HUP developed additional institutions for NUHM. Each project city set up a city program management unit (CPMU) to develop city health plans guided by CCCs and the district health society. HUP helped develop CHPs in 18 cities. It facilitated planning and budgeting for 359 non-HUP cities in the eight states in 2014-15 and 94 in 2015-16. HUP prepared operational guidelines for CCCs, WCCs, urban health cells, UHNDs, and MAS that were adopted by central and state governments.

HUP also include WASH activities such as included hand washing, improving water quality in households and toilet use. Uttarakhand included WASH in the mid-day school meal scheme and PHED used WASH communication material. In Chhattisgarh, community toilets were made under a joint agreement between the Department of Urban Development, ACC Cements Private Limited and NGOs. Vulnerable pockets for water-borne and water-based vector-borne diseases were identified and sanitary inspections and drinking water quality monitoring were conducted in Odisha and Chhattisgarh.

The NUHM implementation framework does not make it mandatory for states to establish WCCs even though HUP's final evaluation recommended it. City health plans are part of NUHM. Similarly, city urban health missions or urban health societies will implement NUHM for ULBs and if they cannot, the district health society will do so.

Collateral benefits

Good WASH practices and infrastructure are critical preventive measures for diarrhoea and other diseases; they were lacking in project slums. During EHP, committee member Raju from Pawanputra Nagar in Indore visited Pune to learn about building and operating community toilets. The committee negotiated with IMC for piloting it in their sum, ensured building the toilet quickly and contributed ₹20 a month for O&M. In Jeet Nagar slum, EHP's programme partners Pushpkunj negotiated with World Vision for making individual toilets for which each household contributed ₹ 1400.

Beyond Indore: National Advocacy

Dr Bateman had said EHP had a two-fold mandate. One was generating evidence, and the other was to inform and influence the development of a national urban health programme.

While EHP was being rolled out, MoHFW started the RCH – II where lessons from phase showed urban health, especially of the poor, needed more resources. The Government identified EHP as the nodal agency to support development of its Urban Health Programme (UHP). For this, EHP organized national and regional workshops for urban health planning. It supported Uttarakhand to develop proposals for three cities - Dehradun, Haridwar and Haldwani – drawing on lessons from Indore regarding vulnerability mapping, community engagement, outreach and service delivery.

The Government of India also tasked EHP to develop a template for city proposals that were used in Delhi, Agra, Bally and Haldwani. The process included a situation analysis, identification and mapping of the urban slum population and other vulnerable groups, development of implementation plan, budgets and in addition to a monitoring and evaluation mechanism.

EHP conducted workshops for three state governments on urban health in Kolkata, Narendra Nagar and Lucknow. Participants were oriented on planning, beneficiaries, coordination mechanisms, problem definition and strategies. The technical advisory groups (TAGs) headed by a joint secretary developed methods of mapping vulnerability, institutional structures, community engagement (such as the ASHA model) and financing. In HUP, these approaches were tried across a much larger population. Finally, the HUP team worked with MoHFW to draft the NUHM framework and guidelines for each component.

Through its current projects, the Challenge Initiative and Building Healthy Cities, USAID keeps the advocacy engagement going with MoHFW and state governments. The challenges identified in EHP and HUP are being systematically addressed.

Replication

In 2005, UHRC was designated by the Government of India as an agency for developing a sample health proposal for Agra city that would guide the health department to expand health services to the large urban poor population[12].

Thereafter, two more pilots were launched. In Meerut, the Urban Health Demonstration Programme was started jointly with the Johns Hopkins Bloomberg School of Public Health, Baltimore, USA, and King George Medical University, Lucknow, India. It aimed to develop and test an effective, affordable and scalable model. At a workshop in August 2006, the challenges, potential stakeholders and possible options for improving health of slum communities in Meerut were discussed. The other pilot was in Delhi's Janata Mazdoor Colony, a poor habitation of about one lac population; between Municipal Corporation of Delhi and the Government of National Capital Territory of Delhi with an objective to improve access to maternal and child health services by pooling resources and skills of different stakeholders.

From Project to Programme

National Advocacy: From the foregoing, it is evident several constituents of EHP and HUP, executed with USAID's support, have been incorporated into the NUHM implementation framework. NUHM developed UPHCs, one for 25000-50000 people providing preventive, promotive and non-domiciliary curative care. The national quality assurance standards of NUHM have been designed for inherent variations in the health system and as many function from rented buildings which allows state governments to customise their approach to UPHCs while meeting national standards.

Identifying the vulnerable: NUHM conducts household surveys through CBOs and NGOs supervised by the ULBs to define the urban poor or uses surveys of the urban poor from various government programs.

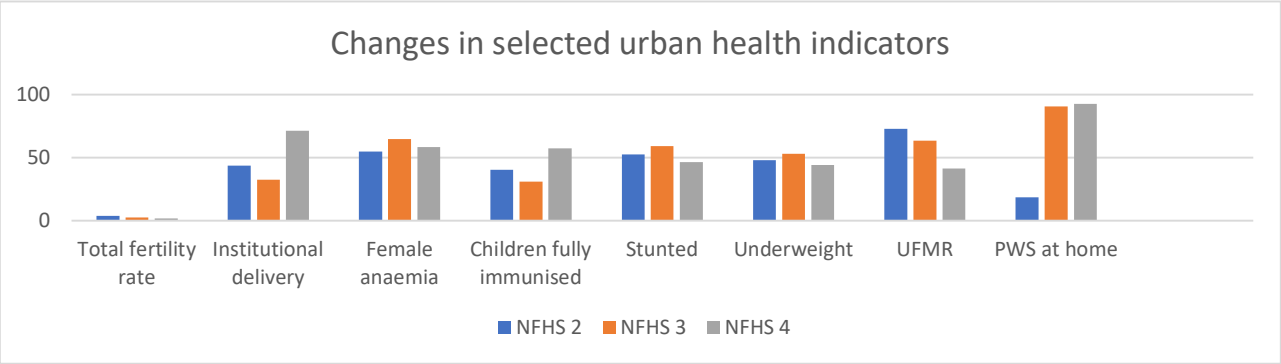
Urban ASHAs: ASHAs have a major role to play as community-level health providers with each of them responsible for a population of 1000-2500 and managing 2-5 MAS., who should be at least Class 10 by education, a resident of the slum and having strong communications skills.

Mahila Arogya Samitis: The MAS guidelines define their roles and responsibilities who are trained on health needs of their communities. NUHM has instituted *Rogi Kalyan Samitis* to manage UPHCs and UCHCs who generate ₹ 250000 and ₹ 500000 each year to run their institutions.

Convergence and planning: Under NUHM each city is supposed to prepare a City health plan, similarly, city urban health missions or urban health societies are to implement NUHM for ULBs, or the district health society would set up and run a similar entity.

The impact was visible in urban health indicators tracked through the National Family Health Surveys. The following graph shows improvement in some indicators from NFHS 2 and NFHS 4.

[12] UHRC Annual Report 2006-07



Institutional deliveries have improved substantially, as has the percentage of fully immunised children. Malnutrition – stunting and underweight – among children has declined more modestly. Under five mortality has also declined substantially. The availability of drinking water piped on premises has also improved. This points to the success of the integrated approach of EHP, HUP and later, NUHM.

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