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USAID/India Health of the Urban Poor Project Mid-Term Evaluation Report

October 2012

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USAID/INDIA HEALTH OF THE URBAN POOR

MID-TERM EVALUATION REPORT

October 2012

AID-386-TO-10-00003

RAN-I-00-09-00019-00

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ACKNOWLEDGEMENTS

The evaluation team wishes to thank the Population Foundation of India's Program Management Unit staff and partner organizations for generous support in providing information and documentation. The team also thanks the HUP state and city teams and partners for facilitating the site visits and providing detailed information on local activities, in addition to state government and municipal officials for making time to meet and answer our many questions. We thank officials from the government of India, external donors including UN agencies, and USAID staff members for their thoughtful responses to the team's questions. Finally, we thank Mannat Travels and Tours and Dr. Ash Pachauri (Social Impact) for in-country logistical and local support.

The Consultant Evaluation Team
October 2012

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ACRONYMS

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
AOTR	Agreement Officer's Technical Representative
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BCT	Bhoruka Charitable Trust
BMC	Bhubaneswar Municipal Corporation
BSUP	Basic Services for the Urban Poor
CBO	Community Based Organization
CEDPA	Centre for Development and Population Activities
CC	Cluster Coordinator
COP	Chief of the Party
CSR	Corporate Social Responsibility
DFID	Department for International Development (UK)
DEA	Department of Economic Affairs
EHP	Environmental Health Project (USAID)
GOI	Government of India
GoO	Government of Odisha
GOV	Government
GRC	Gender Resource Center
HFW	Health and Family Welfare
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HUP	Health of the Urban Poor
ICDS	Integrated Child Development Services
IEC	Information, Education, and Communication
IIHMR	International Institute of Health Management and Research
IIPS	International Institute for Population Studies
INR	Indian National Rupees
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
JSY	Janani Suraksha Yojana (Incentive scheme for promoting institutional deliveries)
LW	Link Worker
MAS	Mahila Swasthya Samiti (Women's Health Committee)
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCH Star	Maternal and Child Health Sustainable Technical Assistance and Research
MCHT	Maternal and Child Health Tracking
MIA	Micro Insurance Academy
MOHFW	Ministry of Health and Family Welfare
MOHUPA	Ministry of Housing and Urban Poverty Alleviation
MOUD	Ministry of Urban Development
MIS	Management Information System
MP	Madhya Pradesh

MTA	Midterm Assessment
NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OPD	Outpatient Department
OR	Operations Research
PFI	Population Foundation of India
PHED	Public Health Engineering Department
PIP	Project Implementation Plan
PMG	Procurement and Grant Management Group
PMTCT	Prevention of Mother-To-Child Transmission
PMU	Program Management Unit
POU	Point of Use
POUZN	Point of Use for Zink
PPP	Public-Private Partnership
QPR	Quarterly Progress Report
RCH	Reproductive and Child Health (national program)
RSBY	*Rashtriya Swasthya Bima Yojana* (National health insurance scheme)
SOW	Scope of Work
STI	Sexually Transmitted Infections
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
UD	Urban Development
UHC	Urban Health Center
UHI	Urban Health Initiative
UHND	Urban Health and Nutrition Days
UHRC	Urban Health Resource Centre
UHP	Urban Health Post
ULB	Urban Local Body
UK	Uttarakhand
UN	United Nations
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
VISTAAR	USAID MNCH Project (Hindi word=to expand)
WASH	Water and Sanitation Hygiene
WCD	Women and Child Development
WESNET	Water and Environmental Sanitation Network

EXECUTIVE SUMMARY

In India, the urban poor are among the fastest growing and especially vulnerable sub-populations, having limited access to clean water, sanitation, and health care. Despite compelling need, urban health has not been a priority issue and receives less attention than rural health care. Since 2001, USAID has engaged in an active partnership with the Ministry of Health and Family Welfare/Government of India (MOHFW/GOI), beginning with the Environmental Health Project-India (which in 2005 transitioned to a nongovernmental organization [NGO], the Urban Health Research Center [UHRC]), in addition to providing long-term assistance for improving water and sanitation in urban areas. In response to GOI's proposed National Urban Health Mission (NUHM), the Health of the Urban Poor (HUP) project in 2009 was designed to work at state, municipal, and community levels to develop innovative policies and program strategies to better meet the health needs of the urban poor.

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The project's main focus is on maternal and child health (MCH), and the improvement of delivery and community-mobilization systems that could prove effective in reaching India's rapidly growing urban slum populations. Because the launch of the NUHM has been delayed, the technical assistance (TA) component of HUP has been aligned with the urban health component of the existing National Rural Health Mission/Reproductive and Child Health (NRHM/RCH) program. HUP is being implemented in the following states: Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, and Uttar Pradesh; in addition to five cities: Bhubaneswar, Jaipur, Pune, Agra, and Delhi.

The Cooperative Agreement (for the total sum of INR 513,601,582/US$10,778,627) was awarded to the Population Foundation of India (PFI) to provide support to USAID/India's Health of the Urban Poor Program. HUP is the first USAID award made directly to an Indian NGO. GOI approval had not been obtained prior to awarding the Cooperative Agreement for HUP in September 2009, thus delaying project implementation for ten months. As a result, the project has been operational for a maximum of one year and in most demonstration sites, for only six to eight months. The four-year project is scheduled to end by September 30, 2013.

PROJECT BACKGROUND

This mid-term HUP evaluation was designed to provide an assessment of the project's progress in addressing five key components (i.e., TA, public private partnerships, convergence, demonstration models, and management and governance) after one year of project implementation. The evaluation addresses the extent to which HUP is developing and implementing innovative urban health interventions and models that can be considered for replication and scale up, in India and possibly other countries as well. By addressing the key questions listed in the scope of work (SOW) at the project's mid-term, the evaluation should provide useful guidance on how well the project has been rolled-out, what appears to be working or not working, and how HUP might be best deployed to ensure positive results during the remainder of the project.

EVALUATION QUESTIONS, DESIGN, METHODS AND LIMITATIONS

The evaluation, commissioned by USAID/India under a contract with Social Impact, was conducted by two U.S. and three Indian consultants over a period of four weeks in-country during June and July 2012. During field visits to four states and four city demonstration models, the evaluation team gathered data through extensive review of documents and project reports, interviews with key informants, including GOI, state and municipal government officials, PFI and its partners, NGOs, foundations, donor/UN organizations, health facility staff and community workers and members. Analysis of these data forms the basis for the report's findings and recommendations.

FINDINGS AND CONCLUSIONS

The evaluation team found that the HUP project has several accomplishments and achievements, despite encountering many challenges which include: on-going delay in the launch of the NUHM and thus, no clear incentive for states to address urban health issues; a 10-month delay in HUP project approval by GOI, resulting in a very short period (six to 12 months) for implementation of project activities to date; and uncertainty about the remaining time period (one or two years) until project completion. Another fundamental challenge is the nature of the project design, which includes a broad range of activities to be provided through a TA approach in eight states and five municipalities representing diverse environments. Also, the project's performance indicators make it difficult to assess achievements in many areas. However, in a relatively short period, the HUP project has helped to delineate national- and state-level policies on urban health, in addition to broadening the participation of relevant stakeholders in the development of NUHM policies, program priorities, and operational strategies (e.g., national- and state-level ministries and departments).

The key findings related to project objectives follow:

Objective 1: Provide Quality technical assistance to the GOI, states, and cities for effective implementation of the National Urban Health Mission (NUHM).

> The HUP team has been successful in establishing relationships and providing a range of TA to national-, state-, and city-level governments and been recognized as a valued partner in urban health. At the same time, there is a need to develop a mechanism to increase involvement of state and municipal governments in developing work plans. TA could be provided more comprehensively in some areas, e.g., for an overall state urban health plan and nutrition program.

Objective 2: Expand partnerships in urban health, including engaging the commercial sector in Public Private Partnerships.

> Despite special challenges to establish public-private partnerships (PPPs) in urban health (e.g., in urban health there are no policies, structures, or PPP cells and limited funding, unclear incentives, and short time-frames), HUP has facilitated the launching of some PPP models and others are under discussion. However, many states, and especially city, teams need more guidance from the project management unit (PMU). Findings also include government preference for working with non-profit

NGOs rather than the commercial sector, and a lack of clarity about the value of alternative insurance models.

Objective 3: Promote the convergence of different GOI urban health and development efforts.

In India, the need to converge the many development initiatives implemented in urban areas (e.g., JNNURM, ICDS, and NRHM through its urban RCH component) through various ministries is recognized. To date, HUP convergence activities have been focused more at state and city levels, including engagement at the national level, rather than attempting to bring convergence with other donors at national or state level, or with NGOs working in slum areas. Convergence in states that have a clearer vision on ways to address urban health (e.g., Odisha and Uttarakhand) facilitated progress on the policy front, and these consultations have led to recommendations on the formation of Urban Health Cells and City Task Forces, micro planning at slum level, vulnerability assessments, etc. Activities for WASH have been limited to three key sub-components (i.e., improving water quality at POU, improving toilet use, and hand washing), in addition to activities designed to inform, at state and city levels, on the status of urban water and sanitation, and to bring convergence with health and other departments. However, the indicators required to capture the facilitation role of HUP do not exist at present, and for WASH, the performance indicators are only related to improved access, for which HUP activities have been limited to date.

Objective 4: Strengthen the evidence-based rigor of city-level demonstration models.

The HUP is undertaking urban health demonstration models in five cities, including 276 slum communities covering 450,000 people. Eleven NGO partners are implementing the demonstration models with a combined field staff of 205 people. The evaluation found that the demonstration sites have been established and are functioning, although still at an initial learning stage. In these communities, there appears to be an increase in access to health services, but not all key areas are addressed under RCH. Although HUP is generating demand, there is less support for strengthening service provision. Among the challenges is the variation in responsiveness of local government resources across slum areas.

Objective 5: HUP management practices and systems.

The HUP project consists of a consortium of experienced partners (including three sub-implementing partners and three technical partners), with PFI providing overall management through the PMU (including specialists in each thematic area) to the eight state teams and five city teams. The Program Management Group (PMG) is to provide program management oversight and the Technical Advisory Group (TAG) is to provide strategic guidance. However, both groups meet infrequently and irregularly. Project administration and financial management were found to be in compliance with USAID regulations, and there is a system of communication and reporting to USAID in place. The delay in project approval and appointment of state and city teams has limited implementation activities. Although most appointed staff were found to be of high quality and had benefited from prior experience with government, some lacked more senior expertise. In some cases, interaction between the PMU and state/city teams was limited, with an expressed need for more technical support and mentoring, including public health expertise. HUP state teams noted the need for clear communication from GOI and for greater USAID support at state level "to open doors"

with the government. Interaction and cross-learning between state and city teams and between states was limited.

OVERALL CONCLUSIONS IN RESPONSE TO SOW QUESTIONS

How has HUP influenced GOI policy on urban health since 2009 and what opportunities currently exist for USAID to influence policy-level changes through HUP?

Despite the challenges, and in a relatively short period, the HUP project has helped to delineate national and state-level policies on urban health, in addition to broadening the participation of relevant stakeholders in the development of NUHM policies, program priorities, and operational strategies (e.g., national and state-level ministries and departments). The HUP project has demonstrated mechanisms for strengthening urban health systems within varying environments and, therefore has the potential to frame strategies for addressing urban health needs and priorities, as well as to accelerate the implementation of NUHM when it is officially launched. HUP is working to develop a comprehensive urban health vision for the country, giving USAID a unique opportunity among donors to make major contributions to the NUHM design and implementation process and, ultimately, improve health and living standards in India's most disadvantaged urban settings.

To what extent has the project contributed to the operationalization of the urban health program at national and state levels? What were the strengths and weaknesses of its implementation?

Although the project's implementation approach has been hampered by the delay in approving the NUHM, HUP has developed operational tools for enhancing access to urban services, strengthened behavior-change communication (BCC) initiatives for urban health, and prepared systematic community mobilization guidelines, in addition to producing many policy documents, research reports and pilot project implementation plans (PIPs) that have helped to advance the urban health agenda. Major strengths include: 1. strong policy capabilities and inputs at the national level; 2. HUP staff members are generally well-connected with government health, urban development, and water and sanitation departments; 3. the project is working to build a supportive environment for learning and documenting results, and 4. the project has developed workable mechanisms for fostering convergence across government and NGO partners.

How effective has the project's technical assistance approach been in building synergies between the public and private partners in implementation of key project strategies?

Developing productive PPP for urban health takes time (e.g., negotiating, officially approving and activating PPP activities). Therefore, HUP's results to date in developing PPP activities have been mixed, owing in part to inconsistent interest in the PPP approaches across HUP's eight states and different levels of PPP expertise within HUP's state and municipal-level teams. However, some good models have been developed during HUP's first year, e.g., in Uttarakhand, and other models are being developed, e.g., Odisha, Pune, Rajasthan.

What lessons can be drawn for future designs from the program governance system, especially its role in promoting convergence strategies of different GOI programs?

The HUP project is making important contributions to improving the "governance system" for urban health through its efforts to engage relevant public-sector and NGO stakeholders in addressing urban health needs and strategies for reaching the urban poor. The project's efforts to promote greater interministerial and interdepartmental convergence in delivering MCH services, enhancing WASH infrastructure in urban slums, and nutritional services are now underway in all eight states, but it is premature to judge the effectiveness of the project's convergence. This work has been well received at state and municipal levels and the MOHFW in Delhi noted that they were especially interested in how different convergence strategies were working.

What has been the outcome of the slum demonstration activities under HUP? What are the key strengths and weaknesses of these interventions and what is the opportunity for potential scale up?

The HUP project has made a good start in implementing the five city demonstration models. Partnering NGOs have been engaged, field offices opened, field staff recruited (cluster and link workers), slum communities mapped, household listings completed, baseline surveys implemented in three cities, management information systems (MIS) developed, and the project's maternal and child health tracking (MCHT) systems deployed. HUP has also made good progress in working with local community organizations, most notably the Mahila Swasthya Samiti (MAS) committees established in all slum communities where HUP is working. Education and urban-health-demand-generation activities (often undertaken in collaboration with the MAS committees) are also underway in HUP's demonstration sites. Owing to the short implementation period (six to eight months), demonstration model potential for replication and scale-up will be difficult to determine without more time for implementation and the gathering and analysis of evidence on results. Also, the focus thus far has been on increasing demand, with less attention given to improving the access and quality of service provision.

How effective are the HUP management systems, including project planning and review, grants management, financial and procurement systems, in scaling-up project activities?

The HUP management system appears to be functioning reasonably well despite early problems stemming from a change in leadership and slow recruitment procedures for state and city teams (both initial hires and replacement staff). A system of written and verbal communication between the PMU and USAID is in place. However, the infrequent meetings of the TAG were seen as limiting opportunities for greater strategic program guidance and review. In addition, PMG meetings are held irregularly. While HUP has taken steps to ensure good coordination within the project, there were reports that communication between the PMU and state/city teams could be improved and greater cross-pollination between state and city teams would be desirable. It was noted that the project spends considerable time developing annual work plans that must be approved by the GOI's MOHFW and USAID. These lengthy clearance procedures can give rise to uncertainty over the timely availability of funds needed to pay staff and procure equipment and supplies. A four-year framework mechanism for all sub-grantee contracts might have been a more efficient approach for ensuring smooth project implementation.

Currently, HUP is facing a challenging situation in planning for the next annual work plan without knowing whether a project extension will be feasible. If the project ends as scheduled in September 2013, the work plan needs to address close-out activities during the next year. If there is a no-cost extension, then the work plan could build on and expand current activities.

SUMMARY OF MAJOR RECOMMENDATIONS

- Continue working to facilitate the development of a state urban health vision and plan.
- Build on what exists in the state to develop an urban health strategy to support implementation of a comprehensive urban plan, e.g., use recently developed Madhya Pradesh as an example for other states.
- Where possible, support the development of a more comprehensive urban health model, beyond RCH.
- Systematically document the capacity of state and municipal health systems.
- Systematically track indicators derived from the MCHT system that document contact with beneficiaries and the extent to which HUP is providing support to urban slum dwellers.
- Invest in an expanded, qualitative research program during the last year of the project to better assess what the five-city demonstration models have achieved.
- Repeat the baseline survey during the last year of the project to measure change in basic output and impact indicators over the life of the project.
- Engage in substantive dialogues with states in preparing specific PPP guidelines for urban health.
- Disseminate documentation on successful PPP models to different states and city governments to encourage adoption of such models.
- Engage in advocacy for utilizing and strengthening PPP cells under NRHM in many states.
- Greater focus should be given to assisting state governments to expedite the formation of ward-, city-, and state-level committees as priority structures for urban health.
- Strengthen information exchange between states on the development of urban health frameworks and strategies.
- Make greater efforts to engage other NGO and donor organizations working in urban health.
- Revisit and prioritize the scope of WASH as listed in the Cooperative Agreement and rework performance indicators to reflect the same.
- Utilize the strength of each partner in HUP by providing flexible strategies.
- Encourage an inter-team exchange program between HUP teams and staff for short periods to share knowledge and skills effectively.
- State work plans need to be formally or informally agreed upon with state governments, which will help align TA with state government priorities.
- Introduce state-wide progress ranking to encourage healthy competition between teams within HUP.
- TAG and PMG meetings need to be conducted regularly to provide guidance to the project that pertains to its original design and objectives.
- Undertake operations research (OR) into meaningful incentives for MAS members that will help ensure their sustainable engagement in urban health activities.
- Reduce the project's internal reporting from a weekly to a monthly schedule (particularly for the project's demonstration models) in order to reduce management loads and allow more time for project implementation.
- Reduce administrative burdens and streamline approval and budgetary procedures through framework contractual agreements that cover the life of the project, rather than biannual contracts with sub-grantees.

Recommendations for USAID

- Maintain an urban health niche through HUP and provide leadership to the donor community by escalating the urban health agenda in India.
- Continue strategic dialogue with GOI and states on ways to adopt evidence created through HUP, as well as in other countries and regions.
- At a later stage, provide feedback to GOI and states on models and innovations based on the Indian experience as documented by HUP, to be shared with Africa and other regions.

The Way Forward: Options for the Future

Due to the initial project delay, limited time was available for the project to demonstrate models and results by the midterm. Going forward, the project has two options: (1) close out in September 2013 as originally planned; or, (2) extend HUP beyond its planned close-out date in order to overlap with the eventual launch of NUHM. As a sequel to option (1), there could be follow-on TA to NUHM once HUP has amassed a larger evidence-base for how to operationalize urban health. The benefits and costs of each of these options are summarized below:

Option 1: Close HUP in September 2013 as planned.

- Benefits include following the proposed timeframe and budget allocation.
- Costs include the removal of any capacities already built because of the delay in NUHM launch, as well as the shortening of implementation by one year.

Option 2: Extend beyond original closure date to have an overlap with NUHM launch.

- Benefits include higher return on investments (ROI) and the recapture of time lost at the beginning of the project.
- Costs include the requirement of a higher budget outlay and the additional effort needed to get GOI/state concurrence for the extension.

Option 3: Plan a Phase II of TA to provide longer-term support to proposed NUHM.

- Benefits include the opportunity to scale-up successful models and look into increasing the leveraging of resources.

The ROI from HUP could be increased if the project is extended at least for a year, in view of the time lost in the start-up phase for reasons beyond the control of PFI. Moreover, additional time would also allow further opportunity to present the successful models developed by HUP to government (and other potential donors) in the future, once the NUHM is launched.

EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The purpose of this evaluation is to conduct an in-depth analysis of urban-health-support activities implemented by the HUP projects in India. The evaluation team was instructed to focus on the main components of the project:

- Technical assistance to the Government of India (GOI) and state, municipal, and community organizations in eight states of India
- Convergence of relevant health and development programs (primarily within the public sector)
- Public-Private Partnerships in addressing urban health service provision and infrastructure
- Community-based demonstration models in slum areas of five cities (Delhi, Agra, Jaipur, Pune, and Bhubaneswar)
- HUP management practices and systems

The objective of this mid-term HUP evaluation is to provide an assessment of how the project is addressing these five components after one year of project implementation (six to eight months in the case of most city demonstration models). The evaluation addresses the extent to which HUP is developing and implementing innovative, urban health interventions and models that can be considered for replication and scale up in India, and possibly other countries as well.

EVALUATION QUESTIONS

The Scope of Work outlines the main evaluation questions (in order of priority) for this evaluation as follows:

- How has HUP influenced GOI policy on urban health since 2009, and what opportunities currently exist for USAID to influence policy-level changes through HUP?
- To what extent has the project contributed to the operationalization of the urban health program at national and state levels? What were the strengths and weaknesses of its implementation?
- How effective has the project's technical assistance approach been in building synergies between the public and private partners in implementation of key project strategies?
- What lessons can be drawn for future designs from the program governance system, especially its role in promoting convergence strategies of different GOI programs?
- What has been the outcome of the slum demonstration activities under HUP? What are the key strengths and weaknesses of these interventions and what is the opportunity for potential scale up?
- How effective are the HUP management systems, including project planning and review, grants management, financial and procurement systems, in scaling-up project activities?

Answers to these questions at the project's mid-term should provide useful guidance on how well the project has been rolled out, what appears to be working and not working, and how HUP activities might be best deployed to ensure positive results during the remainder of the project.

The evaluation was commissioned by USAID/India Evaluation Services IQC under Task Order RAN-I-00-09-00019 with Social Impact. (See Annex I for a copy of the complete Scope of Work.)

PROJECT BACKGROUND

In India, the urban poor are among the fastest growing sub-population, with migration a major factor contributing to this increase. The urban poor are especially vulnerable, owing to cramped living conditions, low quality housing, and limited access to clean water, sanitation, and health services. The health services that are available are often of poor quality, understaffed, and have insufficient medicines and outreach to urban slum communities. Thus, it is not surprising that health indicators for the urban poor are low, and some indicators[1] are worse than the averages of the rural populations. Although such circumstances present a compelling argument for addressing these needs, urban health has not been a priority issue and receives less attention than rural health care.

USAID/India began developing an urban health programming strategy in 2001–2002 with the launch of the Environmental Health Project-India (EHP/India). In 2005, EHP/India began the transition to become a nonprofit NGO, the Urban Health Research Center (UHRC). USAID/India has focused on active engagement and partnership with the MOHFW/GOI to effect improvements in urban health in India at scale. USAID also has a long history of providing assistance for improving water and sanitation facilities in urban areas. The agenda has focused on three principal areas:

1. Building knowledge on the extent and nature of health challenges among the urban poor and using this information in advocacy efforts among the GOI, states, cities, and other stakeholders, e.g., NGOs and the private sector
2. Developing city-level programs to model creative, effective, multi-stakeholder approaches to address urban health challenges
3. Providing technical assistance to the GOI, states, cities, and other stakeholders to promote policy change, planning and implementation of new urban health initiatives

The GOI has responded to increased attention on health needs of the urban poor by forming the Urban Health Task Force under the NRHM and in 2009, proposed the NUHM. In response to the anticipated NUHM, the HUP project, the focus of this evaluation, was designed to work at state, municipal, and community levels to develop innovative policies and program strategies to better meet the health needs of the urban poor.

HUP project objectives include the following: (1) Provide quality TA to the GOI, states, and cites for effective implementation of the NUHM; (2) expand partnerships in urban health, including engaging the commercial sector in PPP activities; (3) promote the convergence of different GOI urban health and development efforts; and (4) strengthen the evidence-based rigor of city-level demonstration and learning efforts in order to improve program learning. The project's main focus is on maternal and child health, the improvement of water and sanitation facilities, and nutrition. One of the project's primary objectives is to design and field test new service delivery and community mobilization systems that could prove effective in reaching India's rapidly growing urban slum population.

1 Proportion of households with access to piped water at home; proportion of stunting, underweight, and anemic children; immunization (completely immunized, measles coverage); proportion of children with diarrhea receiving ORS. Source: reanalysis of NFHS-3 data.

Because the launch of the NUHM has been delayed, the TA component of HUP has been aligned with the urban health component of the existing NRHM/RCH program. Consistent with the MOHFW priority of providing focused attention to underperforming "Empowered Action Group" states, HUP is being implemented in the following states: Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, and Uttar Pradesh, in addition to five cities. The city demonstration models were initially started in Bhubaneswar, Jaipur, and Pune, with Agra and Delhi added later.

The Cooperative Agreement (for the total sum of INR 513,601,582/US$10,778,627) was awarded to PFI to provide support to USAID/India's HUP program. (Approximate budget allocations are listed as follows: 62% for TA; 12% for PPP; 14% for convergence; 11% for city demonstration models). HUP is the first USAID award made directly to an Indian NGO. GOI approval had not been obtained prior to awarding the Cooperative Agreement for HUP in September 2009, thus delaying project implementation for ten months. During this time, PFI was not permitted to implement activities, including staffing for the PMU and the eight state and five city projects. As a result, the project has been operational for a maximum of one year and in most demonstration sites, for only six to eight months. The four-year project is scheduled to end by September 30, 2013.

EVALUATION METHODS & LIMITATIONS

METHODOLOGY

The evaluation was conducted by two U.S. and three Indian consultants over a period of four weeks in-country during June and July 2012. During the first week, team members met to plan the evaluation strategy and clarify with USAID the meaning of specific questions and other evaluation issues. The main information sources included project and partner documents, key informant interviews, and site observations. Prior to the evaluation, site selection was made by the USAID Health Office and PFI, and later amended by the evaluation team in consultation with USAID's Program Office. Each team member had primary responsibility for specific project components that matched the consultant's areas of expertise (refer to Annex II, Evaluation Calendar).

Document Review: The evaluation was informed by an extensive review of key HUP project documents, including three research reports (produced by HUP's technical partners), in addition to reports from the GOI, state and municipal governments, USAID, and other international organizations (documents reviewed are listed in Annex III) .

Interviews: The gathering of field evidence largely was guided by interviews with stakeholders involved in the HUP project, including the following: (1) senior officials from the Ministry of Health and Family Welfare, Government of India, in New Delhi; (2) state-level Ministries of Health; (3) municipal health offices; (4) state ministries and municipal offices working in development sectors convergent with urban health, e.g., Ministry of Urban Development, the Ministry of Women and Child Development, Municipal Departments of Water and Sanitation, and the Ministry of Education, etc.; (5) Population Foundation of India (including the former PFI executive director and first HUP chief of party), and HUP partnering organizations; (6) community organizations and health facilities

in urban slum areas; and (7) bilateral and multilateral organizations and foundations working in urban health (a complete list of interviews conducted is found in Annex IV). Examples of the interview forms developed for state and municipal health offices, PFI and HUP-partnering NGOs, and community health workers and facilities used for collecting evidence are presented in Annex XVIII.

Site Visits: Because of time constraints, the Evaluation Team was only able to visit four of the eight HUP states (Madhya Pradesh, Odisha, Rajasthan, Uttarakhand) and four of the five city demonstration models (Bhubaneswar, Delhi, Jaipur, Pune). These sites provided a representative depiction of HUP activities and progress to date. Additional information was sought from states not visited by the evaluation team.

Data Analysis: The findings of the evaluation are based on an analysis of the data collected from several sources, including detailed notes from interviews and site visits, in addition to extensive document review.

The evaluation methodology utilized by this evaluation also includes an assessment of quantitative results generated by the project's MIS over the first year of implementation and extensive data-gathering in the field through group discussions and in-depth interviewing. Quantitative results are largely drawn from the HUP MIS system that has been established for the project.

At the end of the in-country evaluation, the midterm assessment (MTA) presented preliminary findings to USAID/India and PFI. Feedback from these debriefing sessions was taken into consideration when writing the HUP Evaluation report.

LIMITATIONS

Prior to the evaluation team's arrival in India, a detailed schedule for visiting HUP field sites had been organized, although without prior consultation with the evaluation team. This delayed the beginning of field work, since discussions about the criteria for site selection based on evaluation objectives and reconfiguration of the visitation schedule was necessary. The evaluation team visited as many sites as possible; however, additional time could have been allocated for some sites (e.g., Madhya Pradesh, Uttarakhand).

Although USAID and PFI had assembled many documents as background prior to the evaluation, during the time in-country there were some delays in providing requested HUP documentation, pushing the timeline back further than anticipated. In addition, all documents requested during visits to the state and city sites had to be cleared by the PMU before being provided to the evaluation team, delaying access to this information.

The midterm evaluation was undertaken at a time when the project had been in operation for a little more than a year. Hence, many of the activities are either at an early stage of operation (e.g., convergence) or are in the process of development (e.g., PPP models), making it difficult for the project to disseminate evidence-based models for adoption at state or city levels.

Another limitation pertains to quantitative indicators. The indicators are primarily administrative process measures reporting on activities being implemented by the project. It is therefore not possible to compare project outcome and impact indicators with baseline measures in the city demonstration models, since

activities in these sites only began in late 2011 and early 2012 (see below for a more detailed discussion on measuring project achievements).

MEASURING EVIDENCE OF HUP PROJECT ACHIEVEMENTS

The HUP project has developed an MIS for the project that addresses the four main objectives of the project (technical assistance to national, state and municipal government; convergence activities; public-private partnerships; and demonstration models in urban slums). At the present time, the project is reporting on 35 process and outcome indicators (see Annex V) that report on annual and quarterly activities undertaken by the project. This information is used to report to USAID and the GOI's Ministry of Health and Family Welfare on progress in implementing the HUP project.

Many of these indicators pertain to administrative initiatives for assessing project activities. For example, there are indicators that report on the number of meetings, training sessions, study tours, and reports produced by HUP over various reporting periods. While it is important to track such activities, they do not provide much information on the relevance and effectiveness of these initiatives. The current MIS has not set "planned versus actual" expectations for individual indicators, which makes it difficult to determine whether the project is on track for achieving key objectives and influencing urban health policy and program outcomes.

Indicators currently being reported by the project's MIS cover the period from June 2010 through July 2012. They show that the project is actively engaged in working to achieve its four main objectives. However, since the project is still in its start-up phase, some results are fragmentary. Some state and municipal activities are still under development (e.g., states and cities developing and implementing urban health plans with HUP assistance). These may not yet appear in the project's MIS as an activity that has been formally inaugurated, let alone completed. In addition, many of the process indicators in the project's current MIS only provide a partial picture of what the project is attempting.

Additional information that the project will be generating promises to give a more complete accounting of HUP program outcomes, as well as demographic and health impacts. For example, HUP has been busy establishing demonstration models for urban health in five cities over the past six to eight months. While participating slum communities have been identified, field offices established, and frontline workers recruited, the project is still working to establish and regularize its community-based record keeping and reporting systems. The MCHT system, managed by the project's cluster and link workers (LWs), is currently deployed in all demonstration cities. This information is only now beginning to report on contact information with households, assistance provided to beneficiaries (including immunization services at Anganwadi Centers and other government facilities), community-based initiatives to address local health needs (like the UHND activity), and support provided to government outreach (auxiliary nurse midwives [ANMs], and accredited social health activists [ASHAs]) and facility-based health workers. Once this information is systematically reported and measured over time, interested stakeholders will be better informed on what difference HUP is making to the lives of women and children in its demonstration sites.

Another important data source for HUP is the Baseline Survey, implemented by the International Institute for Population Studies (IIPS). This survey has been conducted in three of the project's five demonstration cities (Bhubaneswar, Jaipur, and Pune). The Baseline Survey questionnaire essentially is a slimmed-down

version of the Indian Family Health Survey (IFHS) questionnaire. It collects information on household characteristics; pregnancy histories for deriving fertility and infant/child mortality rates; family planning use, contacts with health personnel; pregnancy, delivery, and postnatal care; immunization and health; gender relations; and STI/HIV vulnerability. The survey covers urban slum communities where the HUP demonstration models are working and non-slum urban settings that can be used to assess levels and trends in slum and non-slum urban settings.[2]

It is worth noting that quantitative performance indicators are only capable of telling part of the HUP story. There is also an important role for more qualitative research approaches that collect evidence from the field on the effectiveness of HUP activities. Undertaking one-on-one or small group interviews with beneficiaries in slum communities, members of community organizations such as MAS Committees, as well as government outreach workers (e.g., Anganwadi workers, ANMs, and ASHAs) and facility-based health workers can add considerable richness to the interpretation of quantitative indicators. In order to generate a solid evidence base for HUP achievements by the end of the project, investments will need to be made in program research that will encourage the inclusion of qualitative insights into what worked and what didn't during the life of the project.

FINDINGS AND CONCLUSIONS

The findings of the evaluation are presented below, organized by the five major project objectives, in addition to a discussion of overall project conclusions.

FINDINGS: OBJECTIVE ONE (TECHNICAL ASSISTANCE)

Objective One: Provide quality technical assistance to the GOI, states and cities for effective implementation of the National Urban Health Mission (NUHM)

HUP Project Design and the Provision of Technical Assistance

The Health for Urban Poor (HUP) Project is a response to the growing needs of the urban poor. The programmatic and research efforts of bilateral, national and international agencies have generated evidence pertaining to the growing urban need and demonstrated models of providing health care. Parallel developments through the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and its sub-component, Basic Services for the Urban Poor (BSUP), have begun to address the developmental infrastructure needs and critical health determinants like water and sanitation in the urban areas of the

2 Preliminary results for several key impact indicators from the three city Baseline Survey are presented in Annex VI. The complete Baseline Survey report was not available to the MTA team during the period of this evaluation. Preliminary results show that residents of urban slum communities are generally disadvantaged compared to non-slum urban residents, particularly with respect to household living conditions, water and sanitation facilities, utilization of safe delivery services, child immunization, TB incidence, and HIV awareness. However, it was also found that slum residents were not notably deficient with respect to family planning use, Vitamin A supplementation, and the practice of exclusive breastfeeding. It is worth noting that the Baseline Survey does not differentiate between authorized and non-authorized urban slum communities. Residents in non-authorized slums are generally considered to be living in more difficult circumstances in terms of access to health services, reliable electricity supplies, and WASH infrastructure. In many cities, non-authorized slums constitute the majority of all slum communities (and in cities such as Dehradun in Uttarakhand, it is roughly 90 percent of all slum areas).

country. Similarly infrastructural inputs and mechanisms to address nutrition of the urban poor have been universalized through the Integrated Child Development Services (ICDS) scheme.

However, the core of any health policy or plan, the delivery architecture, does not exist in the urban areas to utilize the evidence or leverage complementary support. The proposed National Urban Health Mission not only addresses this gap, but envisions the delivery of urban health care within the context of urban development. This gap, the absence of the health delivery architecture, while it presents a challenge to the HUP program, also presents a great opportunity for informing the design and implementation of NUHM once it is approved.

The HUP project was designed with the objective of providing TA to the proposed National Urban Health Mission. However, in the absence of NUHM and a clear incentive for states to address urban health issues, HUP took up the task of facilitating the creation of demand for urban health services, as well as the institutions and structures in partnering states and cities. The expectation of NUHM and its subsequent delay from the expected launch in 2008 has kept many states waiting for guidelines on structures, systems, funds and functionaries for addressing urban health. HUP had the difficult task of working against this inertia in some states while trying to utilize the vision of other states to facilitate advancement of policy and implementation frameworks. Therefore, the project picked-up momentum late because of the delay in approval of HUP by the government, the time needed to establish HUP teams in different states, and changes in PFI and HUP leadership early in the project.

The design of the HUP project is largely geared to MCH interventions (e.g., antenatal and safe delivery services for pregnant women and child immunization), water and sanitation infrastructure, and nutritional services. This focus largely circumscribes the range of TA initiatives that can be supported through HUP. However, a comprehensive public health approach to urban health would be far broader in conception than HUP's current RCH/MCH strategy and include both infectious and non-communicable disease. For example, a broader public health focus would address infectious diseases such as malaria, TB, polio, meningitis, sexually transmitted infections (STI) (including HIV and AIDS), and newly-emerging infections (e.g., avian flu). Chronic conditions such as cardiovascular disease, diabetes, and metastatic disease that occur more commonly in adults would also be admissible as part of a comprehensive urban health strategy. These broadened agendas will need to be addressed in the NUHM framework when it emerges. While it is beyond the scope of the HUP Project to field-test a more comprehensive public health approach to urban health, the project will need to reflect on how future demand generation and service delivery strategies can best support a public health as opposed to RCH/MCH approach to serving the urban poor.

Key Observations and Findings Pertaining to TA Provision

The key findings and results achieved under objective one are discussed below. Also presented is an 'urban health potential matrix' which identifies the stages (health systemic) of the evolution in urban health programming; juxtaposes that with activities carried out by the HUP; and, delineates potential for action within the context of varying state level environments. The matrix is followed by a brief discussion on the impeding and facilitating factors; and the prerequisites for realizing the opportunities presented to the HUP team. Either by design or fortuitously, HUP's presence in eight diverse policy environments presents an opportunity to demonstrate actions required to accelerate the development of urban health programming at each stage of the evolution.

The stages in the evolution of UH programming and the mapping of TA provided by HUP against this background are illustrated in Annex 7.

There are highly variable policy environments for urban health across the states where HUP is deployed: All states are at different stages of the 'urban health programming evolution'. While states like Uttarakhand have not only articulated their priority for urban health and introduced interventions, but also been innovative with expanding Rashtriya Swasthya Bima Yojana (RSBY) universally to the urban poor, states like Rajasthan await the arrival of NUHM before developing a clear vision for their urban program.

The national level TA provision is strategic in nature: The impetus to establish relationships and relevance of urban health programming is evident at the national level. A series of consultations and advocacy efforts have resulted in a strategic position for the TA team at the national level. The support provided to NUHM (e.g., multi-stakeholder consultations; substantive contributions to the development of the NUHM document; and support to technical review of the urban RCH component of the NRHM PIPs, are valued by GOI.

HUP is recognized as an urban health partner by state governments: HUP teams have established a functional and/or valued partnership with the state governments. The HUP teams at the state and city demonstration level are continuously responding to the needs of the state and program management requirements. Initial orientation and advocacy consultations have been uniformly appreciated by the recipient states. Common feedback at all levels of government was, "we were not aware of the various schemes that this department could leverage from other sectors to strengthen our programs." The acknowledgement of HUP as a partner differs from state to state. Similarly, the state ownership of HUP varies as well. The most common impeding factor cited for fostering relationship and ownership is the perceived absence of any communication from GOI or advocacy by USAID to establish HUP as the preferred partner in urban health programming.

HUP has provided a wide range of TA: HUP has provided a wide range of TA to the national, state and city level governments in a short span of time. These include guidelines for tools, policy papers, policy drafts, memorandum of understanding for partnerships, development of PIPs, monitoring models and capacity building for implementation. A map of TA support provided at the national, state and city level is provided in Annex VIII.

A detailed description of TA efforts provided by HUP for capacity building is presented in Annex XXI.

There is no mechanism and advocacy effort in place yet to develop a comprehensive urban health plan (with the exception of Madhya Pradesh (MP) where this was an explicit request from the government to HUP for assistance in developing an urban health framework), which could serve as a precursor to NUHM and facilitate the participation of all available partners, including HUP towards a collective vision.

Budgets for urban Reproductive and Child Health (RCH) have increased in some HUP states: An attempt was made to analyze the urban RCH budgets and expenditure for HUP and non-

HUP states from 2010-13. While some HUP states have increased budgetary plans for urban RCH, others have decreased it over the same period. The data gleaned from a web search for the non-HUP states indicated that urban health budgets have often decreased in recent years. However, interaction with the HUP staff supports the view that their presence may have facilitated broader urban health planning and an increase in urban RCH budgets. Annex IX presents a table which captures the budget analysis conducted by the evaluation team.

TA is currently fragmented – Project work plans do not emanate from an overall state urban health plan: Despite the consideration of state-level needs and state government input into HUP plans, no structural mechanism exists to formally involve state governments and partners to develop the work plan. However, analysis of the urban RCH program implementation plans in Rajasthan, MP, Uttarakhand, Odisha reveals an opportunity to work in tandem with state governments on urban health planning.

TA to promote nutrition is focused on developing policy briefs, advocacy for convergence, guidelines for implementing urban health and nutrition days (UHND), implementation of UHND, PPPs for strengthening nutrition interventions in urban slums and establishment of nutrition rehabilitation centers. (The UNDF strategy and its effectiveness are discussed in the section on Demonstration Models.) Gaps like limited physical space in Anganwadis (Jaipur); non-availability outreach ANMs (Delhi); and, non-availability of IFA/deworming tablets and salter scales (Jaipur and Delhi) limit the implementation of the range of activities delineated in the UHND guidelines.

TA to promote WASH*:* This issue is discussed in the section on Convergence.

TA to promote gender equity and male engagement as articulated in the project work plan is limited to re-analysis of National Family Health Survey (NFHS) data and the gender gap analysis, the former completed and the latter initiated. The MCH/RCH focus of the project lends itself to addressing gender equity in health outcomes. Male engagement was not observed in the community. There are no specific activities to engage the men in the community and the groups facilitated by HUP do not have male participation.

Opportunities for leveraging potential areas of growth not currently optimized: The mapping in Annex VIII indicates the participation of HUP across the various levels of urban programming. However, several opportunities to address critical programming gaps have not been utilized and opportunities to leverage potentials that exist are not on HUP's radar. Public Health support to the states and cities are defined by the capacities within the state teams. Indicative examples of opportunities as observed and discerned during the field visits include:

Table 1: Potential Matrix for HUP

STATE LEVEL	CITY/DEMONSTRATION LEVEL
• Development of a comprehensive urban health vision in Odisha and Uttarakhand • Delineation of service norms for primary care (Rajasthan), secondary care (Uttarakhand/Odisha) and referral mechanism (all three states)	• Mapping of slums and health facility assessments (Rajasthan and Delhi) • Analysis of parameters of service provision quality (Jaipur/Bhubaneswar) • Identification of primary health structure and promotion of preventive outreach (Delhi) • Coordination with Municipal Health Officer to improve primary care (Delhi)

• Rationalization of services provided by varied urban facilities – dispensaries, urban health posts, urban health centers • Policy inputs on the transition of health from department of health to Urban Local Bodies • Utilization of data for decision making (all three states) • Structured inputs to three key departments on gaps in service provision • Advocacy/TA for making water supply and sanitation accessible (key performance indicators)	• Line Coordination with ULBs/facilities to improve service provision (Jaipur/Bhubaneswar) • Expanding scope of urban RCH to include family planning, adolescent and reproductive health, STIs, RTIs, PMTCT (Odisha/Rajasthan) • Promotion of Intra health convergence to improve access to non-RCH services (malarial prophylactics in health centers, information about nearest DOTS center, promoting linkages between facility and DOTS/ICT centers (Jaipur/Bhubaneswar) • Coordination and advocacy for critical supply issues - chlorine tablets, IFA, deworming tablets, salter scales • Delineation of roles for front line workers – ASHAs, LWs and Anganwadi workers (Odisha) • Convergence of critical community level groups • Operations research on models of urban community participation – incentives and disincentives

CONCLUSIONS RELATED TO TA

HUP's Influence on Urban Health Policy: HUP has contributed to the delineation of GOI policy on urban health by generating participation of multiple stakeholders to inform the NUHM. HUP has helped GOI draft the NUHM mission document through evidence generated by earlier USAID programs. HUP is in the process of generating evidence, which has the potential to inform revisions (if required) in the mission document. However, HUP's contribution at the state level is limited to operationalizing urban RCH as mandated under the project log frame.

USAID has a unique advantage in the form of HUP phases, which are at varying degrees of maturity in the evolution of urban health programming. HUP provides a fertile ground for demonstrating operational mechanisms within varying environments – a potential for influencing accelerated implementation of NUHM by the Indian states upon its inception. Furthermore by facilitating the development of a comprehensive urban health vision in HUP states, USAID has the opportunity to create additional demand for NUHM.

HUP's Contribution to the operationalization of the urban health program at the national and state levels: The scope and range of HUP assistance is limited to RCH/MCH/WASH. Several opportunistic interventions enabled by the environment are being attempted. However in the absence of an overarching urban health plan/vision in the states, HUP will benefit by redefining its approach to TA; namely, to one which creates a favorable and capable environment for the implementation of NUHM in its broadest conception as a public health program. A series of discussions with USAID and HUP reveals an operational reluctance to expand the current MCH/RCH scope. While current efforts are fragmented, the urban RCH PIPs 2012–2013 indicate a maturing urban health programming in the HUP states. The budgetary requests from states and approvals by GOI have increased in some HUP states (Jharkhand and Odisha). It was not possible to assess whether this can be attributed to HUP. However, This could provide an opportunity to support the operationalization of a focused urban RCH program. Indicative interventions in the PIP include: rationalization of health facilities in Rajasthan, strengthening secondary level services in Odisha, and convergence of other national health programs in Uttarakhand and MP.

Assessing TA Effectiveness: The MTA Team observed that the HUP project is currently not addressing several relevant TA opportunities that could strengthen the delivery and utilization of health services to urban slum communities. Performance indicators that could track these additional activities are not well-developed by the project. Several additional TA initiatives that could be assessed include the following:

- Undertaking greater in-depth analysis of urban health needs and profiles of service availability and utilization in each state participating in the HUP Project.
- Organizing and conducting more comprehensive health facility assessments in each state.
- Preparing policy assessments on the scope of urban health services beyond RCH/MCH, as has been done recently in Madhya Pradesh.
- Developing an integrated MIS framework for capturing both RCH and other indicators for urban health.
- Working to identify priority needs for strengthening secondary level services.
- Developing guidelines for the referral of beneficiaries to higher levels of care.
- Identifying institutional mechanisms for promoting community level convergence in the delivery of health services and required health infrastructure.
- Designing program research studies to generate evidence on incentives for community action/mobilization for urban health.

FINDINGS: OBJECTIVE 2 (PUBLIC PRIVATE PARTNERSHIPS)

Objective 2: Expand Partnerships in Urban Health, including engaging the commercial sector in Public Private Partnerships (PPP)

The draft report[3] on the Urban Health Task Force under the MOHFW, GOI recognizes that contracting the delivery of health services to the private sector is a viable option to consider as government health facilities do not have adequate reach in urban slums leading to low demand and poor utilization.

The project had a specific objective of harnessing the capacity of the private sector that includes both the NGO and the for-profit sector, as expressed by its Objective 2. For PPP, the success of models depends on a variety of factors ranging from the presence of a structure to administer contracts in the government, willingness to tap non-government resources, identification of proper opportunities to leverage such resources and clarify roles and incentives of each partner. In the absence of the NUHM, none of these success factors for PPP existed when HUP was launched. The efforts of the HUP team to create demand in state governments for urban health strategies, structures and systems has been continuing in this difficult context.

Although there are many challenges, the HUP was successful in facilitating some positive change in the policy and organizational attributes for PPPs, even though there is still much that needs to be done.

Activities and Achievements Related to Public-Private Partnerships

3 Draft Final Report of the Task Force to Advise the National Rural Health Mission on "Strategies for Urban Health Care". May 2006. Source: http://www.mohfw.nic.in/NRHM/Task_grp/Report_of_UHTF_5May2006.pdf. Accessed 15 July 2012.

Considering the limited time the project has been operational and the different levels of interest in the partnering states, progress in developing PPP models ranged from advanced to nascent. States that had already launched PPP models at their own initiative (e.g., Uttarakhand) were supported by the HUP team with enthusiasm. In others, more time was required to lay the groundwork, as well as generate interest in state governments for supporting potentially effective PPP models. The MTA team considers the very effort of integrating PPP into state plans for addressing Urban Health laudable, regardless of the achievement as outcomes in the field. Some of the indicators on which the project reports (mostly on PPP workshops and meetings held), are reported in Annex 5.

Facilitation of PPP models by HUP

The PPP models in HUP that are in implementation or at discussion stages at present are either a Government-NGO model or those that involve the Corporate Social Responsibility (CSR) wing of an organization. HUP is discussing development of PPP models with a number of potential partners, e.g., Bharti Vidyapith and Kirloskar Foundation in Pune, Lupin and Narayan Hrudayalaya Hospitals for Rajasthan, Ambuja Foundation and Titan Industries in Dehradun. However, most of these models will require more time to be finalized, as the roles and incentives of each partner are still unclear. The types of models being developed by HUP are noted in Table 2 (below) with the details of each model discussed in Annex X.

Table 2: PPP Contracting Models with HUP Assistance in States/Cities

STATE/CITY MODEL IN HUP	ARRANGE-MENTS	SERVICE DESIGN	PROVIDER SELECTION	SERVICE MANAGEMENT / MONITORING	INFRA-STRUCTURE	FINANCING
Urban Health Centers in slums[4]	**GOV-NGO**	GOV	**GOV**	**GOV-HUP**	GOV	**GOV**
Mapping potential partners in Commercial sector (e.g. Kirloskar-Pune; Lupin – Rajasthan, MP; Sea-shore – Odisha)	**HUP–Commercial Partner**	**Commercial Partner–HUP**	**HUP**	**Commercial Partner–HUP**	GOV	**Commercial Partner**

Adopted from: Loevinsohn, B. (2008)[5]

Bolded black text in specific boxes denote scope for further involvement of HUP in future.

Key Observations and Findings related to PPP

Limited funds for Urban Health PPPs in NRHM: In the absence of a National Urban Health Mission and appropriate structures for delivering public services in health in urban areas, a small percentage of funds allocated for the urban RCH program in the states often remains largely unutilized. However, the lack of substantial funding dedicated to urban health issues at the state departments of Health & Family Welfare also limits the ability to contract NGOs for rendering service in urban slums.

4 In Uttarakhand
5 Loevinsohn,B. Performance-Based Contracting in Developing Countries. A Toolkit. The World Bank. 2008.

PPP model development and contractual arrangements are in initial planning stages and would require time to bring clarity regarding the roles of each partner: In most states, the project activities started only a year ago; hence, the time available for project teams to discuss and agree on effective PPP models with government or private partners was limited. A number of PPP initiatives are still under discussion in Pune, Jaipur, Dehradun, and other areas. It takes time to establish a clear delineation of the roles and incentives of each partner, followed by creation of contractual arrangements and arrangement for financing. Almost all government and private sector officials met the requested assistance on contractual documentation and administration.

Lack of specific PPP policies in urban health in states: Some states, like Odisha and Uttarakhand, have a state level PPP policy and all government departments, including Health and Urban Development, are expected to remain within this framework. Therefore, although a PPP policy specifically for such departments does not exist at present, the HUP teams in some states (e.g., Rajasthan, Odisha) have initiated dialogues for assisting governments in creating department-specific PPP Guidelines.

Need for PMU guidance on PPP: Development of PPP models are largely left to the initiative of HUP state and city teams, under the monitoring of the PMU in Delhi. However, owing to the delayed recruitment in mid-2012 of the PPP Specialist in the PMU, guidance for this thematic area to the state HUP teams was limited.

City teams do not have dedicated PPP resource: City teams lack a dedicated PPP specialist. Pune has only a city model (and no state team), while Jaipur and Bhubaneswar have both state and city teams, although the latter does not have a PPP specialist. It appears that cross-sharing of experiences and skills across state and city teams has been limited, resulting in reduced support for multiple themes, including PPP. The Odisha state and city teams, however, seem to have attained better convergence between them, perhaps due to the prior experience of the PPP specialist in NRHM functions and good integration of actions within both teams.

Knowledge products on PPP have not yet received government attention: A draft PPP study, "Public-Private Partnership in Urban Health," was published by the HUP team in December 2011, but has not yet been reviewed by the government. The study describes a number of PPP models, including urban health slum centers; mobile medical units; hospital management through partnerships; partnerships with individual providers; and out-contracting of diagnostic facilities.

Government prefers NGOs to commercial sector for PPP: At the national as well as state levels, government officials have shown decidedly more inclination towards including NGOs in PPP, rather than the commercial sector. Interviews conducted with the commercial sector during field visits reveal that most of the CSR initiatives of for-profit organizations also prefer to work with NGOs and have limited or no interaction with government functionaries beyond the front-line workers.

Lack of clarity on value of alternative insurance models: PPP models in community insurance have not been developed yet in the HUP project, perhaps due to the lack of a clear understanding with all stakeholders regarding the value of such an approach, and compared to the public health insurance scheme for the poor advanced by RSBY. Although the project supported a draft study, "Micro Health

Insurance Schemes in Urban India: A Compendium" in March 2012, which discusses the different models of insurance, it has not been disseminated.

Need for a dedicated PPP structure in government for urban health: PPP cells exist in most states under NRHM, but an equivalent structure for urban health has yet to be established. Until states and cities decide on whether the Health Department or Urban Development Department in the state governments takes the leadership role in addressing urban health issues, cells for themes like PPP are not expected to be created. Discussions with government officials in Bhubaneswar and Pune reveal that, although there is a felt need for such a dedicated Cell to deal with PPP issues, it is still not clear which department would house it.

CONCLUSIONS RELATED TO PPP

Absence of substantial funds and limited state attention on urban health affects development of PPP models. Since most states allocate a small fraction of the NRHM budget for urban health, the attention provided to urban health issues varies by state. Uttarakhand has had better success focusing on government-led models to address urban health, perhaps due to a higher allocation of urban funds in NRHM. Other states and cities appear to be waiting for dedicated funds from the proposed NUHM before deciding on substantive actions on urban health.

Addressing incentives of each PPP partner is imperative for success and can work well through a facilitator like HUP. The HUP team in Bhubaneswar has successfully addressed the incentives of the private and public sector to harness the combined strengths into a good PPP model. It seems unlikely that such a fruitful collaboration would have been established without the active facilitation of the well-experienced HUP team.

Developing scalable PPP models through involvement of the commercial sector is possible when business interests of the organization lie in the same domain. Although a number of CSR initiatives are running in many states across the country (e.g., Kirloskar group assisting community schools on WASH issues), these are mostly stand-alone examples and the scalability of such models is often questionable. Creating scalable PPP models requires integration of CSR initiatives with business interests. The Seashore example in Bhubaneswar, or the possibility of Lupin's engagement through the HUP project to run Urban Dispensaries in Rajasthan, exists primarily because of a strong business presence in the field of healthcare.

Low-cost community health insurance models can be developed only if there is clarity on the design of particular models that can be adopted in specific areas. The complementarity of alternative insurance models to the national RSBY program is not clear at government or project levels. The study on micro-insurance models does explain the different models existing in the country, but advocacy to adopt particular models based on an actual needs assessment of specific areas is still not available.

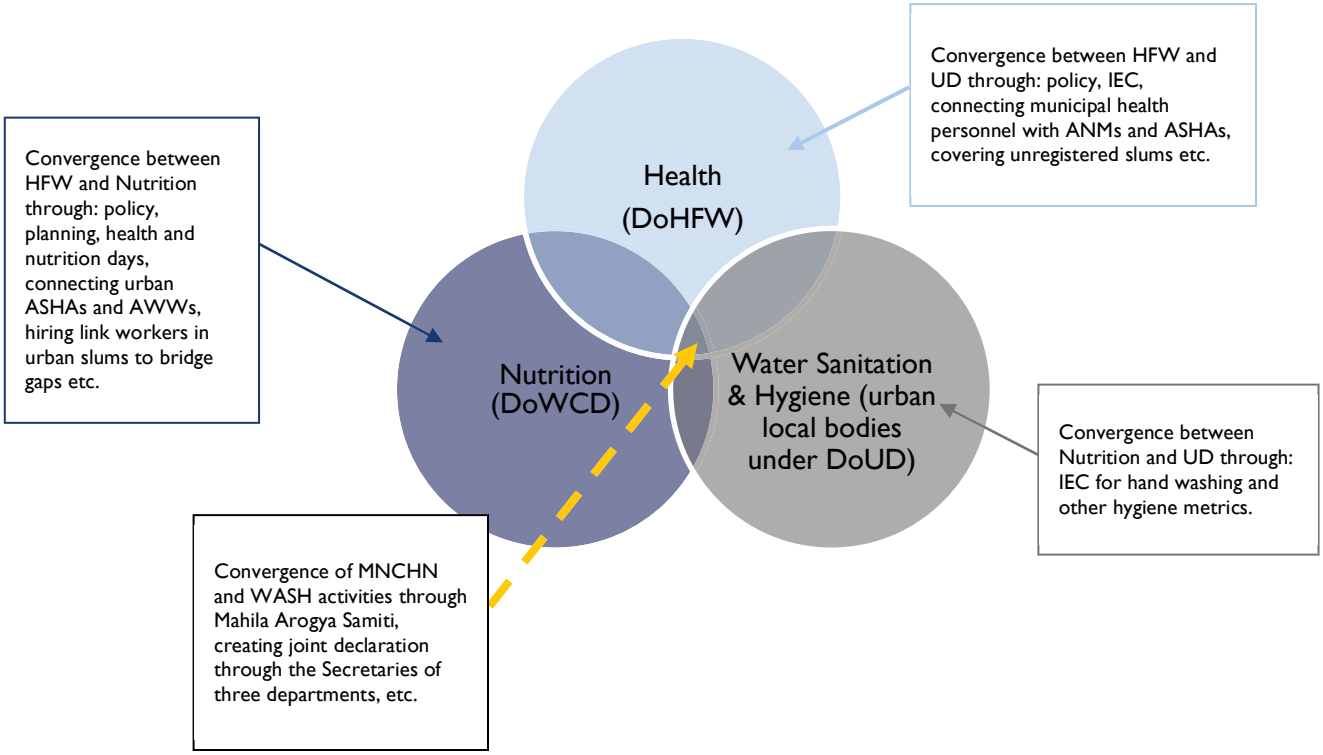
FINDINGS: OBJECTIVE 3 (CONVERGENCE)

Objective 3: Promote the convergence of different GOI urban health and development efforts.

A number of national development programs are implemented in urban areas through various ministries. Notable among them are JNNURM, ICDS, and NRHM (through its urban RCH component), which focus on poor and vulnerable populations and (except for NRHM) have a slum-centered approach. If the proposed NUHM is launched, it will take the lead role in urban health issues. However, because these programs are in organizational "silos" under different ministries and departments, approaches to provide services in a collaborative fashion are still far from optimum (refer to Annex XI: "Key Government Programs for the Urban Poor in India"). Promoting convergence among all these different initiatives through joint planning, demonstrating city-based models, and creating evidence is a key component of HUP.

A schematic representation of these areas covered by government departments and where HUP interventions are targeted is shown in Fig. 1 below.

Fig. 1: Convergence Objectives of HUP



The urban slums thus provide a unique opportunity to converge services at the beneficiary level, which are delivered through multiple public agencies. Inclusion of convergence as one of its major objectives was a strong advantage for HUP, as the need for such an intervention in India has been acknowledged. Reforms at the urban, local-body level, a major objective of the JNNURM program of the national government, would necessitate policy convergence between the different public agencies working for the common beneficiary,

i.e., the urban poor. The JNNURM Overview[6] states, "While several reform initiatives have been taken, e.g., the 74th Constitutional Amendment Act and model municipal law, there is potential for further reform-oriented steps in order to meet the development objectives."

The Request for Application (p. 17) of the HUP project recognizes the importance of planning coordination for all these efforts at district level. It argues that "[c]oordinated, multi-stakeholder consultations to get buy-in from multiple stakeholders and avoid duplicating such efforts, coordinated slum situational analysis to prioritize and optimize resource allocation from multiple initiatives, and use of shared geographic information systems for planning purposes are examples of common efforts" that could benefit the government programs focused on urban poor.

The inclusion of WASH in HUP was a continuation from USAID's Point of Use for Zink (POUZN) Project, which aimed to reduce one of the leading causes of illness and death among children worldwide—diarrhea—by using two proven methods: (1) preventing diarrhea by disinfecting water at its point of use (POU); and (2) treating diarrhea with zinc therapy.

Activities and Achievements Related to Convergence

The performance indicators for convergence, as measured under Objective 3, include process indicators like the number of consultation workshops, number of letters issued jointly by the departments of Health and Family Welfare, Women and Children Development, and Urban Development (HFW, WCD, UD), number of exposure visits held, etc. Neither annual nor quarterly progress reports reflect progress on the basis of "planned versus actual" for any of the components and thus do not allow for clear assessment or measurement of progress. HUP's key indicators to measure progress on convergence included: meetings held with stakeholders at GOI, state, and city levels with respect to convergence, coordination committees formed and meetings held, letters and circulars jointly issued by health and other related departments, consultations and workshops organized to bring in convergence and trainings and exposure visits to successful coordination programs.

It was discussed during the field visits that the states that responded positively to these initiatives are planning to move ahead through actions such as: transfer of NRHM urban health budget to municipalities, linking WASH indicators to NRHM's monitoring framework and planning to create separate budget lines for urban health in the Urban Development Department. Even if the state government's vision is the key factor in initiating such long-term changes, HUP undoubtedly has contributed to such development in the limited time it has been operational. However, the indicators required to capture the facilitation role of HUP for such a paradigm shift in policy and institutional framework in states does not exist at present. The summary of activities at process level that are being pursued by HUP at present is shown below:

Fig.2: Convergence activities in HUP at different levels

6 Source: http://jnnurm.nic.in/wp-content/uploads/2011/01/PMSpeechOverviewE.pdf, p. 6. Accessed July 17, 2012.

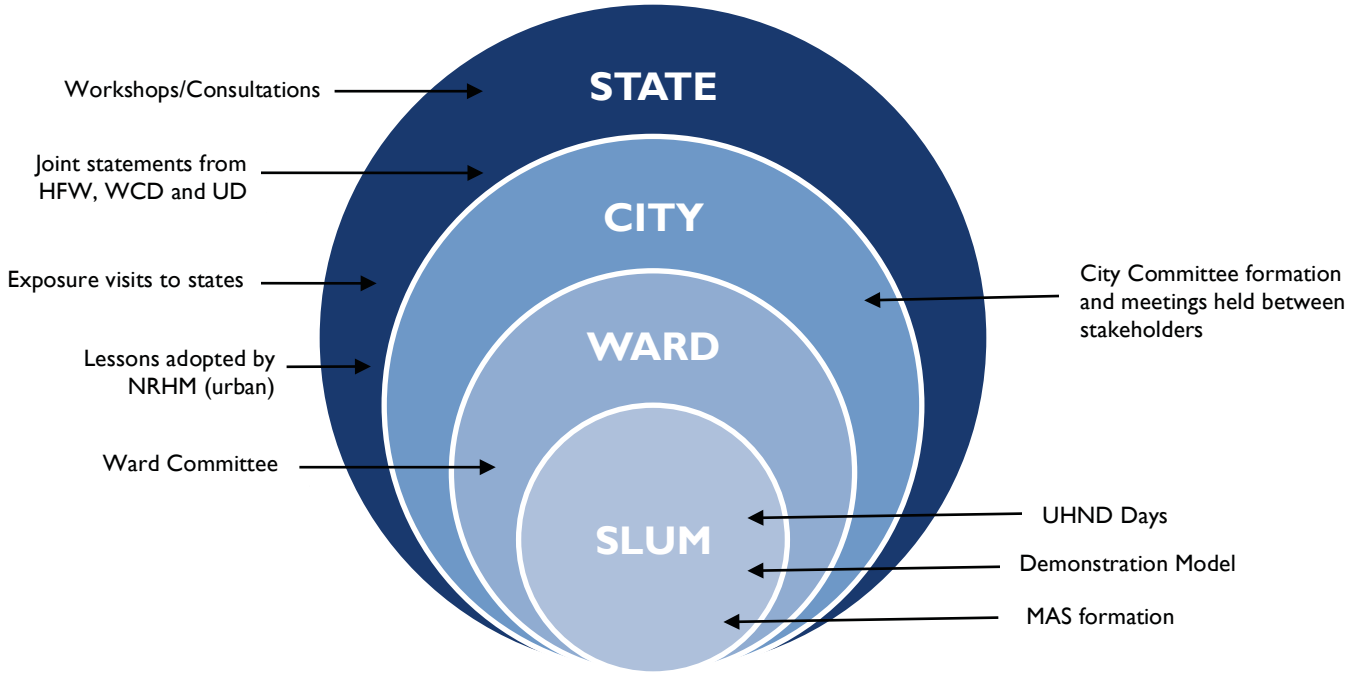


Table 3: Convergence platforms attempted in HUP

MAJOR PLAYERS	NATURE OF ACTIVITY DESIRED	INCLUDED IN HUP?
National government agencies: MOHFW, UD, WCD and PHED.	Joint policies, planning, and resource allocation.	Included in principle. National level consultations were held in 2010.
State (and city) government agencies: HFW, UD/PHED, WCD	Joint policies, planning, resource allocation, and sharing of functionaries.	Started. Joint declaration of HFW, WCD and/or UD in Odisha with HUP facilitation.
Donors other than USAID	Policy frameworks, sharing of international and regional best practices, sharing program details, harmonization of efforts.	Limited or none in sites visited.
USAID financed projects like MCH-STAR, VISTAAR, POUZN etc.	Related activities influencing outcomes; utilization of presence in states.	Tried in first year.
NGOs implementing programs in slums	Implementation of IEC/BCC activities, distribution of resources, service delivery, capacity building, etc.	No formal collaborative effort observed. However, some informal collaboration happened in some slums.

At present, HUP convergence activities are more focused at state and city levels, apart from continuous engagement at the national level. However, attempts to bring convergence with other donors at national or

state levels, or with NGOs working on different aspects in urban slums, have not been observed. States possessing a clear vision regarding methods to address urban health, especially Odisha and Uttarakhand, have made progress on the policy front. Consultations in these states have led to recommendations on the formation of urban c and city task forces, micro-planning at slum levels, vulnerability assessments, etc. Such progress was not observed in all states, perhaps due to the delay in starting the HUP project, different priorities at state level, and different levels of experience with the HUP team.

The WASH approach under the HUP project is well defined and presented in the Cooperative Agreement between USAID and PFI.[7,8] However, the performance indicator set captures only the indicator related to improved access. Thus far, the HUP project activities in WASH have been limited to three key sub-components: improving water quality at point-of-use, improving toilet use, and improving hand washing. In addition, activities were undertaken at the state and city level to inform the status of urban water supply and sanitation and to bring convergence with health and other departments. These activities are summarized below:

At the national level:

- HUP assisted in organizing the national consultation on NUHM in July 2010, to bring together the ministries of Health and Family Welfare (MOHFW), Housing and Urban Poverty Alleviation (MOHUPA), and Urban Development (MOUD) to address the urban health challenges in the country. A similar consultation was held in November 2010 involving MOHFW and MOUD. HUP also engaged in policy analysis on WASH and provided recommendations for Women and Child Development, Urban Development and Health and Family Welfare departments.
- The HUP team engaged with the national government on proposed NUHM discussions and has supported the urban health division of the MOHFW by providing data, information, and helping in organizing the consultations. It also supported MOHFW in drafting an MOU between MOHUPA and MOHFW to improve the health of the urban poor.
- HUP contributed to the chapter on urban WASH for the *UN India Water Development Report*.

At the state level:

- Exposure visits were made to USAID's POUZN program and meetings were organized with their staff to understand the activities and adaptability to HUP strategies.
- Meetings with UHI and representatives from the Commission on Urgent Relief and Equipment Program were held in Agra to shortlist potential slums, map objectives and strategies of the programs, and initiate health collaborations in slums.
- Consultation on "Basic Services to the Urban Poor in Odisha: Issues and Challenges," WESNET meeting in Jharkhand, advocacy event in Rajasthan and stakeholder consultations held in Pune, Bhopal, and Chhattisgarh were some of the activities that highlighted the importance of convergence among different stakeholders.

7 This includes improving provision through adoption of shared financing arrangements by the ULBs and Private Sectors (market financing using the debt-equity model or through the Build operate and Transfer models) with community paying an affordable price for usage; BCC on hygiene practices; evidence based decision-making and improved planning and implementation of water and sanitation interventions targeting the urban poor; and making local government more responsive to water, sanitation and hygiene issues

8 Source: Cooperative Agreement (dated September 25, 2009), Pg. B-18 to B-25.

- WASH activities covered in HUP included:
  - *Building context and information*: needs assessment and stakeholder mapping; preparation of urban WASH profile in the state and analysis of water supply and sanitation policies; contribution to the women's policy and 12th five year perspective plan on water and sanitation (in Jharkhand)
  - *Capacity building*: point-of-use approach paper; WASH indicators incorporated in NRHM's urban health component for monitoring in ODISHA
  - *Implementation/demonstration*: conducting World Water Day (at both state and city levels)

At the city level:

- *Building context and information*: preparation of urban WASH profile in the demonstration city; documentation of best practices
- *Capacity building*: WASH manual for urban local body (ULB) functionaries; and preparing WASH manual for ULB front line workers (in progress)
- *Implementation/demonstration*: partnership with Mission Convergence, an initiative by Delhi government[9] to promote WASH through its two district resource centers and 124 Gender Resource Centers (GRCs) across Delhi[10]; WASH awareness through HUP project staff and MAS members; and information, education, and communication (IEC) materials developed on WASH and distributed; wall paintings on WASH at the demonstration slums in Bhubaneswar

Findings Related to Convergence

The HUP team has been able to promote convergence agendas at state and municipal levels. The HUP team has advocated for the convergence agenda at national, state, and city levels through involvement of departments of Health & Family Welfare, Women and Child Development and Urban Development. The efforts were more successful in states that already possessed a clear vision regarding urban health issues (e.g., Odisha, Uttarakhand), or in cities where the municipal corporation (or the Public Health Engineering Department [PHED] in Rajasthan) was eager to drive the agenda (e.g., in Bhubaneswar and Pune). A number of states have issued joint declarations for convergence through involvement of the three departments mentioned above. State-level steering committee formation, to unify the vision of different public agencies as stakeholders, is at a discussion stage in some states. Certain states hosted Urban Health and Nutrition Days (UHND), an additional good practice.

The opportunity to bring convergence at ward and city levels has been understood by most stakeholders. The strategy of leaving behind institutions or formal and informal rules of engagement is appreciated by some government departments. The project's focus on defining the structure and functions of ward-level committees and city-level committees is appreciated. In Rajasthan, the Chief Engineer of PHED took the lead on bringing convergence with other departments, which evolved as an alternative model.

State and municipal government demand for city demonstration models and action plans for urban health are increasing. In most states and cities visited, the realization for the need to have urban-specific policies and strategies seemed to be very much part of the government's vision. Although

9 A flagship program of the Delhi government seeks to strike the right balance between various government departments, community-based organizations, and people, towards improving governance and empowering the vulnerable populations of Delhi.

10 HUP provided technical support to Mission Converge, Delhi on formats, trainings, manual, and IEC materials on WASH to leverage its network of NGOs and CBOs to promote WASH

it is not possible to determine the extent to which the HUP team's efforts can be attributed to this, the MTA team feels that the constant supply of TA is a positive catalyst.

Activities related to donor convergence, working in different sectors or bringing the "critical mass" of experts together, have not occurred in a structured fashion through HUP, until recently. Although the HUP team tried to establish connections with other USAID projects in the first year of operations (e.g., MCH-Star, M-CHIP, VISTAR, etc.), there has been no perceivable effort to utilize the technical assistance group effectively, or to bring other existing and potential donors together.

HUP assisted in building resources for enhancing capacities of urban local bodies (ULB) and other departments. Manuals developed for ULBs and frontline workers on WASH are useful to build capacities for ULB functionaries and front line workers of urban development, health, WCD, and NGOs. This will be useful as available material for all the states to enhance capacity for delivery of BCC.

Insufficient effort has been made to increase access to water supply and sanitation at demonstration sites/cities. Visits to some slums in demonstration cities suggest that inadequate effort has been made to increase access to services. This also mutes the effort made through BCC to enhance toilet use, especially in the absence of access to toilets. Similarly, even though POU has been the focus, limited efforts were observed by the MTA team in the slums visited to ensure chlorine tablets were available; tablets were not found at most sites visited. Although the scope of work listed in the Cooperative Agreement is much wider, the WASH activities undertaken in HUP relate largely to three key components, i.e., water quality at POU, toilet use, and hand washing.

Limited engagement with JNNURM program. Potential convergence with JNNURM and its sub-missions has been articulated as one of the key elements to extend the urban health agenda in the draft NUHM policy. The Cooperative Agreement between USAID and PFI reiterates the same for HUP. However, there has been limited engagement observed by the MTA team in the states and cities visited. This may also be the reflection of a limited understanding of the HUP team on complementarities of JNNURM sub-mission, such as basic services for urban poor (BSUP) and Rajiv Awas Yojna (RAY), which is mandated to provide infrastructure (housing and other basic services) to the urban poor, and complements HUP's interventions like BCC on WASH. Also, community- and ward-level institutions under JNNURM and its sub-missions present a unique opportunity to converge for taking forward the urban health agenda.

CONCLUSIONS RELATED TO CONVERGENCE

Until NUHM is launched, the differential priorities assigned by states to urban health can only be pushed further with documentation of evidences in HUP. The project is still at an early stage, but it needs to be recognized that such documents are clearly going to make a positive difference in the states' prioritization for urban health. Cross-learning between different teams could also be an effective catalyst for enhancing project coordination.

HUP team has acted as a "convergence agent" in the states and has successfully connected the departmental silos, in most cases, to start the dialogue. The MTA team observed the inclination in most stakeholder departments to create a convergence agenda, but an appropriate

convergence agent was needed to do this. The HUP team has filled the gap appropriately in most cases. The joint declaration on convergence by the departments of HFW, WCD, and UD in Odisha is an excellent example of such an initiative.

Even though HUP enjoys a unique position by being active in state-level urban health programs, it requires a monumental effort to drive the agenda without the help of reputed experts or potential donors in urban health. The Gates Foundation's Urban Health Initiative project, earlier efforts by the European Commission in "Model RCH Project" and the World Bank's policy notes on urban health are some of the examples of explicit or latent interests of potential partners in India. Moreover, there are many other programs funded by donors in water and sanitation, nutrition, and other sectors that have a correlation to urban health. There has been little effort by the HUP team to bring these forces together.

City demonstration models helped to involve the municipal structure in addressing urban health issues(e.g., Pune and Bhubaneswar) in the slums. The PHED, as an alternative to a municipal government structure, led the efforts on convergence in Jaipur. HUP's efforts to cater to the varying capacities and incentives of municipal and health departments to lead urban health matters in different states have been largely successful.

HUP performance indicators for WASH cannot be achieved without working on other components of WASH. In the absence of related activities in WASH for improving "access," the impact of HUP interventions are likely to be limited. The MTA team felt that if slum dwellers do not have access to adequate water supplies, promoting toilet use through BCC/ IEC initiatives would result in limited benefits.

FINDINGS: OBJECTIVE 4

Objective 4: Strengthen the evidence-based rigor of city-level demonstration and learning efforts in order to improve program learning.

The HUP project is undertaking urban health demonstration models in 276 slum communities in five cities of India covering 450,000 people. The objective of these demonstration sites is to generate demand for urban health services and enhance the accessibility, quality, and utilization of services—the "supply provision" component of the model. Demand generation is to be addressed through home visits by project link workers, the formation of MAS, and awareness events on health, WASH, and nutrition organized in slum communities. Supply provision objectives are to be undertaken through TA to state and municipal departments, public-private partnerships, and convergence activities designed to strengthen program outreach, the capacity of primary health care providers, and referral mechanisms in urban slum areas (see Annex XIII, "Framework of HUP Demonstration Model Program").

Eleven NGO partners are implementing the demonstration models with a combined field staff of 205 people. The city demonstration model structure consists of a HUP project coordinator for each NGO partner, HUP cluster coordinators (CCs) for every 12,500–15,000 urban slum dwellers, LWs for every 2,500–3,000 slum residents, and MAS committees for every 200–250 households.

ACTIVITIES AND ACHIEVEMENTS RELATED TO DEMONSTRATION MODELS

Even though the five city demonstration models have been operational for only six to eight months, much has been accomplished in this short time in terms of operationalizing the demonstration sites. Field offices have been established by HUP's partnering NGOs implementing the five city demonstration models. The sites visited by the evaluation team are up and running and fully staffed with project coordinators, CCs, and link workers. Training modules have been developed covering HUP project goals and objectives, maternal health, and newborn and child health. HUP's field personnel have received training from HUP project staff and appear to be well oriented to their work routines and responsibilities.

In collaboration with state and municipal government departments, slum communities have been chosen for the demonstration models. These communities are often "unauthorized" slums that tend to be more inaccessible, lack good access to health services, and have little water and sanitation infrastructure. HUP LWs are visiting homes, identifying beneficiary and community needs, providing information on the prevention and treatment of disease, and referring (and often accompanying) beneficiaries to health facilities to obtain care.

Demonstration sites have been mapped and household listings completed. An MIS for the model demonstration sites has been established for reporting on administrative process and a limited array of outcome indicators. The MCHT system has recently become operational in the five demonstration areas. A "daily planner" calendar for HUP LWs is also being distributed in all demonstration sites, which will allow for more systematic tracking of contact with beneficiaries.

The IIPS has run surveys in three demonstration cities (Bhubaneswar, Jaipur, and Pune) to establish baseline indicators and identify program gaps. The final survey report has not been released by IIPS as of July, 2012. It is anticipated that this survey will be repeated in the last year of the project to assess change in outcome and impact indicators.

FINDINGS RELATED TO DEMONSTRATION MODELS

Demonstration sites have been established and are beginning to gain traction. HUP's field personnel have received training from project staff and appear to be well oriented to their work routines and responsibilities. The MAS committees organized by HUP have also participated in training programs focusing on health needs in their communities. MAS members in several locations said they had received useful training about the importance of antenatal care for pregnant women, institutional deliveries, child immunization, and personal hygiene and sanitation. They seemed especially appreciative of information they received on health entitlements. For example, in Jaipur, HUP cluster workers were helping to organize health camps and transport medicines for local health posts and ANMs working in the community.

There is an apparent increase in access to health services. For example, in slum communities served by HUP in Jaipur, there has been a 100% increase in immunization uptake during March–April, 2012. Similarly, the HUP cluster and link workers in Jaipur have helped to increase the number of beneficiaries going to health posts and hospitals for antenatal and delivery services and child

health care. MAS members have been working to encourage more women (and their children) to attend health camps organized for urban slum dwellers in their coverage areas. The MAS members indicated that they received inputs about the importance of institutional deliveries, immunization, and hygiene from HUP and appreciate them, especially the information pertaining to the health entitlements of beneficiaries. This gain was ascribed in part to HUP community education and mobilization efforts. However, it is difficult to ascribe such gains to HUP project activities alone. While the number of children being registered for immunization has increased in areas where HUP LWs have been working, government health departments have also been running immunization campaigns, so it is not clear to what extent the HUP project may have contributed to this increase.

HUP has introduced an urban birth-planning intervention for pregnant women in Bhubaneswar. Birth planning is discussed with women on first contact, but activates more fully at the seventh month of pregnancy. The birth plan helps in scheduling necessary antenatal visits (including the provision of tetanus toxoid) and access to modern obstetric care at the time of delivery. The birth plan includes the name and number of a "skilled birth attendant" in cases where delivery is forced to take place at home.

Not all key areas of RCH are addressed. The primary focus of the HUP project appears to be on antenatal care, safe delivery services, post natal care, and child immunization. Several key reproductive health components, including family planning and the diagnosis and treatment of sexually transmitted diseases are not being given priority attention in HUP's demonstration areas, although there was evidence of some activity on these issues in Bhubaneswar and Dehradun.

HUP currently is not addressing facility gaps in service provision in a systematic manner. Several deficiencies were observed in the provision of health services. At the Bhala Basti Anganwadi Center in Jaipur, visited during an Urban Health and Nutrition Day, HUP LWs were busy providing health education to the women in attendance at the site. However, no growth monitoring was performed, as the AWC lacked salter scales. The ANMs also lackd blood pressure meters. Both the Anganwadi worker and ANM reported that the AWC had no iron supplementation (IFA), deworming, or chlorine tablets, although the site did have ORS and paracetamol. Antenatal care (ANC) services were limited to registering the woman, providing health education (with HUP LW support), and referral to a higher facility level. HUP has made no systematic attempt, as yet, to address these issues. Even in states like Uttarakhand, where the health facilities operate on the basis of clear-cut guidelines, chlorine tablets were not found in the health facilities visited.

Community mobilization efforts are underway. HUP has developed procedural strategies for working with city and ward committees on addressing health needs among the urban poor and promoting more effective convergence efforts within slum communities. As part of this effort, several NGOs partnering with HUP are investigating how the Anganwadi Centers, LWs, and health posts are interacting with urban slum populations.[11] HUP has also developed operational guidelines for MAS committees, aimed at better defining their roles and responsibilities. MAS committees

11 One senior health professional in Pune noted that Anganwadi Centers need to be reinvented as part of any effort to mobilize health resources in urban slum areas. This respondent thought that Anganwadi centers currently were underutilized, poorly staffed, and often lacking in essential health supplies and equipment. He also noted that Anganwadi workers are poorly supervised and are underutilized resources in many slum communities.

collaborating with HUP have already participated in training programs focusing on health needs in their communities.

While these various community-level initiatives hold considerable promise, serious implementation challenges remain. For example, informants from a HUP-partnering NGO in Pune observed that the municipal government still is not working well with the HUP project. The MTA team was told that there should be better engagement with city and ward coordination committees. The city coordination committee in Pune is still not fully operational. This committee was considered an important nexus for municipal convergence activities in Pune's demonstration slum areas. However, HUP does appear to have some influence with ward committees in Pune. HUP's recent ward committee presentations on personal hygiene, sanitation, and the social and health needs of adolescent girls were reasonably well attended.

HUP has developed guidelines for implementing Urban Health and Nutrition Day (UHND) activities and has started implementing these in the project's slum communities. UNHDs are convergent activities of health nutrition carried out primarily in Anganwadi Centers (AWCs). HUP LWs encourage mothers to bring their children to Anganwadi Centers to meet with ANMs and Anganwadi workers (AWWs) who provide health checks/immunization services and to receive information on personal hygiene and nutrition. Nutritional supplementation products are also often distributed at UHND events.

Currently, the entire complement of services envisioned under UHND is not yet being implemented. At an Anganwadi Center in Jaipur, a review of the registers of the AWC revealed that all eligible children were not being registered for services. The MTA was given to understand that an impending training on nutrition is expected to bridge these gaps and clarify policies pertaining to public health entitlements.

There is a felt need for strengthening the capacities of government employed LWs: NGO partners in Bhubaneswar stressed the need for more training of LWs employed by the Odisha state government. The MTA team was told that LWs were not always well supervised and were unclear about their job responsibilities and daily work routines. The state government currently uses an incentive payment system, similar to the system that has been in place for ASHA cadres for many years, to motivate LWs to perform at a higher level. However, it is not clear whether this approach has had much effect.

Unmet needs are being articulated by communities. Many cluster and link workers noted that the provision of safe water and sanitation facilities was the number one priority in their area. For example, many slum communities where HUP is working have no access to toilets and sewage lines were often clogged or broken. These poor conditions had prevailed in many communities for a long time. Additional needs included health services and community support for adolescent girls, supplemental nutrition programs, and improved community outreach efforts by government ANMs, ASHAs and Anganwadi workers.

In Pune, the strengthening of local funding schemes for health insurance and other self-help programs was identified as an important community need. Some MAS groups are currently collecting funds to support various community funding schemes, but there is no coordination between MAS

and various insurance programs. There is still a major challenge ahead in bringing insurance systems to local community levels, especially to pay for emergency care and hospital services.

CONCLUSIONS RELATED TO DEMONSTRATION MODELS

The HUP demonstration models are still at a learning stage. The problems being faced in some areas include: (1) potential beneficiaries occasionally complain that HUP is not providing any tangible benefits; (2) it is sometimes difficult to get community beneficiaries (residents) to participate in project activities; and (3) introduction of effective coordination between government programs and community organizations for improving the quality of health services and urban health infrastructure remains a major challenge for the project. HUP field staff in several states also noted that demonstration models are limited to the formal scope for the project ("what PFI recommends"), rather than undertaking innovations that might more effectively meet local needs.

At the present time, the HUP project is not addressing the full range of reproductive health needs that women face in urban slum areas. For example, there are no STI diagnosis and treatment interventions at the community level, and family planning services are not always available. In addition, not all women are being adequately served. For example, the sexual and reproductive health needs of adolescent girls are typically being left out of the current mix of reproductive health services offered in urban slum communities.

HUP is generating demand, but not adequately supporting the strengthening of service provision—a missed opportunity. The HUP work plan identified activities pertaining to demand generation; however the achievement of the articulated indicators requires that HUP support service strengthening through negotiation, capacity building and TA. HUP is making progress in generating demand for health services in the project's demonstration sites. A major challenge for the project will be to identify effective means for strengthening service delivery in demonstration sites and coordinating with government agencies to improve health services, water and sanitation infrastructure, and nutrition supplementation.

Partnering institutions were seen to have unique capabilities that should be more fully utilized. In many community demonstration projects, there has been little feedback from senior state and municipal health staff concerning HUP project activities. In some areas, "downstream" participation has not happened.

The responsiveness of local government resources can vary greatly across slum areas. Authorized slums tend to be better served with health facilities, community mobilization efforts (including the formation of MAS and other self-help groups), and infrastructure than non-authorized slums. In the five demonstration cities, non-authorized slums are generally larger than authorized slums.

FINDINGS: OBJECTIVE 5 (MANAGEMENT AND GOVERNMENT)

Objective five: HUP management practices and governance system in HUP

The HUP project brings together a set of experienced consortium partners to advance India's urban health programs. The prime implementing organization is the Population Foundation of India (PFI), known for its policy advocacy work in India. PFI's key sub-implementing partners include the Indian Institute of Health Management Research (IIHMR), known for its research and work in the area of health systems management, Plan India, a subsidiary of Plan International, one of the world's largest community development organizations, and Bhoruka Charitable Trust (BCT), a respected organization in Rajasthan working for community development for over four decades. There are eleven field implementation partners: two in Delhi, two in Agra, five in Bhubaneswar, and two in Pune, (no specific field partner exists in Jaipur, as BCT is a field-implementing agency). (See Annex XIV for a list of key stakeholders and Annex XV for a list of HUP partner organizations.)

In addition to the implementing partners, HUP draws on the experience of its technical partners; the Centre for Development and Population Activities (CEDPA), The Micro Insurance Academy (MIA), and IIPS also provide specific research support.

Overall management of HUP is provided by the PMU located at the PFI office in Delhi, and includes specialists for each of the four thematic objectives addressed by HUP, in addition to grants, financial, and procurement experts. The PMU provides direction and support to eight state and five city teams.

Activities and Achievements Related to Management and Governance

Strategic direction is provided by the national TAG, which coordinates stakeholder inputs, determines program priorities and overall implementation strategies, and serves as the guide for all consortium partners in implementing the project in their respective geographic and technical areas. Although the TAG was scheduled to meet every six months, there have only been three TAG meetings since its inception in February 2010, with a wide gap between the second TAG (in Sept 2010) and third TAG (in May 2012).

The Program Management Group (PMG), consisting of representation from each partner agency, was established to provide oversight for managing the operational aspects of project implementation. In the initial phase of the project, the PMG was to meet weekly, and then every two weeks.[12] However, the PMG to date has met only four times, in January 2010, September 2010, May 2011, and April 2012. Currently, partnership management issues appear to be discussed at bilateral meetings between PFI and sub-partners.

Because of the initial delay (nine months to obtain the Department of Economic Affairs approval), followed by additional delays for clearance of the work plan by GOI (in August 2010), the project effectively started in September 2010. Upon project approval in September 2010, the primary activity for the ensuing six months was to establish offices in each of the implementing states and cities, including recruitment and contracting of sub-partners and sub-sub partners. During this period, financial, procurement, and grant management systems were developed for HUP.

12 Cooperative Agreement document September 2009.

Guidelines developed by PFI for implementing HUP's financial and procurement system were adapted and further modified to comply with USAID policies and reporting requirements. In addition to developing management, procurement and grants manuals, a delegation system for managing the project's finances was approved and implemented. However, PFI's implementing partners follow their own organizational norms for internal management, but report back to PFI as per HUP's agreed framework, in compliance with USAID requirements. Rationalization of travel entitlement and benefits were done among partners, and it was also agreed that all partners must follow the mandatory norms extended by USAID. By the end of June 2012, 36.7% of the total HUP budget had been utilized. (See Annex XVI, "HUP Project Management Structure" and Annex XVII, "A Summary of Findings on Management and Governance.")

Findings Related to Management and Governance

PFIs played an active role in articulating the need for the HUP project. PFI was actively engaged, in association with USAID, in articulating the need for an urban health project like HUP to the MOH and DEA, and the GOI, which aided in obtaining approval from DEA. Also, PFI helped to encourage buy-in from GOI for approval of the HUP annual work plan.

Results of strategy implementation are mixed. The three-pronged HUP strategy of intervening at national, state, and city levels has been effective in several respects, namely: (1) engagement at the national level by PFI with Ministry of Health has improved; (2) there is evidence that the demonstration models are gaining traction at city and ward level; and, (3) the assistance provided for preparing models to utilize urban RCH funds of NRHM has resulted in the utilization of formerly underutilized funds in many states, e.g., in Rajasthan, Odisha, and Madhya Pradesh.

However, cross-learning between sites has been weak and could be improved. In addition, interaction with other donors working in the same state and thematic areas, e.g., urban development, WASH, convergence, and PPP, has been limited, thus minimizing opportunities for cross-learning.

It was also noted that an overemphasis on HUP "branding" appears to have limited the leveraging of internal resources from partnering NGOs engaged on the HUP project. Both Plan India and IIHMR mentioned this issue.

The state teams have invested substantial efforts in positioning HUP with the state governments. HUP state teams often noted the need for greater USAID support at the state level to "open doors" with the government. Also, visits by USAID to HUP states were reported to be infrequent.

The strengths and uniqueness of program partners is underutilized. Although each partner has a different strength, e.g., policy advocacy (PFI), community mobilization and implementation (PLAN), and research (IIHMR), these are not recognized fully when pursing the urban health agenda. For example, IIHMR could be better utilized to create documentation on evidence and policy advocacy.

Cross-pollination between state and city teams remains limited. Learning opportunities between state teams and from one city to another city team was found to be limited. The program

could have benefitted greatly from opportunities, including transfer of knowledge from the Urban Health Centre in Uttarakhand to other state teams, or an exchange of experiences between state and city teams from Odisha to Rajasthan.

Interaction between PMU and states and cities is likewise limited. Interaction between the National PMU and state/city teams was reported to be limited to three to four face-to-face interactions in a year, largely on programmatic review, in addition to periodic reporting and clarification through mail and phone. This has resulted in missed guidance from the PMU at critical times of need by state and city teams. Some PMU thematic and programmatic specialists have provided more frequent interaction, which was reported to be effective, e.g., in WASH.

Prior experience with government systems is beneficial. Prior experience with the government system and programs (e.g., NRHM) was found to be beneficial in establishing relationships with government as a TA agency, in most of the states visited. Staff with prior experience working with government systems successfully connected with government officials and facilitated better convergence outputs.

Limited skill sets available at state and city level. A public health specialist is available only at the PMU in Delhi. Even though in many states the project director or convergence specialist brings substantive knowledge of public health from their prior experience working in the sector (but not trained as a public health person), often a gap is felt with the technical subject knowledge. The state and city teams often reported needing guidance on best practices from a public health perspective. Also, some city teams do not have a PPP specialist (e.g., Pune), although they are expected to initiate PPP activities and reported needing guidance.

Delays in appointing TA teams affected all states. There has been considerable delay in staffing the full TA team in some states and replacing staff in others. Analysis of staff deployment at PMU and in various state teams suggests that on average, it has taken from one to five months from initial recruitment to being in position, with some positions taking even longer; for example, the appointment of MIS officers has been delayed for seven to 12 months in most states. The project suffers from an 18–20% attrition rate and replacement of staff is also delayed. Analysis of available information suggests that an average of four to five months is spent, both at national and state levels, for replacements. This has certainly impacted momentum where attrition has been high, e.g., Madhya Pradesh and Uttar Pradesh.

It is important to note that, irrespective of delays in recruitment and gaps in skill sets in some teams, the professionals recruited so far are of high quality, which adds value in taking the HUP project forward in each state.

Work plans are based on perceived need. Work plans for each state and demonstration city are based on what team members perceive to be the need of the state/city government based on interactions during the last year, and sometimes do not reflect actual state priorities. Hence, even though some governments appreciate HUP's efforts, they could have been more responsive if there had been some form of consultation and agreement during the planning process.

Delays in approval of activities from PMU results in lost time and relevance. Concept notes are now being applied across states in order to promote consistency. However, this requires approval from the PMU for all activities costing more than INR 5,000, which recently (May–June 2012) has been revised to INR 20,000. It often takes more than a month to process PMU approval, resulting in lost time and relevance for activities.

Weekly reporting is seen as "burden" by link and cluster workers. The required weekly reporting by link and cluster workers is viewed as very time intensive, taking time from work activities. An inadequate number of available computers further adds to the problem.

Limited incentives for MAS members and LWs. Visits to urban slums in Jaipur and Bhubaneswar suggest that in the absence of monetary and/or non-monetary benefits for MAS members' time and energy, especially in a highly fragmented and heterogeneous slum population, concerns were raised among project staff about issues related to retention and sustainability. MAS members noted that they also have a limited say about the quality of service provision at community or facility levels. Similarly, incentives or salaries (as the case may be in different states) for LWs and cluster workers are often low, resulting in attrition problems.

Annual contracting instead of framework contracting with sub-grantees poses a risk to the project. PFI, as the prime agency for HUP, has a signed agreement with USAID for the entire project period (Cooperative Agreement signed on September 25, 2009). In addition, based on the annual work plan, USAID obligates the necessary amount required for any given year. According to USAID's obligation and approval of the work plan by GOI, PFI signs contracts with its sub-grantee for only one year (covering the work plan period) at a time. Similarly, the sub-grantees sign contracts with sub-sub grantees based on the work plan period.

In the absence of any framework agreement like the Cooperative Agreement between USAID and PFI, the sub-grantee or sub-sub-grantee is not bound to remain engaged with HUP for the entire project period, and if any group chooses to withdraw from the consortium, there is no binding agreement, MOU or contract—which poses a risk to the project.

TAG and procurement and grant management group meetings are irregular: Only three TAG and four PMG meetings have been conducted since the initiation of the HUP project. This deviates from the project design for semi-annual TAG meetings and bi-weekly PMG meetings.

Relationship with USAID and GOI: USAID is regularly informed about HUP's progress bi-weekly, through chief of the party to agreement officer's technical representative (AOTR) meetings or conference calls once or twice weekly, in addition to joint meetings with the Joint Secretary responsible for NRHM and Urban Health, MOH/GOI every two months. The AOTR also attends the TAG and PMG meetings of HUP when the meetings are held.

CONCLUSIONS RELATED TO MANAGEMENT AND GOVERNANCE

PFI's role in grounding the HUP project has been commendable. Engagement of PFI, in association with USAID, in articulating the need for an urban health project like HUP to the DEA,

GOI, has been commendable and helped obtain approval from DEA and buy-in from government. Approval of the HUP annual work plan by GOI puts HUP in a unique position, as government is rarely involved in approving similar work plans of bilateral agencies or of NGOs.

HUP does not effectively utilize consortium strengths: Even though the consortium comes with a rich experience in each of the HUP programmatic areas, partner strengths are not optimally utilized.

Cross-pollination is not by design. The HUP project demonstrates only limited learning opportunities between teams (state and city) and also from other donors who may have overlapping program experience in health, nutrition, and water supply/sanitation in the same state. Project implementation is not designed to facilitate cross-learning, nor have any specific efforts or mechanisms been developed for this purpose.

HUP has capitalized on past experiences and staff contacts, rather than institutional standing of PFI or USAID. A substantial leverage in terms of individual contacts and experience working with the government prior to HUP has helped in establishing the project as a TA agency in each of the states, even though this has taken a substantial amount of time. USAID's presence in states as a donor to "open doors" with the government could have helped reduce the time taken to establish HUP in states.

Substantial amounts of time are being lost in filling staff positions. An average of four to five months is lost every time any staff leaves and a new person is appointed to fill the vacant position. Invariably, the process of recruitment starts after the staff member leaves, rather than when the resignation is accepted. Such delays have had a negative impact on project momentum.

Substantial amounts of time spent in generating weekly reports without any feedback leads to frustration among link and cluster workers. Weekly reporting takes considerable time for information processing, especially by the bottom of the HUP project implementation pyramid. However, insufficient time to process this information by middle or top level staff means the feedback loop is not completed. The lack of feedback often leads to frustration among link and cluster workers.

Limited incentive to MAS members and LWs poses issues of sustainability. The NUHM draft document envisages MAS members as volunteers and presumes that they will draw their identity and status in the community by promoting health. Limited incentives for MAS members—either monetary or non-monetary—in addition to having no say in the provision of health care services at community or at facility level, raises concerns about the future of volunteer services. This poses sustainability issues and will be a future challenge for HUP, as well as NUHM if and when it is approved.

Irregular TAG and PMG meetings undermine the initial design. The TAG and PMG were designed and constituted in the HUP project to provide strategic and programmatic guidance. Infrequent meetings of TAG and PMG undermine the basic design of the project.

SUMMARY CONCLUSIONS

In addition to specific conclusions identified above for each of the main objectives of the project, the MTA was able to reach summary conclusions for the six evaluation questions listed in the Scope of Work for this assessment.

1. **How has HUP influenced GOI policy on urban health since 2009 and what opportunities currently exist for USAID to influence policy-level changes through HUP?**

In a relatively short period of time, the HUP project has helped to delineate national- and state-level policies on urban health. The HUP team has helped the MOHFW draft the current version of the NUHM. The project has also worked to broaden the participation of relevant stakeholders in the development of NUHM policies, program priorities, and operational strategies (e.g., national- and state-level ministries and departments (see Annex XIV for a list of key stakeholders).

The HUP project has demonstrated mechanisms for strengthening urban health systems within varying environments. The project therefore has the potential to frame strategies for addressing urban health needs and priorities as well as accelerate the implementation of NUHM once it is officially launched. HUP is working to develop a comprehensive urban health vision for the country. The project therefore gives USAID a unique opportunity among donors to make major contributions to the NUHM design and implementation process and ultimately improve health and living standards in India's most disadvantaged urban settings.

2. **To what extent has the project contributed to the operationalization of the urban health program at national and state levels? What were the strengths and weaknesses of its implementation?**

As noted, India still has no comprehensive, national urb- health program and the NUHM has not been approved. During the design of the HUP project, it had been assumed that the NUHM would be in place when HUP was launched. However, the project has helped to improve the utilization of NRHM resources for urban health. To this end, HUP has developed operational tools for enhancing access to urban health services, strengthened BCC initiatives for urban health, and prepared systematic community mobilization guidelines. The project has also produced numerous policy documents, research reports, and PIPs that have helped to advance the urban health agenda. As noted above, it is difficult to determine, after only six to eight months, the extent to which HUP's demonstration models have contributed to the operationalization of a national health strategy.

Major strengths of HUP include: (1) strong policy capabilities and inputs at the national level; (2) HUP staff members are generally well-connected with government health, urban development, and water and sanitation departments; (3) the project is working to build a supportive environment for learning and documenting results; and (4) the project has developed workable mechanisms for fostering convergence across government and NGO partners. For example, the Odisha convergence experience developed during the last year has considerable potential for replication in other states.

To some extent, the project's implementation approach has been hampered by the delay in approving the NUHM. Some states (Rajasthan and Uttar Pradesh) seem reluctant to undertake major initiates in urban

health without clear directives from the national level and formal approval of the NUHM, while other states (Madhya Pradesh and Odisha) are moving ahead with state-level initiatives in urban health. Operating in different supportive environments for urban health has inevitably led to some unevenness in the receptivity to HUP and the extent to which the project is addressing its main objectives.

3. How effective has the project's TA approach been in building synergies between the public and private partners in implementation of key project strategies?

Developing productive public-private partnerships for urban health takes time. Potential partners must be identified, program objectives clearly articulated, interventions well designed, and activities adequately resourced. To date, HUP's results in developing PPP activities has been mixed, owing in part to inconsistent interest in the PPP approaches across HUP's eight states and different levels of PPP expertise within HUP's state and municipal-level teams. However, some good models have been developed during HUP' first year. For example, elements of the Seashore Project in Odisha and the Ambuia Cement Foundation partnership in Uttarakhand have potential for replication in other settings. Other models are under development with Bharti Vidyapith University and the Kirloskar Foundation in Pune, Lupin and Narayan Hrudayalaya Hospitals in Rajasthan, and Titan Industries in Dehradun.

Given the long lead time often entailed in negotiating, officially approving, and activating PPP activities, it is unclear how much HUP will be able to achieve on PPP during the remainder of its project life. It is also too early to reach conclusions regarding the ability of HUP to leverage resources for public-private partnerships.

4. What lessons can be drawn for future designs from the program governance system, especially its role in promoting convergence strategies of different GOI programs?

Experience to date indicates that HUP's efforts to improve coordinated policy and program design between national and state/municipal bodies (e.g., through sub-allotment funding schemes in Bhubaneswar and Pune) have helped to increase attention to urban health within the NRHM framework. Convergence activities have also shown promise, although effective coordination at state and municipal levels between health, urban development, water and sanitation, and women and child development remain more promissory than realized at this stage of the project. WASH and nutrition convergence efforts are less advanced than maternal and child health. However, HUP can take some credit for the recent inclusion of WASH indictors in Odisha's NRHM urban health framework. This seemingly modest example of successful convergence could prove seminal in achieving better inter-ministerial/ departmental collaboration and implementing more holistic urban health programs.

5. What has been the outcome of the slum demonstration activities under HUP? What are the key strengths and weaknesses of these interventions and what is the opportunity for potential scale up?

The HUP project has made a good start in implementing the five city demonstration models. Partnering NGOs have been engaged, field offices opened, field staff recruited (cluster and LWs), slum communities mapped, household listings completed, baseline surveys implemented in three cities, MIS systems developed, and the project's maternal and child health tracking (MCHT) systems deployed. HUP has also made good progress in working with local community organizations, most notably the MAS committees

established in all of the slum communities where HUP is working. Education and urban health demand generation activities (often undertaken in collaboration with the MAS committees) are also underway in HUP's demonstration sites.

Unfortunately, HUP's demonstration models have only been operational for six to eight months. The full complement of potential performance indicators that will be generated by the demonstration models (e.g., from the MCHT system now being deployed) are only beginning to come on line and the final report of the three-city baseline survey has not been released. Demonstration-model potential for replication and scale-up will be difficult to determine without more time for implementation and the gathering and analysis of evidence on results.

Despite these very real drawbacks, the MTA team was told by many respondents that HUP field activities are beginning to have a positive impact. Mention was made of HUP's role in promoting greater health awareness and knowledge among potential beneficiaries; stimulating greater demand for health services; increasing the utilization of health services; clarifying the roles and responsibilities of government outreach and facility-based health workers; implementing referral mechanisms for improved access to appropriate levels of care (e.g., for safe deliveries); and identifying weaknesses in urban health delivery systems and supportive infrastructure for WASH, particularly in the non-authorized slum communities where HUP staff members are present. It will be imperative for the project to document results for these various elements of the demonstration models.

Despite the considerable promise of HUP's demonstration models, the MTA team did observe some weaknesses in implementation. It was not always clear whether the rational for the HUP project in terms of goals and objectives was clearly understood at the community level. There was also doubt expressed by some potential beneficiaries concerning the "tangible benefits" to be gained from HUP. This should become clearer with greater household contact and educational outreach over the duration of the project.

Based on findings gathered from the field, it also appears that HUP is not giving reproductive health (including family planning and STI/HIV diagnosis and treatment) high priority at the present time. The project's current emphasis is more oriented to the provision of safe delivery services for pregnant women and the immunization of infants and children. It was also noted that efforts have been limited so far in assessing the range and quality of services provided by facilities at different levels of the urban health system (e.g., health posts, urban health centers, tertiary municipal hospitals and clinics). The situation analysis study on health facilities undertaken by Plan India (HUP's partnering NGO in Uttarakhand) at the request of the state's Ministry of Health is a notable exception.

Numerous HUP field staff reported that the reporting requirements for the project (especially in the case of the demonstration models) are excessive. A monthly reporting system might work better and allow more time for executing project activities. There is also some frustration among HUP frontline workers in demonstration sites, who feel they are kept busy gathering evidence from the field, but receive little feedback on their performance and how to become more productive. This important feedback in large part is missing from the project at the present time.

6. How effective are the HUP management systems including project planning and review, grants management, financial and procurement systems in scaling-up project activities?

The HUP management system appears to be functioning reasonably well, despite early problems stemming from a change in leadership and slow recruitment procedures for state and city teams (both initial hires and replacement staff). In terms of administrative practice, the MTA team found that PFI grant management, financial systems, and procurement policies are being effectively implemented and appear to be in-line with USAID policies. A system of written and verbal communication between the PMU and USAID is in place. However, infrequent TAG meetings were seen as limiting opportunities for greater strategic program guidance and review. In addition, PMG meetings are held irregularly.

It was noted that the project spends considerable time developing annual work plans that must be approved by the GOI's MOHFW and USAID. These lengthy clearance procedures can give rise to uncertainty over the timely availability of funds needed to pay staff and procure equipment and supplies. A four-year framework mechanism for all sub-grantee contracts might have been a more efficient approach for ensuring smooth project implementation.

Currently, HUP is facing a challenging situation related to planning for the next annual work plan, without information about project extension. If the project ends as scheduled in September 2013, the work plan would need to address close-out activities during the next year; if there is a no-cost extension, then the work plan would build on and expand current activities.

While HUP has taken steps to ensure effective coordination within the project (e.g., by holding quarterly progress review meetings for all state- and city-level partnering organizations), there is always room for making improvements in how the project communicates internally. The MTA was told that currently, there is limited cross-pollination between PFI's PMU and state/city teams working on the project. At the state level, sub-grantee partnering NGOs (usually working in demonstration model sites) did not have sufficient contact with the prime NGO partner in their respective states. The MTA team concluded that HUP could be doing a better job with internal communication. One obvious step would be to increase the number and duration of field visits to HUP implementation sites to see the project firsthand and be available to trouble-shoot implementation bottlenecks that will inevitably arise.

One managerial challenge for the project will be to develop incentives for MAS workers to remain engaged with the project, as there are no incentives in place to encourage greater retention. The MTA team was also concerned that the low salaries paid to HUP frontline workers (CCs and LWs) may cause morale and retention problems for the project going forward.

RECOMMENDATIONS

The following recommendations are based on the findings of the evaluation.

RECOMMENDATIONS RELATED TO TECHNICAL ASSISTANCE

- **Continue working to facilitate the development of a state urban-health vision and plan, identify various stakeholders who can participate, delineate their roles, and include HUP as a contributing partner.** Generate HUP work plans, which incorporate and feed into state urban-health plans and include activities which feed into HUP objectives.

- **Wherever the environment is considered conducive, support the development of a more comprehensive urban health model. Provide a broadened public health perspective and inputs to state and city teams.** Use the recently developed Madhya Pradesh urban-health strategy to support implementation of feasible components of a comprehensive urban plan. Use the precedents in pioneer states to effectively advocate in more hesitant states.
- **Redefine what 'health' means to HUP, articulate this vision, and reorient staff when appropriate.**

RECOMMENDATIONS RELATED TO PUBLIC-PRIVATE PARTNERSHIPS

- **Engage in substantive dialogues with states in preparing specific PPP guidelines for urban health.** Since urban health requires convergence of health, urban development, WASH, and nutrition sectors together, a specific PPP policy for this theme would help in identifying approaches to be taken, funding requirements, mapping of potential partners, and creating contractual arrangements.
- **Disseminate documentation on successful PPP models to different states and city governments to encourage adoption of such models**. The Urban Health Center example in Uttarakhand and the Bhubaneswar Municipal Corporation-Seashore-HUP model in Odisha are good examples of scalable models for the future. The HUP team should document these practices and assist governments in other states and cities to adopt and implement these models. The national government should also be briefed about such models for possible inclusion in the proposed National Urban Health Mission draft. The project has also prepared a publication with a list of existing best practices for PPPs in Urban Health through its partner CEDPA, which could also be disseminated at workshops/conferences as an advocacy tool for adoption by districts/cities/states.
- **Engage in advocacy for utilizing and strengthening PPP Cells under NRHM In many states.** PPP cells under NRHM typically do not consider urban health interventions to be part of their work. Making greater use of NRHM's existing PPP structures, especially in contracting with NGOs and commercial partners, could be a way to ensure effective public sector engagement in working with the private sector.

RECOMMENDATIONS RELATED TO CONVERGENCE

- **Greater focus should be given to assisting state governments to expedite the formation of ward-, city-, and state-level committees as priority structures for urban health.** The formation of these structures is an essential deliverable to prepare states for the introduction of NUHM. Unless structures are formed, fund flow and reporting mechanisms will not take shape. HUP's community-level convergence initiatives (e.g., with ICDS, JNNURM, and PMC) are still in a formative stage. These efforts will need to be intensified and carefully documented as the project unfolds.
- **Strengthen information exchange between states on the development of urban health frameworks and strategies**. Early sharing of thoughts on convergence mechanisms by leading states would reduce the time for policy development in other states and give a head start to most participants. Waiting to document such policies and frameworks until they are fully developed could delay interventions in participating states.

- **The HUP project should make greater efforts to engage other NGO and donor organizations working in urban health.** Greater exchange of information on program approaches in different regions of the country should strengthen urban health advocacy and program support activities.

RECOMMENDATIONS RELATED TO TECHNICAL ASSISTANCE FOR WATER, SANITATION, AND HYGIENE

- **Revisit and prioritize the scope of WASH as listed in HUP's Cooperative Agreement and rework performance indicators to reflect the same.** Given the delay of the HUP project, it is difficult to address all aspects of WASH listed in the Cooperative Agreement in all states/cities. However, a comprehensive plan will need to be developed that can be executed by various partners (including government, private sector, donors, and NGOs). Leveraging of partnerships with other NGOs, ULBs, and other partners are required in order to expand the WASH agenda, including solid water management and menstrual hygiene.

RECOMMENDATIONS RELATED TO DEMONSTRATION MODELS

- **The HUP project should more systematically document the capacity of state and municipal health systems.** Such assessments would include municipal hospitals, urban health posts, urban health centers, Anganwadi Centers, and facility-based and community outreach workers (ANMs, ASHAs, cluster and LWs, etc.) to address the health needs of the urban poor. A situation analysis of the urban health system was recently completed by Plan India in Uttarakhand. Similar assessments should be completed in the remaining states and municipalities where HUP is working.
- **HUP should systematically track indicators derived from the MCHT system that documents contact with beneficiaries and the extent to which HUP is providing support to urban slum dwellers.** This information will be essential in determining the extent to which the project's demonstration models have been successful in generating demand and increasing the utilization of services (e.g., antenatal care, safe delivery services, child immunization, and nutritional support). The HUP Mother and Child Tracking System is not currently linked to the government's facility-based MIS tracking system. Mechanisms need to be explored to harmonize these two systems so that beneficiary records maintained by HUP can be cross-linked with facility records. This would allow the establishment of beneficiary contact histories with service providers and better document the need for follow-up care.
- **It will be imperative to have the HUP Baseline Survey repeated during the last year of HUP to measure change in basic impact indicators over the life of the project.** The HUP Baseline Survey is the only tool available to HUP to measure potential impacts stemming from the project's field activities. Without this information, it will not be possible to adequately determine whether the HUP project had a demonstrable impact on urban health conditions in the communities where it had been working.
- **HUP will need to invest in an expanded research program during the last year of the project to better assess what the five city demonstration models have achieved.** During the last year of the HUP project, a systematic assessment will need to be undertaken to document the extent to which the demonstration models have been successful and identify model components that should be considered for scale-up under the NUHM. In addition repeating the behavioral baseline survey in

the last year of the project and continuing to track MIS information, the HUP project should undertake a more qualitative assessment that will obtain information from various stakeholder groups on what the project has been able to achieve. Informant groups would include beneficiaries in slum communities (both authorized and unauthorized slum areas), MAS members, HUP cluster and LWs, Anganwadi and ASHA community workers, and facility-based government health workers. An assessment report summarizing the outcomes of HUP's five city demonstration models should be the centerpiece of any formal end-of-project evaluation planned for the project. The HUP demonstration models have only been operational for around 6-8 months. During this time, much effort has been expended in launching the project in selected slum communities, including the recruitment and training of field staff and the opening of state and local community offices. It is still too early to assess the effectiveness of the community education, mobilization, and referral systems that the project has setup in the project's demonstration areas. It is recommended that the project be given additional time (beyond June 2013) to assess the effectiveness of these interventions.

- **Undertake OR on meaningful incentives for MAS members that will help ensure their sustainable engagement in urban health activities.** Options emerging from such research should be piloted in selected demonstration model areas. This initiative will provide useful guidance when NUHM is launched.

RECOMMENDATIONS RELATED TO MANAGEMENT AND GOVERNANCE OF THE HUP PROJECT

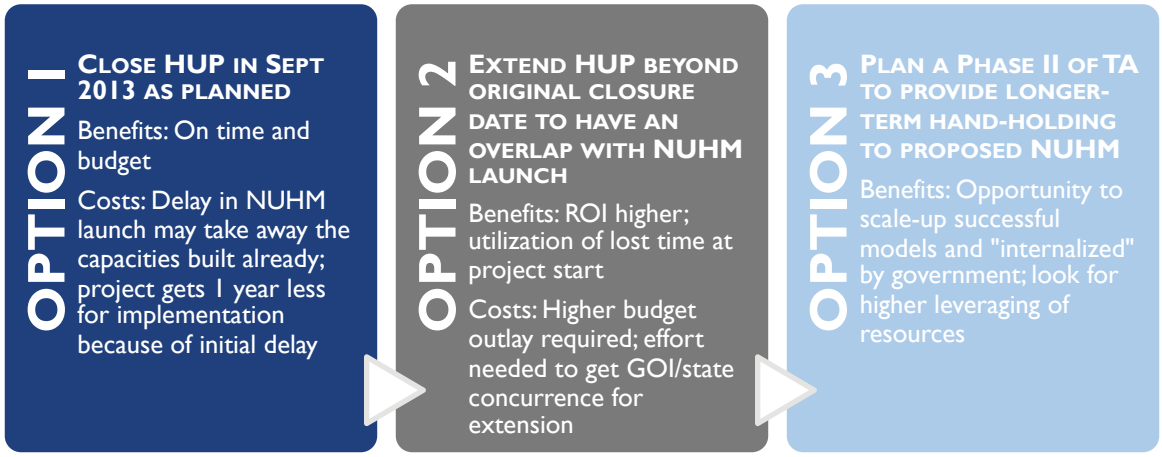
- **Utilize the strength of each partner in HUP by providing flexible strategies.** Moreover, in recognition of the differential capacities and preferences of each state, flexibility in strategies is logical to maximize the returns on efforts by the HUP team.
- **Encourage an inter-team exchange program between HUP staff for short periods to share knowledge and skills effectively.** The project could also develop a more fruitful method of interaction between state teams through inter-team exchange programs for staff for short periods to provide teams with skills and knowledge that currently are deficient.
- **Framework contractual agreements that cover the life of the project, rather than biannual contracts with sub-grantees, would reduce administrative burdens and streamline approval and budgetary procedures.**
- **State work plans need to be formally or informally agreed upon with state governments, which will help align TA with state government priorities.**
- **Introduce state-wide progress ranking to encourage healthy competition between teams within HUP.** It is possible that rankings based on annual achievements, when shared with the GOI and individual states, will stimulate actions at public agency levels to excel in certain domains.
- **TAG and PMG meetings need to be conducted regularly to provide guidance to the project pertaining to its original design and objectives.** A semi-annual meeting of TAG and quarterly meetings of PMG would be useful.
- **The project's internal reporting should be reduced from a weekly to monthly schedule in order to reduce management loads and allow more time for project implementation.** This less burdensome reporting system should be coupled with an improved feedback mechanism for HUP sub-grantees to ensure that HUP staff on the ground, especially the project's frontline workers, can assess their work and suggest operational adjustments that improve the effectiveness of the project.

RECOMMENDATIONS FOR USAID

- **Maintain an urban health niche through HUP and provide leadership to the donor community by escalating the urban health agenda in India.** Organize workshops, conferences, and meetings involving government and all potential donor partners to share experiences and views on urban health.
- **Continue strategic dialogue with GOI and states on ways to adopt evidence created through HUP as well as in other countries and regions.** Direct interaction by USAID at state and city levels could help open doors at various government levels. Moreover, visits by USAID officials to states should happen at least twice a year to: get feedback from government departments on effectiveness of TA; develop models in project components; and assess the willingness of states to engage in urban health.
- **At a later stage, provide feedback to GOI and states on models and innovations based on the Indian experience as documented by HUP, to be shared with Africa and other regions.** Providing evidence of the contribution made by HUP-led models to other countries (which could be presented on USAID-administered websites and literature) could open avenues for future inter-country learning and exposure visits. Such an exercise should also secure USAID's standing as a major partner in urban health.

THE WAY FORWARD: OPTIONS FOR THE FUTURE

Due to the initial project delay, there was limited time available for the project to demonstrate models and evidence by the mid-term. Going forward, the project has two options: (1) close out in September 2013 as originally planned; or (2) extend HUP beyond its planned close-out date in order to overlap with the eventual launch of NUHM. As a sequel to option (1), there could be follow-on TA to NUHM once HUP has amassed a larger evidence-base for how to operationalize urban health initiatives. The benefits and costs of each of these options are summarized below.



The ROI from HUP could be increased if the project is extended at least for a year, in view of the time lost in the start-up phase for reasons beyond the control of PFI. Moreover, additional time would allow further opportunity to present successful models developed by HUP to government (and other potential donors) once the NUHM is launched.

EXIT STRATEGY

It is important to manage the risk of creating unmet demands through HUP in partnering states in the event NUHM is delayed beyond project closure. If HUP is successful in creating demand for urban health services, USAID needs to develop a strategy to involve resources from government, donors, and the private sector so as to meet the urban health demands in the absence of NUHM. While a long-term engagement strategy would be the best option, interim measures could include extension of HUP or design of a follow-on project to begin immediately after the closure of HUP.

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ANNEX I: EVALUATION STATEMENT OF WORK

I. PROGRAM PROJECT INFORMATION

a. **Program Project Title:** Health of the Urban Poor (HUP)

b. **Start-End Dates:** October 1, 2009-September 30, 2013

c. **Budget:** $10,778,627

d. **Program/Project Description:**

Urban health issues have received little attention in the past as compared to rural health programs in India. However, USAID/India has been active in the urban health sector since the 2002. In 2010, WHO World Health Day theme, "1000 cities 1000 lives" have brought in the much needed focus towards the much needed public health issues in urban health. The main purpose of the Health of the Urban Poor (HUP) is to provide TA to the proposed National Urban Health Mission (NUHM), National Rural Health Mission (NRHM) and the Reproductive Child Health II (RCH II). This TA is provided through program learning, institutional strengthening, assistance in policy formulation and implementation development of framework and guidelines, implementation, capacity building and strategic dissemination of urban health knowledge. Through strategic pilot interventions and demonstration projects highlighting comprehensive packages of maternal and child health and nutrition interventions, and the promotion of safe water, sanitation and hygiene services, HUP is paving the way to improve the health status of poor urban communities in India by working closely with GOI counterparts at center, state and city level.

HUP's primary objectives are:

1. Provide quality TA to the GOI, states and cities for effective implementation of the NUHM
2. Expand Partnerships in Urban Health including engaging the commercial sector in PPP activities
3. Promote the convergence of different GOI urban health and development efforts
4. Strengthen urban planning initiatives by the state through evidence-based city-level demonstration and learning efforts

The HUP project is implemented by Population Foundation of India (PFI). The project works closely with central, state, and city local authorities for institutional convergence of quality public health services for the urban poor. The key strategies of the project include:

1. Need-based Technical Assistance for the operationalization of urban health programs within the public health system at all national, state and city levels
2. Convergence at all levels for improved health, nutrition, water, sanitation and hygiene through institutional capacity building
3. Capacity building for high quality accessible and sustainable health, nutritional and water and sanitation services
4. Leveraging resources
5. Gender equity and male engagement

6. Empowering community for improved negotiation
7. Fostering strategic alliances and partnership at all levels
8. Demonstration , documentation, systematic replication of successful urban health intervention models

The geographical focus of the project is mainly at the national level and in the selected states of Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand and Uttar Pradesh. At a national level, HUP supports the MoHFW to formulate the NUHM. The final draft and process for NUHM has been finalized and communiqué from Ministry of Finance provides the budgetary allocation for NUHM[13].At a state level, the project provides technical support to state governments in implementing urban health programs. In addition, the project has initiated model demonstrations in five cities (Agra, Bhubaneshwar, Delhi, Jaipur and Pune). The project has also created opportunities for dialogue and interaction amongst key stakeholders such as policy makers, managers, academicians and civil society organizations on various issues related to urban health implementation and policy making.

Some of the key initiatives undertaken by the project are:

Technical Assistance at National and State level

- Organizing joint meetings among various ministries such as the MoHFW and Ministry of Housing and Urban Poverty Alleviation.
- Contribute to the finalization of the NUHM Implementation Framework and State Program Implementation Plans (PIPs) of NRHM
- Facilitating roundtable discussions among key state-level urban health stakeholders such as senior government officials of health urban development departments and representatives of national and international development agencies.
- Participation in MoHFW's Common Review Mission to review NRHM progress, particularly the urban health component.

Research and Advocacy

- Conducted a baseline survey and facility assessment in all three priority demonstration cities (Pune, Jaipur and Bhubaneswar) to determine strategic inputs for effective program interventions. Moreover, the study will bring in for the first time urban poor specific data at the city level.
- Completed the study of Disease Burden in Bhubaneswar, Jaipur and Pune which will specifically inform community risk pooling/health insurance aspects of urban heath program
- Facility assessment of Urban Health Centers which are being operated under PPP mode in UP
- Commissioned a study on PPP models in all HUP states, conducted by CEDPA.
-

Slum Demonstration Program

- City Slum lists prepared/updated and vulnerability assessment process completed in Bhubaneswar, Jaipur and Pune. Baseline studies have been done.
- Initiated the city demonstration program in Sanjay Gandhi slum in Delhi under a partnership MOU with Hope Foundation.

[13] http://pibmumbai.gov.in/scripts/detail.asp?releaseId=E2012PR2457.

- Strengthened efforts for maternal and child health service delivery to the urban poor community through empowered women groups and convergence of service provider.
- More than 1,000 women benefitted from the regular health camps, water & sanitation awareness campaigns organized in partnership with the city authority i.e. New Delhi Municipal Council (NDMC) at the Delhi project site. Community members have benefitted from the outreach services in the settlement.
- Over 8,000 individuals have benefitted from the efforts initiated to bring behavior change for safe drinking water and access to improved sanitation facilities.

II. STATEMENT OF WORK

a. Evaluation Purpose:

The purpose of the mid-term assessment is to carry out an in-depth analysis of Urban Health support activities implemented by the Health of the Urban Poor (HUP) projects in India. Specifically, the assessment will focus on the following:

i. **Technical Assistance to Govt. of India:** Assess the process and effects of TA provided to the GOI and its partners in the designated states and the cities. The assessment should be able to document and substantiate the progress and process in the context of current GOI policies and strategies on urban health.

ii. **PPP and Convergence:** The assessment will analyze the involvement of private sector partnerships in urban health and convergence of various development and health programs in the context of urban poor. The assessment should be able to provide insights on how the HUP program strategies are aligned with and have contributed to the policy priorities of state governments and GOI.

iii. **Demonstration models:** The assessment will also document the pilot models created under this project for replication in terms of relevance, acceptability and credence as an immersion learning model in Urban Health**.**

iv. **Management systems:** The assessment team will finally provide an objective overview of the management practices followed by this project in meeting the intended objectives of the project.

a. Intended users and other audiences for the evaluation:

The primary **intended users** of this evaluation are the GOI at national and state levels, and USAID/India. In particular the Health Office, Program Support Office, and Mission management are interested in lessons learned concerning health innovations and partnerships as the Mission drafts the 2012-2017 Country Development Cooperation Strategy (CDCS). USAID/India will be particularly interested in findings and recommendations concerning how innovations and public-private partnerships can further this strategic plan.

USAID/India will also use this assessment to make mid-course corrections as recommended by the assessment report. The recommendations will also be used to inform USAID's new designs that increasingly focus on innovations in health systems including technology, institutional capacity building,

human resources for health, and health-related demonstration models that can be widely replicated and scaled up in India and globally.

The **secondary audience** of the evaluation is local institutions, other donors, and perhaps USAID/Washington and other missions worldwide.

c. Evaluation Questions:

This evaluation will answer the following questions, in priority order:

- How has HUP influenced GOI policy on urban health since 2009, and what opportunities currently exist for USAID to influence policy-level changes through HUP?
- To what extent has the project contributed to the operationalization of the urban health program at the national and state levels? What were the strengths and weaknesses of its implementation?
- How effective has the project's TA approach been in building synergies between the public and private partners in implementation of the key project strategies?
- What lessons can be drawn for future designs from the program governance system, especially its role in promoting convergence strategies of different GOI program?
- What has been the outcome of the slum demonstration activities under HUP? What are the key strengths and weakness of these interventions and what is the opportunity for potential scale up?
- How effective are the HUP management systems including project planning and review, grants management, financial and procurement systems in scaling -up project activities?

III. TECHNICAL REQUIREMENTS FOR EVALUATION:

a. Data collection and Analysis Methods

USAID/India anticipates a 'mixed method' evaluation methodology that would include both quantitative and qualitative approaches. Data collection methodologies will be discussed with, and approved by, the USAID/India Health Office team prior to the start of the assignment. The evaluators should consider a range of possible methods and approaches for collecting and analyzing the information which is required to assess the evaluation objectives. The evaluators should also assess the performance of the project against the baselines set by the project for key indicators. Data collection methodologies will be discussed with, and approved by the USAID/India team prior to the start of the assignment.

The evaluation will address the key questions stated above, while articulating the framework that has led to desired outcomes of the project. It is envisioned that this elaborated framework would then be used as a guide to inform future replication strategies. We anticipate that the specific methodology will be discussed at length and refined during the evaluation planning phase and the Team Planning Meeting.

Desk review of documents: USAID/India will provide the team with all relevant country and project specific documents including proposals, evaluation reports, monitoring indicators and other relevant documents for conducting this desk review. The evaluation team is expected to collect and collate relevant international documents, reports, and data, and all team members are expected to review these

documents in preparation for the team planning meeting. This desk review will help to organize the materials for the external evaluation team analysis and review of progress to date, and facilitate their utilization during the field work, analysis and report writing stages.

Data sources: Data sources that the team will be expected to utilize, review and analyze include the project design documents, project proposal, annual work plans, M&E data including relevant baseline information on project sub-components, evaluation reports, and other project-related documents and reports. Additional relevant documents related to health programming in India may be utilized as supporting documents, as well as relevant international standards.

b. Composition, Technical Qualifications and Experience Requirements of the Evaluation Team

USAID seeks a five-member evaluation team (two international and three local experts) comprised of a Team Leader (Senior Technical Advisor and Policy Expert), an Evaluation Methods Specialist (International), a Senior Public Health Analyst, a Senior Private Health Sector Expert and a Management and Governance Expert. All team members must have relevant prior experience in India, familiarity with USAID's objectives, approaches, and operations, and prior evaluation/ assessment experience. Collectively, the team must have experience in evaluating urban health programs. The responsibilities and technical qualifications and required experience of individual team members identified are given below:

1. **Team Leader (Senior Technical Advisor and Policy Expert) (International):** The Team Leader should have extensive experience in managing public health programs. S/he should have proven experience in leading and managing large scale health evaluations both in the public and health sector. S/he should have a good understanding of project administration, financial and management skills, including an understanding of USAID functioning. S/he should have excellent English language writing, editing and communication skills. In addition to proven ability to provide this leadership role, involving a technically and logistically complex program, s/he should have substantial and demonstrated expertise in evaluation techniques involving projects with TA, training, advocacy, and partnership components. S/he should be familiar with the functioning of large donor funded programs in India. The Team Leader will be responsible for coordinating evaluation activities and ensuring the production and completion of a quality report, in conformance with this scope of work. These reports may become a public document for distribution among the program's key stakeholders, including high-level U.S. government policy makers and officials, host country government officials, private sector and NGO leaders, and other audiences. The person must have ability to lead a diverse team of technical and management experts and to interface with various stakeholders ranging from government to non-government organizations, donors and beneficiaries. A minimum of 15 years' experience in design, management and evaluation of health programs is required. (LOE up to 34 days)

2. **Evaluation Methods Specialist (International):** This expert will have deep knowledge of evaluation methodologies and their practical applications in public health settings and complex TA programs. A minimum of ten years of experience in strategic planning, OR, and/or monitoring and

evaluation of global and national urban health programs is required. S/he should also have strong experience in understanding of secondary literature reviews and developing evaluation methodologies. Experience in presenting research publications and/or complex qualitative and quantitative information will be an added advantage (LOE up to 30 days).

3. **Senior Public Health Analyst (Local):** This Senior Public Health Specialist should have extensive and strong experience in designing, implementing, and evaluating public health programs with a focus on maternal child health and water sanitation and hygiene projects. S/he should be an expert in integrated public health programming in the context of urban health programs. S/he should be familiar with the public and private actors in the health sector and have a good grasp of issues related to the private sector. Additionally, a good understanding of the relevant national programs is desirable. A minimum of 10 years of experience in the design, management and evaluation of public health programs including urban and private health sector is required. Excellent writing and communication skills are required. Having an excellent understanding of USAID operational, management, and technical approaches including health systems strengthening will be an added advantage. (LOE 30days)

4. **Senior Private Health Sector Expert (Local):** This expert will be responsible for assessing private commercial sector involvement in the project and assess the public-private partnerships (PPPs) piloted by the project. S/he should assess and analyze the processes of identification of opportunities for partnerships and mechanisms to accelerate participation, as well as the sustainability and scalability of PPPs. In addition, s/he should assess mechanisms to accelerate participation as well as constraints faced in greater involvement. S/he should document lessons learned and provide recommendations for strengthening the project partnerships as well as suggestions for new directions for any future design. This expert should have extensive and proven experience in implementing core health strategies including urban health in the private sector. Experience in institutional capacity issues related to PPPs will be an asset. Additionally, s/he should have exceptional conceptual, analytical and reasoning skills as well as the ability to analyze disparate information. The expert should have at least 10 years of experience in the health private sector specifically working on public-private partnerships. S/he should have an understanding of marketing, promotion and consumer research. (LOE up to 30 days)

5. **Management and Governance Expert (Local):** This expert should have an extensive experience in managing and governance of health and non-health programs. Specifically, s/he should have an excellent understanding of project administration, governance and management in the health and non-health sectors in India. S/he should be familiar with the functioning of large donor funded programs in India. The expert should have at least 10 years of experience in the development sector. This expert will assess the overall governance of the HUP project at the state and the national level and must have a thorough knowledge of the project governance of large donor funded programs which manage networks of NGOs and institutions; experience working with government and various management issues related to such projects is required. (LOE up to 30 days)

Other Team Participants: This evaluation may include USAID/India, implementing partners' staff and GOI experts from Ministry of Health (MOH). USAID/ India staff (non-technical staff) may also join

the evaluation team during the site visits. PFI staff may accompany the team on site visits as appropriate, but will not be present during interviews with stakeholders or beneficiaries.

IV. EVALUATION MANAGEMENT

a. **Roles and Responsibilities:** The Health Evaluation Specialist in conjunction with the Evaluation COR, the HUP AOR and Activity Managers, other key Health Office team members and the Contracting Officer (CO), will provide overall direction to the assessment team.

- The Contractor will be responsible for obtaining visas and country clearances for travel for consultants.
- The Contractor will be responsible for coordinating and facilitating assessment-related TPM, field trips, interviews, and meetings in conjunction with USAID and the HUP Project.
- The Contractor will be responsible for submitting an illustrative budget for all estimated costs incurred in carrying out this review. The proposed cost may include, but not be limited to: (1) international and in-country travel; (2) lodging; (3) M&IE; (4) in-country transportation; and (5) other office supplies and logistical support services (i.e., laptop, communication costs, etc.) as needed.
- The Contractor will be responsible for in-country logistics including transportation, accommodations, communications, office support, etc.

b. Schedule:

The duration of the evaluation will be for five weeks, from late June to July 2012.

The evaluation team is expected to provide a schedule (in a tabular form) defining when specific steps in the evaluation process will occur and when deliverables are due.

Team Planning Meeting (TPM): A two-day team planning meeting will be held by the evaluation team at an offsite location before the evaluation begins. This will be facilitated by the evaluation team leader, and will provide the Mission with an opportunity to present the purpose, expectations and agenda of the assignment. The evaluators shall come prepared with a draft set of tools and guidelines and a preliminary itinerary for the proposed evaluations. In addition, the TPM will also:

- Clarify team members' roles and responsibilities
- Establish the timeline, share experiences and firm up the evaluation methodology
- Finalize the methodology guidelines including tools and questionnaires to be used by the team
- Discuss and finalize evaluation questions based on the SOW
- Review and revise the draft schedule proposed by USAID

Site Visits and Interviews: Conduct a thorough review of the Project through site visits and interviews. Interviewees will include key members from all stakeholder groups, including commercial sector partners, professional associations, health care providers, RNTCP staff, USAID/India and its implementing partners and sub-partners, other donors, communication agencies and beneficiaries. Interview guidelines will be prepared in advance and finalized during the TPM. Site visits will be planned taking into consideration factors like geographical diversity, representation of various beneficiary groups, and scale of interventions. After the TPM and Delhi meetings, the evaluation team will travel to selected sites to conduct their research. The team will travel together to two sites and will split up into two teams to conduct simultaneous research at three sites. During visits to the two joint city demonstration/state sites, the team will also split up for conducting interviews and making field visits.

c. Reports and Deliverables:

i. **Draft Work Plan and Pre-Departure Briefings**: The evaluation team will develop a draft work plan prior to arrival in Delhi. The team will meet with USAID/India and other relevant contractor staff for at least three working days prior to departure for the field.

ii. **Mid-Point Review/Briefing:** The evaluation team will provide a mid-point briefing to the USAID/India team, including evaluation and technical members, to clarify any outstanding queries that may have emerged since the initiation of the evaluation process. If this is not feasible based on scheduled field work, the Team Leader will submit weekly progress reports to the COTR via email by OOB beginning of the next week.

iii. **Oral Presentation**: The evaluation team will provide an oral briefing on its findings and recommendations to relevant staff in the field, to GOI and state government officials, and to USAID staff at the conclusion of the visits to the various project sites and implementing partners. The team may be requested to do a presentation at the MOHFW attended by all eight state representatives. The evaluation team will be required to debrief the Mission Director and Deputy Mission Director separately on the observations and recommendations.

iv. **Reports:** The evaluation will be required to submit the following reports:

a) Draft Report: The evaluation team will present a draft report of its findings and recommendations to the USAID/India's HUP AOTR and Activity Managers, Health Evaluation Specialist and Evaluation COTR, and other key Health and Program Support Office staff one week after return to the United States.

b) Final Report: The final report, with executive summary and in electronic form, must be received by the Evaluation COTR, Health Evaluation Specialist and USAID/India HUP AOTR within seven working days after receiving the final comments on the draft evaluation report from USAID/India team. The final report should also be submitted to PPC/CDIE/DI. The final report should include an executive summary of no more than three pages, a main report with conclusions and recommendations not to exceed 20 to

30 pages, a copy of this scope of work, evaluation questionnaires used to collect information on each of the program components, and lists of persons and organizations contacted.

d. Evaluation LOE and Budget:

i. Level of Effort:

LABOR CATEGORY	LEVEL	MAXIMUM
Team Leader (Technical Advisor/Policy Expert)	1	40
Evaluation Methods Specialist	1	37
Senior Public Health Analyst	1	31
Senior Private Health Sector Expert	1	31
Management and Governance Expert	1	31

PROPOSED METHODOLOGIES

The following data collection tools and interview guides will be used during the field visits. If necessary, these will be revised in Jaipur and as needed.

1) Key Stakeholders for the HUP Project

2) HUP Analysis Workbook

3) Stakeholder Interview Forms:

- Ministry of Health and Family Welfare, GOI
- Ministry of Health, State Level
- Municipal Health Offices, State Level
- HUP Partnering Implementing Agencies
- Community Organization and Health Facilities
- Bilateral and Multi-lateral Agencies

Evaluation tools and questionnaires are available upon request and are uploaded to the Drop Box.

ANNEX II: EVALUATION TIMELINE AND CALENDAR

PERIOD OF PERFORMANCE: June 18 – August 31						
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Prep Week-US	US 18	US 19	US 20	US 21	TRAVEL 22	New Delhi 23
Day off	**Contract Start Date** Home-based drafting instruments and eval work plan	Home-based doc review, drafting instruments	Home-based drafting instruments and eval work plan Expats travel to DC am and	SI HQ Briefing	Kantner travels to NY for visa Justice departs USA for New Delhi	Kantner travels to New Delhi
India Week 1 24	New Delhi 25	New Delhi 26	New Delhi 27	New Delhi 28	New Delhi 29	New Delhi 30
Justice & Team arrive Delhi (AM) TPM in PM Kantner arrives New Delhi PM	Internal SI Team Planning meeting w/ full team **½ day USAID Team Planning Meeting (pm)**	Team planning meeting to develop tools and work plan **½ day USAID Team Planning Meeting (pm)**	Full Team: Meetings in Delhi (with implementing partner/s)	Full Team: Meetings in Delhi	Full Team: Meetings in Delhi	Review & Analysis Day
India Week 2 1	Jaipur 2	Jaipur 3	Jaipur/Pune 4	Pune/Delhi 5	New Delhi 6	New Delhi 7
Travel to Jaipur Team Meeting	Meetings in Jaipur	Meetings in Jaipur Sub-team travel to Pune (PM)	Sub-team : Meetings in Pune Sub-team : Meetings in Jaipur Jaipur team travels to Delhi (PM)	Data analysis/prepare for debrief Pune team travels to Delhi (PM)	**Mid-term debrief with USAID**	Review & Analysis Day

India 8 Week 3	Bhubaneswar 9	Bhubaneswar 10	Bhubaneswar 11	MP/Dehradun 12	MP/Dehradun 13	Return Delhi 14
Full Team travels to Bhubaneswar	Meetings in Bhubaneswar	Meetings in Bhubaneswar PM: Call with Kerry Pelzman, USAID Health Officer	Meetings in Bhubaneswar	Sub-team Travel to Bhopal Sub-team travel to Dehradun	Sub-team meetings in Bhopal Sub-team meetings Dehradun	Sub-team meetings in DehradunSub-team travel from Bhopal to Delhi (AM) Sub-team travel from Dehradun to Delhi
India 15 Week 4	New Delhi 16	New Delhi 17	New Delhi 18	New Delhi 19	New Delhi 20	New Delhi 21
Day Off	Data Analysis	Data Analysis	Data Analysis	Data analysis	**Presentation to PFI and selected partners (AM)** **3 PM: Informal debrief with USAID**	Data Analysis/Report Writing
India/US 22 Week 5	New Delhi 23	New Delhi 24	US 25	US 26	US 27	US 28
Day off	**Presentation to Ministry of Health (Urban)** Prepare for USAID debrief (pm)	**Oral Debrief for USAID (am)** Team Departs India (pm)	Travel to US	Report Finalization	Report Finalization	

US 29 Week 6	US 30	US 1	US 2	US 3	US 4	US 5
Day off	Report Finalization	Report Finalization	Report Finalization	SI Quality Assurance and Review	SI Quality Assurance and Review	
US 6 Week 7	US 7	TBD	TBD	TBD	TBD	TBD
Day off	**SI Submit DRAFT report to USAID**	**USAID Review the draft report**	**USAID provides SI comments on draft**	Finalize report based on USAID feedback	Finalize report based on USAID feedback	
TBD	TBD	TBD	TBD	TBD	TBD	
Day off	SI internal review/editor	SI internal review/editor	**SI Submits Final Report to USAID 7 days after comments received from USAID**			

ANNEX III: KEY REFERENCES/DOCUMENTS REVIEWED

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ANNEX IV: INDIVIDUALS AND ORGANIZATIONS CONSULTED/INTERVIEWED

USAID/India

Elizabeth Callender, Program Officer, Evaluation
Charushila Lal, Program Development Specialist, Monitoring & Evaluation
Anand Rudra, Program Management Specialist, Urban Health and Water Lead,
Sanjay Kapur, USAID
James Browder, Deputy Director, Health Office,
Dr. Sachin Gupta, Project Management Specialist (Child Health, Health Office)
Patricia Ramsay, Acting Mission Director
Buzz Enroth, Acting Deputy Mission Director

Other Donor/International Organizations

Dr. Gita Pillai, Director/Chief of Party, Urban Health Initiative (BMGF)
Ramesh Govind Raj, Lead, Health Specialist, World Bank/India
Billy Stewart, Head, Health Unit, DFID/India
Dr. Sanjay Panday, UNICEF (Former Director, HUP/PMU/PFI)

Population Foundation of India (PFI)

Mr. Surojit Chatterji, Programme Director, HUP/PFI
Shipra Saxena, Water and Sanitation Specialist, HUP/PFI
Dr. Subrato Kumar Mondal, Director, - Knowledge Management and Research, HUP/PFI
Dr. Mainak Chatterjee, Public Health Specialist, HUP/PFI
Dr. Sainath Banerjee, Chief of Party, HUP/PFI
Guatam Chakraborty, Public Health Economist, HUP/PFI
Shekhar Waikar, Senior Public Private Partnership Specialist, HUP/PFI
Poonam Muttreja, Executive Director, PFI
Bijit Roy, Programme Officer, Community Monitoring, HUP/PFI
Dr. Swati Mahajan, Demonstration Officer, HUP/PFI

Mr. A. R. Nanda , IAS (Retd)(Former Executive Director PFI

HUP/PMU debrief at PFI:

Madhu Loehi, CEDPA/India
Aparajita Gopoi, Country Director, CEDPA/India
Ash Pachauri, Social Impact, India
Shipra Saxena, HUP-PFI
B. S. Singh, PD-HUP/Rajasthan
Smarajit Chakraborty, Project Director, HUP-PFI, Odisha
Ashok Lal Soni, PD-HUP, Jharkhand
Dr. Sneha Siddham, Plan India
RashmiSliehathi, HUP-Plan India, Pure
Ashish Kumar, PD-HUP/Plan-Bihar
Sainath Banerjee, COP, HUP-PFI
Dr. Swati Mahajan, Demonstration Officer, HUP-PFI
Shekhar Waikar, Sr. PPP Specialist, HUP-PFI
Gautam Charraborti, Health Economist, HUP-PFI

Dr. Mainak Chatterjee, Public Health Specialist, HUP-PFI
Monica Sahri, Finance and Administration Manager, PFI-HUP
Jatin Dhingra, Consultant, City Demonstration, PFI-HUP
Shahid A. Anari, Grants Manager, HUP-PFI
Lalitendu Jagatdeb, IS Manager, PFI-HUP
Gaugam Sadhu, IIHMR, Jaipur
Dr. Pradeep Panda, Micro Insurance Academy (MIA), Delhi
Rajiv Saurastri, PD-UP, HUP-PFI
Anujesh Mathur, P.D., MP, PFI
Dr. Bharati Dangwal, PD-HUP, Uttarakhand
Dr. Subrato K. Mondal, Director, KMR, PMU-PFI
Poonam Muttreja, Executive Director, PFI
Partha Roy, City Coordinator, Bhubaneswar
Surojit Chatterji, Director, Program, HUP Delhi
Dr. Naresh, City Coordinator, HUP, Jaipur

HUP Consortium Partner Organizations

Dr. Pradeep K. Panda, Deputy Director Research, Micro Insurance Academy (MIA)
Dr. Sneha Siddham, Sr. Program Manager, Urban Health, Plan India
Mohammed Asif, Director Programs, Plan India
Dr. Aparajita Gogai, Executive Director, CEDPA

Government of India, Ministry of Health, New Delhi

Manoj Jhalani, Joint Secretary, MOHFW/GOI
Priti Pant, Director Urban Health, MOHFW/GOI

Delhi Municipality/City Demonstration Project

Medical Officers at NDMC Hospital (Chanakyapuri)
Dr. Alka Saxena, Medical Superintendent, Charak Palika Hospital, New Delhi Municipal Corporation
Lizzy Cherian, Senior Nursing Superintendent, Charak Palika Hospital, New Delhi Municipal Corporation
Amrita Valli, Project Coordinator, Hope Foundation
Saji Verghese, Project Director Hope Foundation
HOPE Foundation, MAS and Community in Sanjay Gandhi slum:
Amrita Valli, Project Coordinator, Hope Foundation
Saji Verghese, Project Director Hope Foundation
Leela Bhatt, Deputy Director, Samajik Suvidha Sangam, Mission Convergence, Govt of NCT of Delhi
Prachi Kaushik, Associate Program Officer, Mission Convergence
Kamlesh Singh, Specialist Urban Poverty Management, Mission Convergence
R. B. Prashant, Executive Director, Kalyanam, (GRC, Sangan Vihar Slum), New Delhi
Kanchan Gera, Project Cordinator, Kalayanam (GRC, Sangam Vihar Slum), New Delhi

Madhya Pradesh

Anujesh Mathur, Project Director, HUM/MP
Rambir Singh Sikarwar, Convergence Advisor, HUP/MP
Chandan Verma, Public Private Parnership (PPP) Specialist, HUP/MP
D. Johnson Rhenius Jeyaseelan, Water Supply & Sanitation Specialist, HUP/MP
Prabhu Nath Mishra, Finance & Admin Officer, HUP/MP
Chanchal Sur, MIS Officer, HUP/MP
Dr. Veena Sinha, Civil Surgeon, J. P. Hospital, Bhopal
Dr. K. L. Sahu, Joint Director, NRHM, Bhopal, Madhya Pradesh

Dr. R. Shrivastava, Deputy Director, Urban Health, Bhopal, GoMP
Dr. Ajay Khare, Deputy Director, SPMU
Dr. Ravindra Pastor, Mission Director, NRHM, Directorate of Health Services Madhya Pradesh
Dr. Harendra M. Mishra, Officer on Special Duty (Training), Urban Administration & Development Department, GoMP
Rakesh Munshi, Advisor, State Planning Commission , GoMP (earlier Jt. Director NRHM)
Pravir Krishna, Principal Secretary, Department of Health and Family Welfare, GoMP
D. S. Bhadauriya, Principal Programme Coordinator, Lupin Human Welfare & Research Foundation, Bhopal

Odhisha and Bhubaneswar

Samarajit Chakraborty, Project Director, HUP-PFI, Odisha
Niladri Chakraborti, NGO-CBO Coordinator, HUP-PFI, Bhubanerswar
Biraja Kabi Satapathy, Water & Sanitation Specialist, HUP/PFI, Bhubaneswar
Basudev Panda, Documentation Officer, HUP/PFI, Odisha
Partha Roy, City Coordinator, HUP/PFI, Bhubaneswar
Dr. Hrudananda Mohanty, Convergence Advisor, HUP/PFI, Odisha
Shekh Nausad Akhatar,. MIS Officer, HUP/PFI, Odisha
Ranjit Kumar Nayak, Finance and Administration Officer, HUP/PFI, Odisha
Dr. Dinandhu Sahoo, MD (O&G), C.M.M.O Municipal Hospital, Bhubaneswar
Sunand Maharana, Project Coordinator, HUP/My Heart (Health Post)
Barita Mahaptra, Cluster Coordinator (Junta Nagar slum, Saliasahi, BBSR)
Manorama Nayak, Cluster Coordinator
Basanti Singh, Cluster Coordinator
Rashmi Rekha Barik, ANM, Coordinator of Urban Slum Health Post
Rashmi Rekha Sahoo, ANM, Urban Slum Health Post
Sabitri Moharana, MAS member
Bhasi Mohapatra, MAS member
Sarajini Bhiswal, MAS member
Jyotshna Rani Sahwo, MAS member
Pramoda Senapati, Anganwadi Worker
Ms. Sujata Kartikeyan, Director Social Welfare, Department for Woman and Child Development, GoO
Dr. BK Mishra, Special Secretary Health (Technical), Department of Health Medical and Family Welfare, GoO
Dr. BK Panda, Joint Director (Technical), NRHM, DoHMFW, GoO
Mr. Santosh Naik, PPP consultant NRHM, GoO
Mr. Srimanta Mishra, OAS-I, SIO cum-Nodal Officer, RAY and PO Jn NURM, Bhuvaneswar Municipal Corporation
Mr. Binoy Kumar Das, Slum Improvement Officer, Bhubaneswar Municipal Corporation
Dr. M. R. Mishra, Deputy Director, Seashore Health Care Foundation, Seashore Health Training & Resource Centre, Cuttack, Orissa
Dr. Dushasan Muduli, MD, (C.M.O.), Seashore Health Care Pvt. Ltd. (Former Special Secretary to Government (Tech), Health and Food Dept, GoO
Mrs. Sanshamih-Pattnaili, Seashore Health Care Pvt. Ltd.
Mr. Debabrata Mohortra, (M.M.), Seashore Health Care, (P) Ltd.
Sanjib Kumar Mishra, Addl Secretary, H&UD Department, Bhubaneswar, Orissa
Er. Dilip Singh, EIC-cum Special Secretary, H&UD Department, Bhubaneswar, Orissa

Meetings with Community Workers and Members

Shaktidhar Sahoo, Director, My-Heart, March of Youth for Health, Education, and Action for Rural Trust, Bhubaneswar
Itishree Praharaj, Project Coordinator, HUP, OFI, OVHA, Bhubaneswar

Satyaram Beura, Project Coordinator, HUP, Bhairabi Club, Bhubaneswar
Laxanan Kumar Bamisal, HUP, Bhairabi Club, Bhubaneswar
Artatrana Behera, Secretary, Gopinath Juba Sansha, HUP, Bhubaneswar
Abhaya Subudhi, Project Coordinator, HUP, Family Planning Association of India, Bhubaneswar
Umakarita Behera, Project Coordinator, Gopinath Juba Sansha, Bhubaneswar
Ashok Kuman Samantareay, Branch Managen, Family Planning Association of America, Bhubaneswar
Sunand Muharana, Project Coordinator, My-Heart, March of Youth for Health, Education, and Action for Rural Trust, Bhubaneswar
Subrat Kumar Bisoyi, Executive Director, OVHA, Bhubaneswar

Pune Municipality/City Demonstration Project

Rashmi Shirhatti, City Coordinator, HUP, Plan India
Lina Rajan, NGO/CBO Coordinator, HUP, Plan India
Jayanta Chowdhury, MIS Officer, HUP, Plan India
Vijay G. Naik, Secretary and Treasurer, Kirloskar Foundation
Dr. V.N. Karandikar, Direcotr, Health Sciences Education and Research, Bharati Vidyapeeth University
Dr. A.V. Paranjape, Executive Director, Community Aid and Sponsorship Programme (CASP
Dr. S.T. Pardeshi, Acting Medical Officer of Health (MOH), Pune Municipal Corporation

Rajasthan and Jaipur

Indian Institute of Health Management and Research (IIHMR):
Shivendra Kumar, NOG/CBO Coordinator, City HUP Team
Naresh Kumar, City Coordinator, HUP Team,
Dr. Himani Tiwari, Water and Sanitation Specialist, HUP-Rajasthan
Pooja Bharuch, Documentation & MIS Officer, HUP
Phanindra Hari Krishna, MIS Officer, HUP State Team
D. S. Bisht, Finance Officer, HUP
Prafull Kumar Sharma, Convergence Advisor, HUP
Dr. B. S. Singh, Project Director, HUP
Nisha Ameta, Project Coordinator, HUP
Madhur Mathur, Support Staff, HUP
Dr. S. D. Gupta, Director, IIHMR
Goutam Sadhu, Associate Professor, Associate Dean and Programme Coordinator of HUP (Rajasthan & Chhattisgarh)
Amitava Banerjee, Executive Director, Bhoruka Charitable Trust, Jaipur, Rajasthan
Ms. Gayatri A. Rathore (IAS), Special Secretary and Mission Director, National Rural Health Mission, Dept of Medical Health & Family Welfare, GOR
Visit to Community July 2nd – Jawahar basti – Tilla number 3
Observation of UHND, Interaction with ANM (Mani Radha), AWW (Shobha Rani), Link Worker (Mamta)
Meeting with Jawahar Nagar Basti Till no 3 MAS members – Chairperson Shamim Begum
Meeting with Reproductive Child health Officer, Department of Health and Family Welfare: Dr. Rommel Singh Pawar
D- Health Post Jawahar Nagar: Dr Satjeet Sondhi
Review of supplies in Government Dispensary Jawahar Nager with Dr. Sondhi
Cluster Coordinators
Kamlesh Dr. Jangid, Cluster Coordinator, BCT/HUP
Vinod Kumar, Cluster Coordinator, BCT/HUP
Hari Narayan, Cluster Coordinator, BCT/HUP
Umili Solanki, Cluster Coordinator, BCT/HUP

Visha Aamera, Cluster Coordinator, BCT/HUP
Pooja Bharuch, D. O., BCT/HUP
Virerendra Singh, Cluster Coordinator, BCT/HUP
Manoj Kumar Shiv, Cluster Coordinator, BCT/HUP
Renu Sharma, Cluster Coordinator, BCT/HUP
Mithlesh Arora, Cluster Coordinator, BCT/HUP East Cluster
Dr. Naresh Kumar, City Coordinator
Shivendra Kumar, NOG/CBO Coordinator
Dr. Anil Bhargava, Chief Engineer, Public Health and Engineering Department, GOR
Dr. Mala Airun, Medical Superintendent, Narayana Hrudayalaya Hospitals, Jaipur
Dr. Noopur Prasad, Joint Director, Reproductive & Child Health, Dept of Medical Health & Family Welfare, GOR
Shikka Sharma, Consultant, RCH Services, URCH, GOR
Col. Murli Nair, Chief Program Manager, Lupin Human Welfare & Research Foundation, Bharatpur
Rahul Charterjee, Program Coordinator, Health, Lupin Foundation
Dr. S. M. Mittal, Additional Director, Department of Medical Health and Family Welfare, GOR
Dr. P. K. Sarda, Director (RCH), Directorate of Medical Health & Family Welfare Services, Jaipur
Loknath Soni, CEO, Jaipur Municipal Corporation, Jaipur

Uttarakhand

Dr. Bharti Dangwal, Project Director, Health of the Urban Poor (HUP) Program, Plan India, Dehradun
Merajuddin Ahmad, Water and Sanitation Specialist, Health of the Urban Poor (HUP) Program, Plan India, Dehradun
Devraj Bhatt, Convergence Advisor, Health of the Urban Poor (HUP) Program, Plan India, Dehradun
Gaurav Joshi, PPP Specialist, Health of the Urban Poor (HUP) Program, Plan India, Dehradun
Dr. Umakant Panwar, Secretary, Department of Urban Development, Uttarakhand Secretariat, Dehradun
Dr. Geeta Khanna, Consultant Pediatrician, Executive Director, KMS Hospital, Director Combined School Health Care Services, Dehradun, Secretary Samarpan NGO
Samarpan managed UHC: Dr. Arunima Goyal, Medical Officer, Mr. S.P Pokhriyal, Project Manager,
Mr. Amit Negi, IAS, Additional Secretary to GoUK and Director ICDS
Mr. PK Bisht, Joint Director, Midday meal scheme, Department of Education, GoUK
Mr. Jagdish Sajwan, Senior Lecturer, MDM, DoE, GoUK
Dr. Sushma Dutta, Director, National Programs, DoHFW, GoUK
Mr. Piyush Singh, IAS, NRHM Mission Director and Additional Secretary Health
Mr. Vinod Chamoli, Mayor Dehradun

Social Impact

Anna Jacobson, Program Associate, Social Impact
Dustin Homer, Program Assistant, Social Impact
Paige Mason, Program Associate, Social Impact
Lee Briggs, Social Impact
Richard Blue, Vice President, Social Impact
Ash Pachauri, Social Impact India Coordinator

ANNEX V: CURRENT PERFORMANCE INDICATORS USED BY THE HUP PROJECT

PERFORMANCE INDICATORS	SOURCE (PRIMARY/ SECONDARY)	TYPE (OUTPUT/ OUTCOME)	MEANS OF VERIFICATION	JUNE 2010– SEPT. 2011	OCT. 2011– SEPT. 2012	CUMULATIVE ACHIEVEMENTS
Objective 1: Provide quality TA (TA) to the GOI, states and cities for effective implementation of the NUHM and/or urban components of NRHM						
No. of meetings of Technical Advisory Group (TAG)	Secondary	Output	Annual Report	2	1	3
No. of meetings of State Counter Part teams/Coordination forum	Secondary	Output	QPR	0		0
No. of training programs/ sensitization sessions organized for staff and different stakeholders	Secondary	Output	QPR	4	4	8
No. of program planning and review meetings/workshops at state level	Secondary	Output	Annual reports	2	2	5
No. of study tours organized for government/ and other stakeholders	Secondary	Output	QPR	4	1	5
Number of local institutions identified/developed to provide TA to NUHM/urban components of NRHM on sustainable basis	Secondary	Output	Govt. Records	1	3	4
Number of state/ city Project Implementation Plans (PIPs) prepared with recipient's support	Secondary	Outcome	Govt. Records	1	1	2
Number of states provided TA through urban health cells or consultants with recipient's support	Secondary	Output	Govt. Records	0		0
Number of new cities developed and implemented urban health plans.	Secondary	Outcome	Govt. Records	0		0

PERFORMANCE INDICATORS	SOURCE (PRIMARY/ SECONDARY)	TYPE (OUTPUT/ OUTCOME)	MEANS OF VERIFICATION	JUNE 2010– SEPT. 2011	OCT. 2011– SEPT. 2012	CUMULATIVE ACHIEVEMENTS
Objective 1 (cont.): Provide quality TA (TA) to the GOI, states and cities for effective implementation of the NUHM and/or urban components of NRHM						
Number of reports / Program lessons, documentation published/ disseminated	Secondary	Output	Reports	0	4	4
Number of dissemination events organized for the key officials from MOHFW, MoH&UPA and MoWCD with recipient's TA support	Secondary	Output	Workshop Report	0		0
Number of advocacy events/ symposiums/seminars organized	Secondary	Output	Annual Report	4	4	8
Objective 2: Expand partnerships in urban health including engaging the commercial sector in PPP activities						
Number of MOUs signed by state/city governments with non-government and commercial sector partners through recipient's TA	Secondary	Output	Govt. Records - MoUs	0		0
Number of service delivery models developed/strengthened in collaboration with private/commercial sector	Secondary	Output	MoUs signed	0		0
No. of consultations/meetings for sharing best practices on PPP	Secondary	Output	Annual Report	0	2	2
No. tools (MOUs, EOI/ToR/evaluation criteria) developed for establishing Partnership	Secondary	Output	Annual Report	0	4	4
No. of potential partners identified for resource leveraging	Secondary	Output	QPR	0	12	12

PERFORMANCE INDICATORS	SOURCE (PRIMARY/ SECONDARY)	TYPE (OUTPUT/ OUTCOME)	MEANS OF VERIFICATION	JUNE 2010– SEPT. 2011	OCT. 2011– SEPT. 2012	CUMULATIVE ACHIEVEMENTS
No of USAID partners having convergent actions in their work-plans	Secondary	Output	Submitted work plans	0		0
Objective 3: Promote the convergence of different GOI urban health and development efforts						
Number of consultations/workshops organized to operationalized convergence	Secondary	Output	Workshop reports	8	4	12
No. of letters jointly issued by Departments of Health and Family Welfare, Housing and Urban Poverty Alleviation and Woman and Child Development	Secondary	Output	Govt. records	0	1	1
Number of CRM/JRM/JMM of NUHM with participation of officials from Housing & Urban Poverty Alleviation and Women & Child Development	Secondary	Output	Govt. records	3	2	5
Number of cities with models of convergence between NUHM/Urban components of NRHM and JNNURM/ICDS	Secondary	Output	Govt. records	0	8	8
No. of exposure visits and cross visits to successful convergence models	Secondary	Output	QPR	1		1
No. of meetings of city multi-stakeholder coordination committee organized	Secondary	Output	QPR	0	2	2
Lessons of community level convergence are documented and adopted by NUHM/urban components of NRHM	Secondary	Output	Govt. records	0		0

PERFORMANCE INDICATORS	SOURCE (PRIMARY/ SECONDARY)	TYPE (OUTPUT/ OUTCOME)	MEANS OF VERIFICATION	JUNE 2010– SEPT. 2011	OCT. 2011– SEPT. 2012	CUMULATIVE ACHIEVEMENTS
Objective 4: Strengthen the evidence-based rigor of city-level demonstration and learning efforts in order to improve program learning						
No. of cities where slum and facility mapping and vulnerability assessment conducted	Secondary	Output	QPR	3		3
No. of city demonstration and learning models developed and documented	Secondary	Output	Annual Report	0		0
No. of baseline or feasibility studies conducted	Secondary	Output	Report	3		3
Number of new cities implementing city programs with learning from USAID supported demonstration and learning sites	Secondary	Outcome	Govt. records	0		0
Number of people in target areas gaining access to improved drinking water supply as a result of USG assistance	Primary	Outcome	Rapid Assessment	4804		4804
Number of people in target areas gaining access to improved sanitation facilities as result of USG assistance	Primary	Outcome	Rapid Assessment	3404		3404
No. of people in target areas with access maternal and child health-care services	Primary	Output	Quarterly Report	**	**	**
A Toolkit to undertake baseline research studies developed	Secondary	Output	Annual Report	1		1
Toolkits developed with recipient's support is adopted by the national/state/city governments	Secondary	Output	Annual Report	0	1	1
Number of scientific articles published in peer reviewed indexed journals	Secondary	Output	Scientific journal	0		0

ANNEX VI: SELECTED PRELIMINARY INDICATORS FROM 2012 HUP BASELINE SURVEY IN JAIPUR, BHUBANESWAR, AND PUNE

INDICATORS	JAIPUR			BHUBANESWAR			PUNE		
	Total Urban N=1997	Slum N=370	Non-Slum N=1627	Total Urban N=1839	Slum N=279	Non-Slum N=1560	Total Urban N=1884	Slum N=447	Non-Slum N=1437
Environmental Conditions (Water and Sanitation)									
Percentage of households using one room for sleeping 3 or more persons	48.2	59.9	42.2	37.5	67.1	35.0	53.3	69.8	49.7
Percentage of households having access to improved toilet facility	94.1	86.4	98.1	94.1	71.3	96.0	98.2	93.8	99.3
Maternal Health Status									
Percentage of currently married women not using any method of contraception	18.7	28.7	15.5	32.8	28.6	33.1	20.4	17.2	20.8
Percentage of pregnant women who had at least three ANC visits for the last birth	92.2	92.0	92.2	93.9	83.3	94.9	99.0	94.7	99.5
Percentage of pregnant women consuming IFA tablets/syrups during the 90 day period before the last birth	49.0	39.4	54.6	77.0	65.3	78.7	81.2	74.5	82.4
Percentage of mothers who delivered in an institution for the last birth	85.5	77.6	90.5	95.8	81.8	97.5	97.8	96.7	98.2

INDICATORS	JAIPUR			BHUBANESWAR			PUNE		
	Total Urban N=1997	Slum N=370	Non-Slum N=1627	Total Urban N=1839	Slum N=279	Non-Slum N=1560	Total Urban N=1884	Slum N=447	Non-Slum N=1437
Child Health Status									
Percentage of children (12-23 months) fully immunized	41.0	32.4	46.5	58.6	32.4	62.2	56.2	63.6	54.7
Percentage of children (12-35 months) who have received at least 1 dose of Vitamin A	46.2	42.4	48.5	80.1	85.4	80.0	75.8	74.4	75.8
Percentage of children (0-5 months) who were exclusively breastfed	74.4	70.4	77.3	88.3	97.0	87.5	83.1	83.3	83.2
Percentage of children with diarrhea in last two weeks treated with ORS	52.8	42.9	59.0	67.9	68.4	65.0	72.0	85.7	64.7
Other Health Burdens and Risk Factors									
Percentage of households having any member suffering from of malaria in last two weeks	1.7	1.5	1.8	0.9	3.1	0.7	0.1	0.5	0.0
Percentage of households having any member suffering from TB in last year	1.2	1.3	1.2	0.5	1.3	0.3	0.7	1.2	0.5
Percentage of women aware that consistent condom use can reduce chances of HIV	78.3	67.5	83.1	64.5	46.2	66.0	63.5	48.8	66.7

ANNEX VII: STAGES IN THE EVOLUTION OF URBAN HEALTH PROGRAMMING

ANNEX VIII: MAPPING OF TA PROVIDED BY HUP

	VISION AND POLICY	FINANCING UH	HR AND GOVERNANCE	SERVICE DELIVERY	INFORMATION SYSTEMS	PROCUREMENT	FINANCIAL MANAGEMENT	DEMAND GENERATION
GOI	-Draft NUHM document -Evidence generation - Disease Burden Study; Study on PPP, micro-insurance schemes, BCC		-Review of state PIPs	-NUHM implementation framework	Component of NUHM implementation framework	Component of NUHM implementation framework	NUHM budgetary framework	Yet to be completed – successful models for demand generation being field tested
STATES	Evidence: Facility Assessment- (JK,UK) -Advocacy &/government orders for convergence -Planning and mapping tools -Technical Resource group (JK) -Policy analysis of WASH Efforts for urban RCH cell/PPP cell	Supporting an increase in urban RCH budgets PPPs afoot for secondary level services – Odisha and Rajasthan -Mapping of potential partners for WASH/nutrition/health Support for tailoring RSBY to urban areas (UK)	Drafting of urban RCH component of PIPs in 4 states Advocacy & Capacity Building (CB) – training on PPP/MNCH and WASH modules/visits	-Micro plans for immunization in (JK) Operationalizing UHNDs (UK&JK) -Defining service norms for URCH centers (UK)	Mother and child tracking tools (all states) HMIS formats and tools MIS for urban services (Odisha)	Drafting MOUs for NGO and commercial partnerships for service delivery	Efforts afoot to create budget line for urban programming at district health society	BCC tools for demand generation
CITY	City health plans Advocacy for convergence	City specific PPPs in Pune – efforts afoot	Advocacy & CB of front line workers, 'Point of Use' training in WASH (Raj/Od)	Promotion of Urban health and Nutrition Days -Facilitating outreach -Guidelines for MAS/CCC/WCC				Implementation of demand generation models– BCC in health, nutrition and WASH

ANNEX IX: COMPARISON OF THE CHANGE IN URBAN RICH BUDGETS OF HUP AND NON-HUP STATES, 2010–2013

STATE	2010–2011 BUDGET	EXPENDI-TURE %	SPENT	UNSPENT	BUDGET 2011-12	ADDITIONAL AMOUNT REQUESTED	CHANGE IN %	BUDGET 2012–2013	CHANGE IN %
MP	153.32	55.64	85.30	68.012	236	167.99	53.93	846	258%
Bihar	108	33.17	35.82	72.17	108	35.82	162.48	56.5	-47.69
Jharkhand	80.1	10.18	8.15	71.94	23.5	-48.45	-71	39	65.96
Rajasthan	768.82	56.00	430.56	338.26	567	228.74	-26.25	404.8	-28.61
Orissa	293.81	42.93	126.13	167.68	275.64	107.96	-6.18%	427	54.91
UP	1674.36	64.01	1071.81	602.55	2062.68	1460.13	23	NA	NA
Uttarakhand	369.08	95.04	350.76	18.32	801.2	782.88	117.08	NA	NA
Chattisgarh	NA	NA	NA	NA	NA	NA	NA	NA	NA
Manipur	80.12	33.99	27.23	46.13	88.32	61.09	10.23	NA	NA
Punjab	190.44	89.09	169.67	101.35	345.6	175.93	81.47	288.92	-16.40
Karnataka	480.73	44.14	212.2	436.59	576	363.80	19.82	146.8	-74.51

Figures in INR Lakhs (Hundred Thousand)

ANNEX X: PUBLIC-PRIVATE PARTNERSHIPS

Knowledge Work and Information, Education and Communication on PPP

The project's logical framework stresses the creation of documents and evidence, as well as mapping of potential partners in the private sector. Due to the initial delay in the project and time taken to put things together, not much could be achieved in the first year of operations in PPP, although the project did consult with other USAID programs like MCH Star, VISTAR and POUZN. The project had also established partnerships through an MOU with the Hope Foundation for improving access and availability of health care services at the Sanjay Gandhi slum in Delhi. Orientation workshops held for Urban Local Bodies (ULBs) and the private sector on PPP and governance, as well as completing a study on disease burdens and micro insurance could also have implications for PPP models in the future. Some important activities from the 2nd year (October 2011 onwards) included:

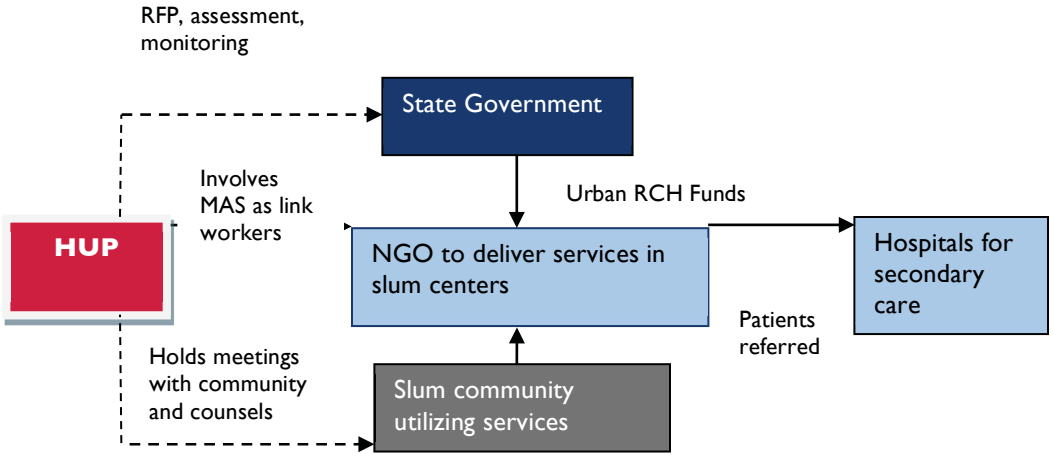
- A draft PPP study titled "Public Private Partnership in Urban Health" was completed by the HUP team in December 2011
- HUP Program Management Unit (PMU) organized meetings of PPP specialists and their representatives from different states on 25-26 March 2011. The meeting discussed the concept of PPP in the context of urban health and the development of the operational framework for PPP
- In Chhattisgarh a state level meeting titled "Public-Private Partnership on role of corporate sectors and NGO's in promoting health of the urban poor" was organized in Raipur on July 5, 2011. Representatives from corporate and nongovernmental organizations participated in the discussion
- The Rajasthan team organized a two-day State-level workshop on "Capacity Building of Municipal Representatives on Public-Private Partnership and Governance" at Jodhpur on 17th - 18th August 2011 in partnership with the Department of Housing and Urban Development, Govt. of Rajasthan
- The Chhattisgarh team had organized a consultation workshop on PPP on 23rd Sept. 2011. Mr. Rajendra Jani, Chairman, Raman Group facilitated sessions on the PPP models
- An exposure visit was organized by HUP Odisha to Bruhat Bengaluru Mahanagar Palike and National Rural Health Mission (NRHM), Bangaluru to observe the urban health and public private partnership initiatives undertaken by the Health and Family Welfare Department, Government of Karnataka during 27th to 31st December 2011

PPP Models Showing Promise for the Future

Urban Health Centers (UHC): Government-NGO collaboration

Twenty-one Urban Health Centers rendering outpatient department (OPD) services in slums in Dehradun are run by NGOs contracted through NRHM's urban RCH funds. The Government of Uttarakhand has identified 17 more locations for starting similar services this year. HUP conducted a Needs Assessment Study for UHCs on the request of the state government and is currently assisting the government in conducting a Performance Assessment as well as NGO contracting exercises.

Fig. 3: Urban Health Center Model



The UHC model is working well and seems to have raised health-seeking behavior of the urban poor living in and around the slums. With 3 ANMs, 1 Pharmacist and helping staff, a doctor in the slums is providing quality care through the UHC. The HUP team assists the government in creating monitoring tools and generating demand through counseling the Mahila Arogya Samiti (MAS) members on sanitation, ANCs, infection prevention, etc.

Incentives for all parties are positive in this model and seem to be a good scalable option for other areas of the country.

Running of Primary Health Centers and dispensaries through CSR wings of commercial organization

Seashore Foundation, the CSR wing of the Seashore group of Cuttack in Orissa, has been running seven Primary Health Centers in rural areas for more than a year. HUP approached the organization and discussed incentives for running government facilities in urban areas. With the agreement of Seashore, a three-way Memorandum of Understanding between the Bhubaneswar Municipal Corporation (BMC), Seashore Foundation and HUP-PFI is planned to be drawn up shortly to run two Urban Dispensaries at Gadakana and Kapil Prasad in Bhubaneswar for five years. The contributions of each partner are shown in the table below:

Table 3: Contributions of each partner in BMC-Seashore-HUP partnership

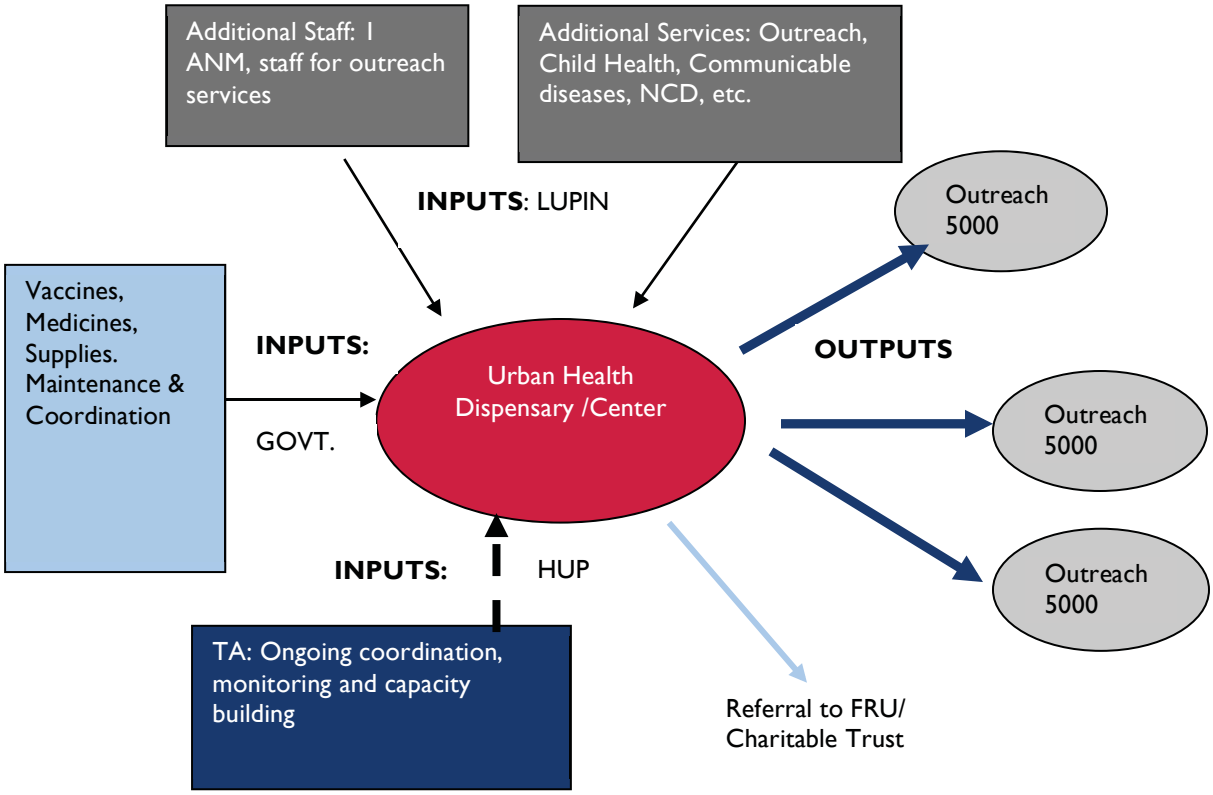
PARTNER	ROLE	INCENTIVES
BMC	Provides infrastructure (dispensaries) and rights to Seashore to run urban dispensaries against MoU; policy management and recurring support.	OPD services for the poor would be free; would be designated as an RSBY hospital which poor can access against insurance; plans to have accreditation of facility under JSY for institutional delivery under NRHM.
Seashore Foundation	Provides funds (Rs. 25 lacs per annum/ dispensary) for operations in 5 years and charges user fees for diagnostics and pathology services;	Image building through CSR as Seashore Healthcare Private Limited is already running commercial facilities; giving back to the society through funds and expertise; potential earning avenue through commission as RSBY facility; potential to utilize land for further expansion into BMONC in future.
HUP-PFI	Brings partners together; jointly prepares proposal; assists government in monitoring and provides other technical support; joint assessment of dispensaries; acts as a bridge between government and the commercial sector.	Leveraging funds from commercial sector as per objectives of project; creating PPP models that are scalable.

Some PPP models being developed by HUP at present

Running of Urban Dispensaries in Rajasthan through Lupin

The Lupin Human Welfare and Research Foundation, the CSR wing of pharmaceutical company Lupin, and Government of Rajasthan are developing ways to contract out Urban Dispensaries in Bharatpur in Rajasthan, facilitated by the HUP. Lupin's choice as a potential partner is due to its experience in running Urban Health Posts in Bharatpur (as a CSR initiative). The crux of each partner's contribution is detailed in Fig. 4, below.

Fig. 4: Urban Dispensary Operationalization in PPP mode



Other PPP models that are being developed

A few other PPP models are being developed by different states/cities under HUP. Notable among them are:

(a) Government of Uttarakhand-Ambuja Cement-HUP Partnership:

This initiative, proposed in Roorkee, is expected to deliver the following benefits:

- Address behavioral changes in the community and strengthen preventive health services
- Induce health-seeking behavior in the community leading to better health outcomes.

- Strengthen Govt. Service Delivery Mechanism
- Provide primary health care and reach to approx. 50000 slum population

Proposed contributions of each partner for a slum population of 50,000:

PARTNER	PROPOSED CONTRIBUTIONS
Government of Uttarakhand (DOHFW, ICDS) & HUP	Rs. 13 lacs (approx.)
Ambuja Foundation	Rs. 6.4 lacs (amount requested)
HUP	Technical assistance in developing MoU and connecting private partner with government.

(b) WASH activities in PPP mode in Pune through Kirloskar Foundation

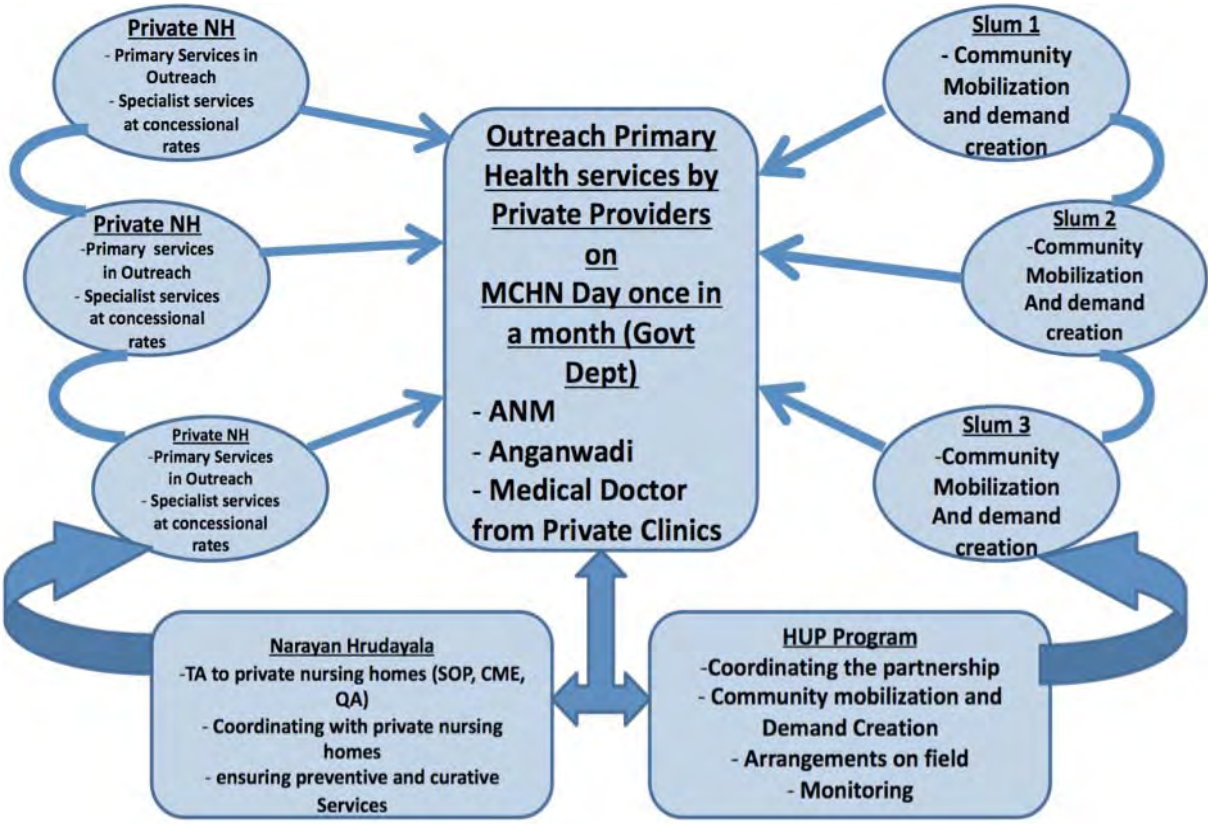
In recognition of Kirloskar Foundation's CSR work in the field of school health, the HUP team discussed and agreed with the Foundation to participate in WASH activities in slums through the involvement of MAS. At the suggestion of Kirloskar, the All India Institute of Local Self-Governance, a policy advocacy institute supported by the TATA group, was also proposed to be involved. The role of each proposed partner is described below.

Kirloskar Foundation	HUP	All India Institute of Local Self Governance (AILSG)	Pune Municipal Corporation (PMC) Urban Development Department
• Overall coordination with partners and PMC • Organizing resources for implementing the activities in two slums nearby the Kirloskar school health intervention area	• Implementation of the activities in selected two slums of HUP through community groups. • Providing technical support for the material development, module development, designing tools etc. • Coordination with Pune Municipal Corporation (PMC)	• Providing resource material for the training and capacity building of community groups. • Designing and developing communication tools. • Providing training to the community groups.	• Ensuring provision of hardware component for water and sanitation where ever needed.

(c) Government of Rajasthan-Narayan Hrudayalaya-HUP Partnership

The proposed partnership, a write-up of which has been submitted by HUP to the state government, proposes to run as per Figure 5.

Fig. 5: Schematic diagram showing proposed model with Narayan Hrudayatula Hospitals



The role of each partner, including HUP-IIHMR and HUP-BCT, is shown below:

DOHFW	Narayan Hrudayala Hospital and Private Nursing Homes	HUP-IIHMR with support from HUP-PMU	HUP-BCT with Support from HUP-PMU
• Provision of two ANMs to attend MCHN day on rotation basis. • Provision of vaccines for children and pregnant women • Linkages with Vaccine ILR point Provision of contraceptives VG. Condoms, OCP • Monitoring formats of MCHN day • Beneficiaries register • Nomination of one person for monitoring	• Empanelment of private clinics • Certificate of association to empanelled practitioners • Provision of services in the health camps on the scheduled days through empanelled practitioners • Provide OPD, referral, outreach and specialist services • Participate in monthly review meeting for quality assurance	• Facilitating the Partnership • Providing Technical support for operationalizing, monitoring of the proposed Urban camps through partner NGO. • Provide technical support in the operational model • Developing a monitoring mechanism • Partnership monitoring for its successful implementation • Documentation of best practices	• Community level awareness and demand creation for services through MAS members, LWs and CCs • Logistic Support for organization of the camp. • Capacity building of staff in essential package of MCH services, MIS, developing referral linkages and community mobilization. • Maintaining MIS and reporting data on monthly basis

ANNEX XI: KEY GOVERNMENT PROGRAMS FOR THE URBAN POOR IN INDIA

GOVERNMENT PROGRAM	FOCUS	MINISTRIES INVOLVED	STATE PUBLIC AGENCIES INVOLVED	WHAT IS NOT COVERED IN PROGRAM
JNNURM	- Improve urban infrastructure and governance - Providing basic services like shelter, civic amenities to the urban poor	Ministry of Urban Development Ministry of Urban Employment and Poverty Alleviation	Municipal corporations and Urban Local Bodies under Department of Urban Development; some states have separate department for Drinking Water Supply as well as Public Health & Engineering Department.	Health aspects for the poor
ICDS	- Nutrition and pre-school education to children aged zero to six years as well as Nutrition and Health Education	Ministry of Women and Child Development	Department of Women and Child Development or Social Welfare department in some states like Bihar	(Three of the six services are related to health) Civic amenities and infrastructure in slums
NRHM	- All disease control programs (except HIV/AIDS) with RCH as flagship	Ministry of Health & Family Welfare (MOHFW)	Department of Health & Family Welfare	Limited urban RCH funds in programme do not cover aspects other than health
NACP III	- HIV/AIDS	National AIDS Control Organization under the MOHFW	State AIDS Control Societies	Barring some collaborations with TB program, does not cover aspects other than HIV/AIDS

ANNEX XII: TA TO WATER SUPPLY, SANITATION, AND HYGIENE (WASH)

Water, Sanitation, and Hygiene (WASH) are pre-requisite contributions for good public health and environmental outcomes. The majority of the urban poor in India suffer from having inadequate access to or linkages with formal systems of water supply and sanitation service delivery. It is now globally understood that more than 80 percent of the diseases are directly or indirectly related to improper water and sanitation facilities. Thus, water supply sanitation and hygiene practices serve as key health determinants.

The inclusion of WASH in HUP is a logical step forward from the USAID's POUZN Project that aimed to reduce one of the leading causes of illness and death among children worldwide—diarrhea—via two proven methods: preventing diarrhea by disinfecting water at its point-of-use (POU), and treating diarrhea with zinc therapy. Water treatment at the point-of-use, such as at households or schools, has been found to reduce diarrhea caused by waterborne pathogens by 30 to 50 percent. POU water disinfection makes contaminated water safe to drink through methods such as filtration, boiling, radiation, or chemical treatment.

THE APPROACH

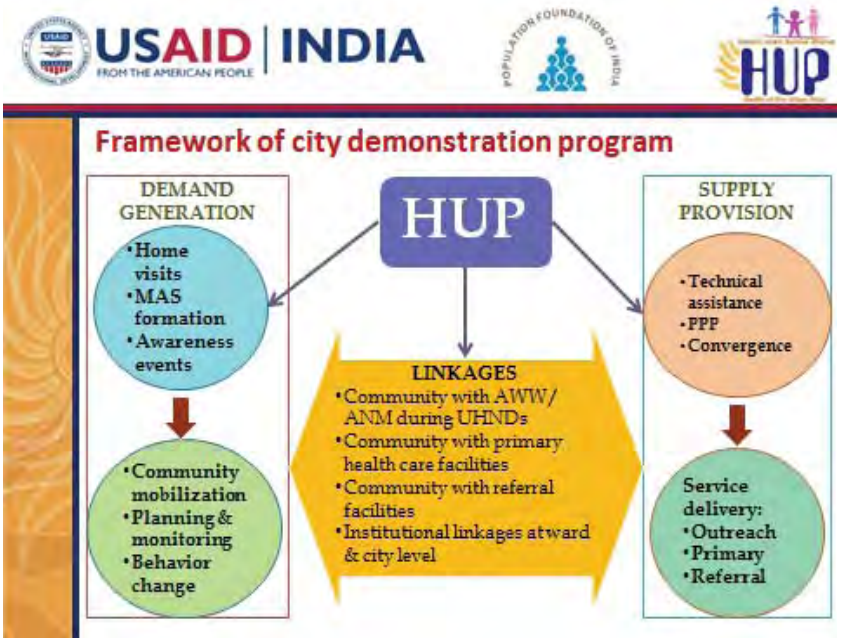
In order to act upon the WASH agenda set in the Cooperative agreement, it is important to look at WASH services in a more holistic manner and map out the key components and potential activities, as presented in the Table below, to guide the HUP project interventions.

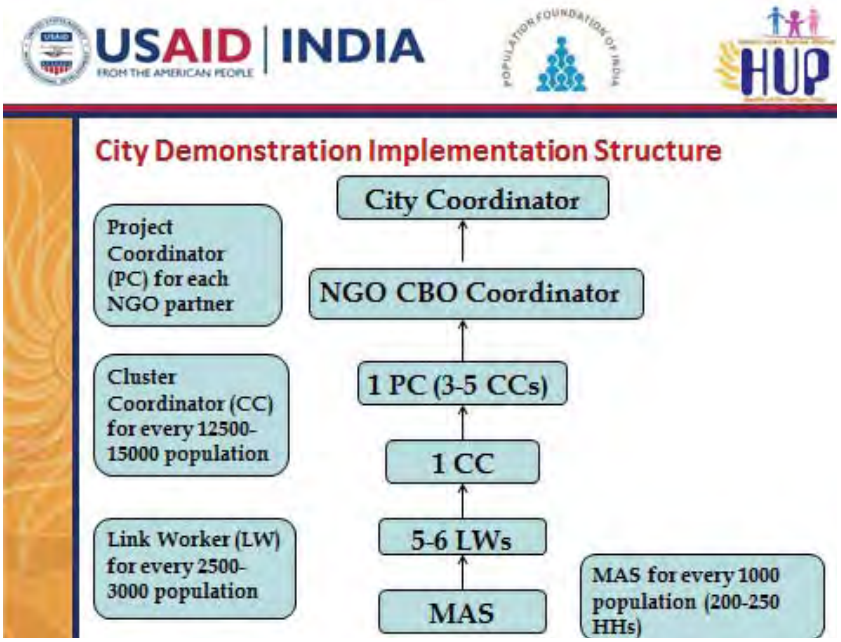
KEY COMPONENTS	SUB COMPONENTS	SUB-SUB COMPONENTS	POTENTIAL ACTIVITY SET (WITHOUT CAPITAL INVESTMENT)
IMPROVING WATER SUPPLY	IMPROVING ACCESS	IMPROVING ARRANGEMENTS	• Mapping of existing status of target areas/ locations • Improving access and adequacy through building linkages and influencing service providers' e.g. PHED, Water supply division of ULB etc. • Improving provision through PPP initiatives • Building community linkages with service providers
		IMPROVING ADEQUACY	
	IMPROVING QUALITY	AT SOURCE	• Water quality mapping sources in target areas/ locations by building linkages with service providers' e.g. PHED, Water supply division of ULB etc. and/or through private sector initiatives • Building community linkages and influencing service providers for improving quality supply and periodic quality testing
		AT POINT OF USE	• Behavior change communication (BCC) through front line workers of service providers, NGOs/ CBOs • Training and capacity development of LWs/CCs and MAS members • Providing incentives and building linkages with service providers to ensure availability of Chlorine tabs, other filters etc
IMPROVING SANITATION	IMPROVING ACCESS	IMPROVING ARRANGEMENTS	• Mapping of existing status of target areas/ locations • Improving access and adequacy through building linkages and influencing service providers' e.g. PHED, Sanitation division of ULB etc. • Improving provision through PPP initiatives • Building community linkages with service providers to raise demand • Instituting community management systems of public toilets
		IMPROVING ADEQUACY	
	IMPROVING TOILET USE		• Behavior change communication (BCC) through front line workers of service providers, NGOs/ CBOs and HUP project staff

KEY COMPONENTS	SUB COMPONENTS	SUB-SUB COMPONENTS	POTENTIAL ACTIVITY SET (WITHOUT CAPITAL INVESTMENT)
IMPROVING SOLID AND LIQUID WASTE	IMPROVING ACCESS	IMPROVING ARRANGEMENTS IMPROVING ADEQUACY	• Mapping of existing status of target areas/ locations • Improving access and adequacy through building linkages and influencing service providers' e.g. ULB. • Improving provision through PPP initiatives • Building community linkages with service providers
	IMPROVING MANAGEMENT SYSTEM		• BCC through front line workers of service providers, NGOs/ CBOs and HUP project staff on solid and liquid waste management • Building community participation and monitoring
IMPROVING HYGIENE PRACTICES	IMPROVING HAND WASHING PRACTICES		• BCC through front line workers of service providers, NGOs/ CBOs and HUP project staffs on hand washing
	IMPROVING MENSTRUAL HYGIENE MANAGEMENT (MHM)		• BCC through front line workers of service providers, NGOs/ CBOs and HUP project staff on MHM • Building community linkages and influencing service providers including Health and potential private sector initiatives

ANNEX XIII: FRAMEWORK OF THE HUP DEMONSTRATION MODEL PROGRAM

Taken from Health of the Urban Poor Project: Overview and Status – PFI Presentation on June 27, 2012





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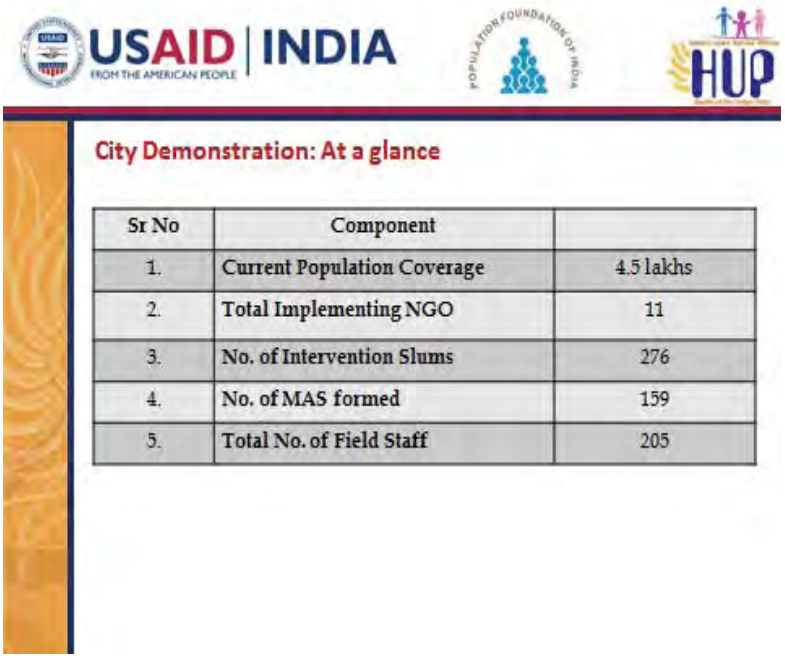


Sr No	Component	
1.	Current Population Coverage	4.5 lakhs
2.	Total Implementing NGO	11
3.	No. of Intervention Slums	276
4.	No. of MAS formed	159
5.	Total No. of Field Staff	205

ANNEX XIV: KEY STAKEHOLDERS FOR THE HUP PROJECT

National Level

Ministry of Health and Family Welfare
Ministry of Urban Development
Population Foundation of India (PFI)
USAID/India
Other Donors supporting Urban Health Programs

State Level

State Ministry/Departments

Ministry of Health and Family Welfare (MOHFW)
Public Health Engineering Department (PHED)
Urban Development
Women and Child Development
Municipal Corporations
Other State-Level Donors working on Urban Health/NRHM

State Partners and Sub-Recipients

Plan India
Indian Institute of Health Management Research (IIHMR)

Technical Sub-Partners

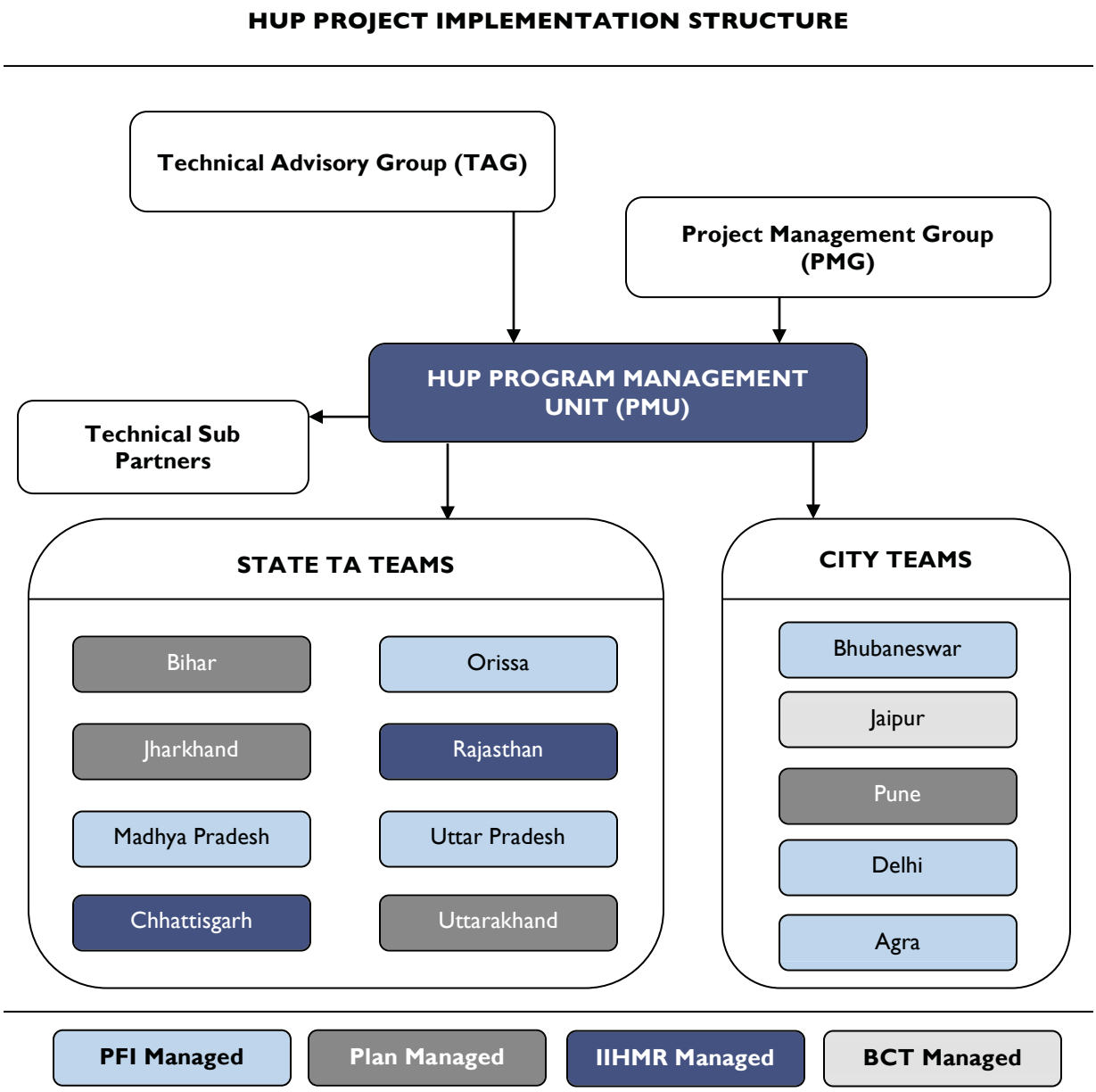
Micro Insurance Company (MIA)
Centre for Development and Population Activities (CEDPA)
Business Community Foundation (BCF)
International Institute for Population Sciences (IIPS)

ANNEX XV: HUP PROJECT PARTNERS

	LOCATION	ADDRESS	OFFICE TEL. NO.	NAME OF CONTACT PERSON	DESIGNATION	EMAIL ID
1	Population Foundation of India	B-28 Qutab Institutional Area, New Delhi 110016	011-43834100	Ms. Poonam Muttreja	Executive Director	pmuttreja@populationfoundation.in
2	Plan International (India Chapter)	E-12, Kailash Colony, New Delhi	011-46558484	Ms. Bhagyashri Dengle	Executive Director	Bhagyashri.Dengle@planindia.org
3	Indian Institute of Health Management Research (IIHMR)	1, Prabhu Dayal Marg, Sanganer Airport, Jaipur - 302100	0141-3924700	Dr. S. D. Gupta	Corporate Director	sdgupta@iihmr.org
4	Bhoruka Charitable Trust	1, Prabhu Dayal Marg, Sanganer Airport, Jaipur - 302100	0141-3191666	Amitava Banerjee	Executive Director	amitava.jpr@bctngo.org
5	The Centre for Development and Population Activities (CEDPA)	C-1, Hauz Khas, New Delhi - 110016	011-47488888	Aparajita Gogoi	Executive Director	agogoi@cedpaindia.org
6	Indian Institute of Population Sciences (IIPS)	Govandi Road, Deonar, Mumbai - 400088	022-25563254/55	Prof. F. Ram	Director & Sr. Professor	director@iips.net
7	Micro Insurance Academy (MIA)	52-B, 1st floor Okhla Industrial Estate, Phase III, New Delhi - 110020 India	011-43799100	Mr. Dharmendra Kumar	Chief Trustee	dkumar@mia.org.in
8	Hope World Wide	H-6/B, Hauzkhas, New Delhi- 110016	011-26515374	Saji Geevarghese	Sr. Program Director	saji@hopeww.in
9	SMILE Foundation	V-11, Level - 1, Green Park Extension, New Delhi - 110 016	011-43123700	H N Sahay	Director (Operations)	hnsahay@smilefoundationindia.org
10	Shri Niroti Lal Buddha Sansthan (SNBS)	3/4 – P – 2A, Bank Colony, Opp. Subhash Park M.G.Road, AGRA – 282010, Uttar Pradesh	0562-6534816	Ravi Kashyap	President	president@snbsindia.org

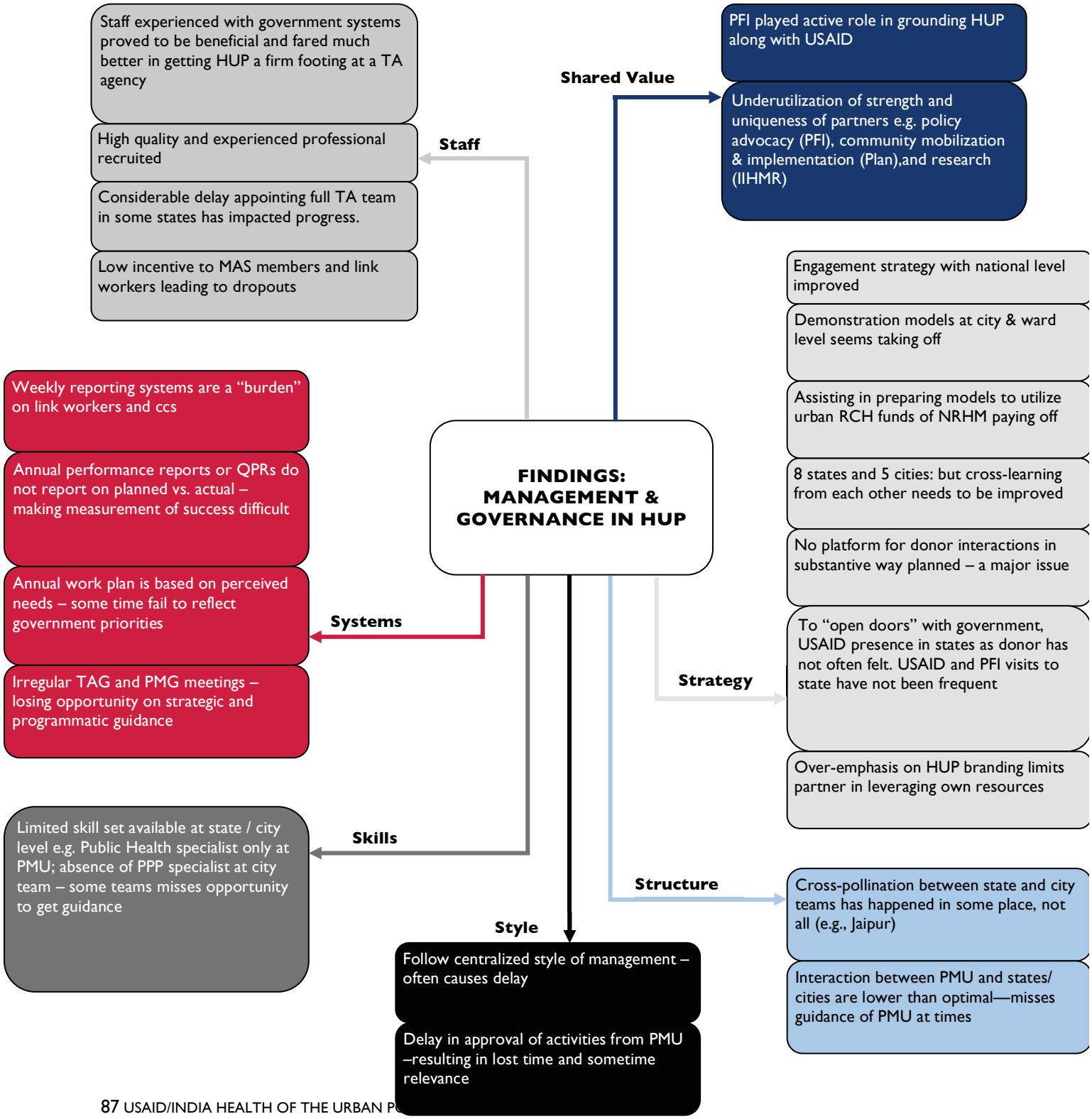
	LOCATION	ADDRESS	OFFICE TEL. NO.	NAME OF CONTACT PERSON	DESIGNATION	EMAIL ID
11	Centre for Urban and Regional Excellence	CAP Office, Room No. 313, 2nd Floor, Agra Nagar Nigam, Agra - 282002, Uttar Pradesh	0562-4007943	Renu Khosla		renukhosla@cureindia.org
12	MY-HEART	R P 115, Pandav Nagar, Tamkapani Road, Bhubaneswar 18	0674-2430548	Mr. Shaktidhar Sahoo	Director	myheartbbsr@hotmail.com
13	Orissa Voluntary Health Organization (OVHA)	Lokaswasthya Bhawan, Plot No.165, Laxmi Sagar Square, Bhubaneswar, Khurda, Orissa – 751006	0674-2572849	Mr. Subrata Kumar Bisoyi	Executive Director	ovha2008@gmail.com; subratovha@hotmail.com
14	Family Planning Association of India (FPAI)	Plot No. 392, (Ground Floor), B.J.B. Nagar, Bhubaneswar - 751014, Odisha	0674-2436427	Ashok Samantaray	Branch Manager	bhubaneswar@fpaiindia.org
15	Gopinath Juba Sangha (GJS)	At.-Alisisisan,P.o.-Darada,P.s.-Balipatan Dist.-Khordha, Pin.-752102, Odisha,	06755-245001	Baikuntha Nath Marth	Director	bhairabi_27@yahoo.co.in
16	Bhairabi Club	AT-Kurumpada, P.O.-Hadapada, District – Khordha, Odisha-752018	0674-2460521	Mr. Aratatrana Behera	Secretary	secretary.gopinath@gmail.com
17	Community Aid and Sponsorship Program (CASP)	CASP BHAVAN, Survey No.132/2, Plot No.3, Pashan-Baner Link Road, Pune- 411 021	020-25862839	Dr. Anil Paranjape	Executive Director	caspheadoffice@gmail.com
18	Family Planning Association of India	202, "Western Court," 1082/1, Ganeshkhind Road, Opp. E-Square Cinema, Pune 411 016	020-25654148	Mrs V. A. Tulpule	Branch Manager	Email-pune@fpaindia.org

ANNEX XVI: HUP PROJECT MANAGEMENT STRUCTURE



ANNEX XVII: SUMMARY OF FINDINGS ON MANAGEMENT AND GOVERNANCE

A summary of findings on management & governance using McKinsey 7-S Framework is presented in figure below.



ANNEX XVIII: STAKEHOLDER INTERVIEW FORMS: PFI AND HUP PARTNERING IMPLEMENTING AGENCIES

State and Municipal Health Offices

General Observations on Local Area Health Status and the HUP Project

I. Local Area Health Status

1. What are some of the health problems among the poor pockets of your catchment area?
2. How do the health centers, municipal hospitals/district health office relate to each other?
3. How do the primary and secondary levels of care link with each other?
4. What is the scope of service provision of primary health structures?
5. How are the national health programs implemented in your city – who implements them, what is the involvement of the municipal apparatus?

HUP Project

1. In your opinion, what are some of the main objectives the HUP Project?
2. Can you describe some of the main ongoing HUP activities in support of urban health?
3. Has the project been playing a useful role in support of urban health initiatives?
4. Are there areas in which HUP could be playing a more effective role?
5. In your view, what are some of the main urban health challenges that the HUP Project might best address during the remainder of its current lifecycle (until 2013)?

II. HUP Technical Assistance to National, State, and Municipal Governments

1. Has HUP enabled better understanding of health needs of the urban poor? To what extent has HUP been able to influence urban health care delivery under NRHM?
2. Can you describe the type of TA that the HUP Project has provided in urban health at the municipal level?
3. What efforts have been made under HUP to promote joint planning by various state departments and municipal corporations?
4. Are there cities and states that have developed city level urban health plans and how are they being addressed in the absence of NUHM or leveraging of NRHM?
5. What efforts have been made by HUP in developing and disseminating methodologies for city level health planning?
6. Can you suggest ways in which HUP TA might more effectively support initiatives in urban health?

III. Sectorial Convergence in Support of Urban Health

1. How has the HUP Project collaborated in the development of joint urban health policy and program formulation/planning? Can you cite a few examples?

2. Has the HUP Project collaborated in improving the implementation of joint urban health programs? How has this implementation been operationalized? Can you cite a few examples?
3. To what extent have HUP's efforts brought various State departments and ULBs (Department of Health and Family Welfare, WCD, and PHED) and Municipal Corporations to converge in planning and implementing urban health initiatives for the urban poor?
4. What effort has been made towards converging with the Jawaharlal Nehru National Urban Renewal Mission (JNNURM)?
5. How has HUP worked with slum development committees? Have convergence programs promoted by HUP been undertaken by these committees? If so, can you cite a few examples?
6. In your opinion, what urban health convergence initiatives should be given greatest priority in future years? For example, in the fields of maternal and child health, environmental health (water and sanitation), infectious disease, non-communicable disease, and nutrition?
7. Are there ways in which future urban health convergence activities could be strengthened? For example, through pooling of funds? Pooling of human resources?
8. Do you have any suggestion for ways in which the HUP Project might play a more useful role in supporting joint urban health programs in the future?

IV. Private – Public Partnerships

1. How would you characterize the current status of Private – Public partnerships (PPP) in urban health? What is the nature of current private-public relationships?
2. Can you cite some examples of how the HUP Project has built more effective urban health synergies in PPP? In corporate social responsibility (CSR)?
3. To what extent have existing slum level committees/Busti Vikas Samitis under JNNURM been engaged in improving access and utilization of health services and improved water supply and sanitation?
4. Are there ways in which social marketing initiatives could be more effectively deployed in support of urban health? What role could your foresee for the HUP Project in this area?
5. In your opinion, are current PPP activities being adequately assessed with respect to effectiveness, the potential for replication, and scale-up?

V. Demonstration Models

1. What are the main features of the urban health demonstration models that are being implemented through the HUP Project?
2. Can you describe how were they developed?
3. Do any other NGOs work in your demonstration area?
4. What are the main strategic objectives of these demonstration models?
5. How are the baseline household listings in demonstration areas being used?
6. Are MIS in place to monitor relevant process and outcome indicators for these demonstration models?

7. Has HUP made efforts to develop more effective referral mechanisms (linkages) between the urban poor and primary and higher levels of the health care system in urban areas?
8. Has there been HUP collaboration with ANM (auxiliary nurse midwife) and Anganwadi community workers in urban slum demonstration sites? If so, can you describe these linkages?
9. How has the project developed operational guidelines for promoting and strengthening Mahila Arogya Samiti (MAS) organizations in demonstration sites?
10. Can you describe the communications (BCC) component in the demonstration models currently being implemented?
11. Have community organizations and other local NGOs participated in the implementation of these models? If so, how has this happened?
12. In your opinion, what elements of HUP's demonstration projects could best support the operationalization of the National Urban Health Mission (NUHM) once it officially comes into being?
13. Is it possible at this early juncture to draw some conclusions about what is working and not working in these demonstration models?

VI. HUP Project Management Systems

1. In your opinion, has the HUP Project been well managed and effectively implemented?
2. Do you have any observations to make on the effectiveness of HUP's (1) project monitoring and review procedures, (2) financial and procurement systems, and (3) delegating roles and responsibility, (4) team deployments and capacity building of PFI and its partnering organizations?
3. Has the HUP Project developed an efficient MIS for monitoring project activities and progress? Has the information been routinely utilized for purposes of project monitoring and evaluation?
4. Do you have any suggestions for how to make the project's MIS more effective for monitoring and evaluating project activities?
5. Have HUP management procedures been effective in analyzing and resolving implementation bottlenecks? If yes, can you cite a few examples?

PFI and HUP Partnering Implementing Agencies

I. General Observations on the HUP Project

1. Can you provide some background on how the HUP Project came into being?
2. In your opinion, what are some of the main objectives of the HUP Project?
3. Can you describe some of the main ongoing HUP activities in support of urban health?
4. Has the project been playing a useful role in support of urban health initiatives?
5. Are there areas in which HUP could be playing a more effective role?
6. Does the HUP project have a frame work for engaging with national, state, and municipal levels of government?

7. In your view, what are some of the main urban health challenges that the HUP Project might best address during the remainder of its current lifecycle (until 2013)?
8. What do partnering organizations hope to achieve through HUP during the remainder of its project cycle?

II. HUP Technical Assistance to National, State, and Municipal Governments

1. Has HUP enabled better understanding of health needs of the urban poor?
2. To what extent has HUP been able to influence urban health care delivery under NRHM?
3. What is the current practice in planning urban health initiatives?
4. Does NRHM cover all aspects of the health care needs of the urban poor? If not, what additional priority health care needs currently exist for the urban poor?
5. Can you describe the type of TA that the HUP Project has provided in urban health at the (national, state, municipal) level?
6. Has the TA from the HUP Project been appropriate for addressing health needs of the urban poor?
7. Has this TA been provided in a timely and effective manner? If not, why not?
8. How have the special research studies undertaken by the project been utilized?
9. What efforts have been made under HUP to promote joint planning by various state departments and municipal corporations?
10. Are there cities and states that have developed city level urban health plans and how are they being addressed in the absence of NUHM or leveraging of NRHM?
11. What efforts have been made by HUP in developing and disseminating methodologies for city level health planning?
12. Can you describe ways in which HUP is promoting greater health seeking behavior among women in urban slum areas?
13. Can you suggest ways in which HUP TA might more effectively support initiatives in urban health?

III. Sectorial Convergence in Support of Urban Health

1. How has the HUP Project collaborated in the development of joint urban health policy and program formulation/planning? Can you cite a few examples?
2. Has the HUP Project collaborated in improving the implementation of joint urban health programs?
3. How has this implementation been operationalized? Can you cite a few examples?
4. To what extent have HUP's efforts brought various State departments and ULBs (Department of Health and Family Welfare, WCD, and PHED) and Municipal Corporations to converge in planning and implementing urban health initiatives for the urban poor?
5. What effort has been made towards converging with the Jawaharlal Nehru National Urban Renewal Mission (JNNURM)?
6. How has HUP worked with slum development committees? Have convergence programs promoted by HUP been undertaken by these committees? If so, can you cite a few examples?

7. In your opinion, what urban health convergence initiatives should be given greatest priority in future years? For example, in the fields of maternal and child health, environmental health (water and sanitation) infectious disease, non-communicable disease, and nutrition?
8. Are there ways in which future urban health convergence activities could be strengthened? For example, through pooling of funds? Pooling of human resources?
9. Do you have any suggestion for ways in which the HUP Project might play a more useful role in supporting joint urban health programs in the future?

IV. Private – Public Partnerships

1. How would you characterize the current status of Private – Public partnerships (PPP) in urban health?
2. What is the nature of current private-public relationships?
3. Has there been a compendium made of different models of PPP initiatives for the health sector?
4. Has the HUP Project undertaken mapping of potential PPP partners?
5. What advocacy efforts have been undertaken to promote PPP through potential partners?
6. Can you cite some examples of how the HUP Project has built more effective urban health synergies in PPP? In corporate social responsibility (CSR)?
7. To what extent have existing slum level committees/Busti Vikas Samitis under JNNURM been engaged in improving access and utilization of health services and improved water supply and sanitation?
8. Are there ways in which social marketing initiatives could be more effectively deployed in support of urban health?
9. What role could your foresee for the HUP Project in this area?
10. In your opinion, are current PPP activities being adequately assessed with respect to effectiveness, the potential for replication, and scale-up?

V. Demonstration Models

1. What are the main features of the urban health demonstration models that are being implemented through the HUP Project?
2. Can you describe how were they developed?
3. Has HUP undertaken systematic gap analysis studies of urban health needs in demonstration sites to better prioritize project initiatives?
4. Do any other NGOs work in your demonstration area?
5. What are the main strategic objectives of these demonstration models?
6. How are the baseline household listings in demonstration areas being used?
7. Are MIS in place to monitor relevant process and outcome indicators for these demonstration models?
8. Has HUP made efforts to develop more effective referral mechanisms (linkages) between the urban poor and primary and higher levels of the health care system in urban areas?

9. Has there been HUP collaboration with ANM (auxiliary nurse midwife) and Anganwadi community workers in urban slum demonstration sites? If so, can you describe these linkages?
10. How has the project developed operational guidelines for promoting and strengthening Mahila Arogya Samiti (MAS) organizations in demonstration sites?
11. Can you describe the communications (BCC) component in the demonstration models currently being implemented?
12. Have community organizations and other local NGOs participated in the implementation of these models? If so, how has this happened?
13. In your opinion, what elements of HUP's demonstration projects could best support the operationalization of the National Urban Health Mission (NUHM) once it officially comes into being?
14. Is it possible at this early juncture to draw some conclusions about what is working and not working in these demonstration models?
15. In conclusion, what categories of activities/strategies have worked well, which may require an amendment in approach, and have there been significant implementation impediments for the project?

VI. HUP Project Management Systems

1. In your opinion, has the HUP Project been well managed and effectively implemented?
2. Do you have any observations to make on the effectiveness of HUP's (1) project monitoring and review procedures; (2) financial and procurement systems; (3) delegating roles and responsibility; and (4) team deployments and capacity building of PFI and its partnering organizations?
3. How would you characterize working relationships between PFI and its sub-partners?
4. Are there ways in which these working relations could be strengthened?
5. Has the HUP Project developed an efficient MIS for monitoring project activities and progress?
6. Has the information been routinely utilized for purposes of project monitoring and evaluation?
7. Do you believe current reporting requirements for the project are reasonable?
8. Do you have any suggestions for how to make the project's MIS more effective for monitoring and evaluating project activities?
9. Have HUP management procedures been effective in analyzing and resolving implementation bottlenecks? If yes, can you cite a few examples?

Community Organizations and Health Facilities

I. At the Community Level

1. What are some of the major health problems of this community?
2. Where does this community seek curative care from? How far are these facilities?
3. Where does the community seek preventive care from? How far are these facilities?
4. Are there any other facilities nearby? Why they are not utilized?

5. Who are the public providers visiting this community? (Probe for ANMs, health visitors, TB workers, other NGO workers)
6. What are the health inputs being provided by the Aanganwadi centers in the community?
7. When was the MAS formed?
8. Why did you want to join the MAS? What determines your continued participation in the MAS?
9. What inputs have you received from the HUP program?
10. Can you give us some examples of how you have benefitted?
11. What are the other health inputs that if introduced by HUP, will benefit the community?

II. At the Health Facility Level

1. What is the catchment area of this facility?
2. What is the scope of service provision – only curative – combines preventive, combines supervision to lower facility, or receives supervisory support from higher facility, has referral linkage?
3. Timing of services and human resources available – are there any gaps?
4. Does the facility have chlorine tablets? What is the current stock?
5. What are some of the health problems among the poor pockets of your catchment area?
6. If the facility a primary level structure – what is the stock of malaria prophylaxis, ORS and chlorine tablets?
7. What is your association with HUP – formal/informal? Scope?
8. What inputs has this facility received from HUP? Capacity building? Gap analysis? Outreach strengthening, community mobilization, community awareness?
9. In your opinion which have been the most important contributions of the HUP? What other inputs from HUP will make a difference to the state of health in your catchment area?

ANNEX XIX: HUP INDICATORS BY EFFECTIVENESS AREAS

TA EFFECTIVENESS AREA	HUP TA EFFECTIVENESS INDICATORS			
	INPUTS	PROCESSES	OUTPUTS	OUTCOMES
Timeliness *Is the TA able to keep pace with reasonable and relevant assistance needs of the implementing agency?*	Currently not measured by any indicator			
Relevance	• Number of advocacy events/ symposiums/seminars organized • No. of exposure visits and cross • visits to successful convergence • models • No. of cities where slum and • facility mapping and vulnerability assessment conducted • No. of baseline or feasibility studies conducted	• No. of meetings of State Counter Part teams/Coordination forum • Number of state/ city Project Implementation Plans (PIPs) • prepared with recipient's • support • No. of meetings of city multi-stakeholder coordination • committee organized	• Number of service delivery models developed/strengthened in collaboration • with private/commercial sector • No. of city demonstration and learning • models developed and documented	• Number of new cities • developed (output) and implemented urban health • plans (outcome) • Number of new cities • implementing city programs • with learning from USAID supported demonstration • and learning sites
Flexibility and Responsiveness	Currently not measured by any indicator			
Quality	No. of training programs/ sensitization sessions organized for staff and different stakeholders No. tools (MOUs, EOI/ToR/evaluation criteria) developed for establishing Partnership	No. of program planning and review meetings/workshops at state level No. of study tours organized for government/ and other stakeholders Number of states provided TA through urban health cells or consultants with recipient's support No. of consultations/meetings for sharing best practices on PPP	Number of reports / Program lessons, documentation published/ disseminated Lessons of community level convergence are documented and adopted by NUHM/urban components of NRHM	

Sustainability	Number of local institutions identified/developed to provide TA to NUHM/urban components of NRHM on sustainable basis No. of potential partners identified for resource leveraging		Number of reports / Program lessons, documentation published/ disseminated Number of dissemination events organized for the key officials from MOHFW, MoH&UPA and MoWCD with recipient's TA support Number of MOUs signed by state/city governments with non-government and commercial sector partners through recipient's TA No of USAID partners having convergent actions in their work-plans Number of CRM/JRM/JMM of NUHM with participation of officials from Housing & Urban Poverty Alleviation and Women & Child Development	No. of letters jointly issued by Departments of Health and Family Welfare, Housing and Urban Poverty Alleviation and Woman and Child Development Number of cities with models of convergence between NUHM/Urban components of NRHM and JNNURM/ICDS

ANNEX XX: MCH/RCH APPROACH TO TA

TA AREAS	TA INPUTS
Support Planning for strengthening urban MCH/RCH programming	• Gap analysis in delivering MCH/RCH services in urban areas • How will primary and secondary care be provided? Which facilities will provide them? • What services will be provided? • How will adequacy and utilization (quality of services) addressed? • How will these be measured by the government?
Support Implementation of urban RCH/MCH interventions	• Rationalize all available RCH facilities (whether with health or urban development department) to increase adequacy • Address governance and human resource issues through PIPs • Strengthen definition of MCH/RCH services - develop services norms • Develop guidelines for quality of services • Develop or strengthen M&E systems • Support convergent activities • Support additional financing through PPPs and insurance • Support community mobilization to increase demand
Support M&E of urban RCH program	• Rationalize and strengthen current MIS • Design and implement operational research to demonstrate various models • Support utilization of data for feedback and decision making • Lay the ground for expanding urban health programming beyond MCH/RCH

ANNEX XXI: Capacity Building (CB) Efforts of HUP

CB AREA	AUDIENCE	TOOLS	RESULTS
Orientation to Urban Health	Key stakeholders of states c- health, WCD, Urban Development departments; City urban local bodies	Workshops with presentations on situation of urban health and national best practices	Effective; all stakeholders cited this effort as the reason for generating interest and awareness about urban health in the states. The Odisha approach discussed elsewhere in the report was seen as an effective approach to facilitating leadership within the three key departments.
Maternal and child health	Providers of urban health clinics	Training modules covering areas of antenatal, delivery, post natal care; early childhood interventions including breast feeding, immunization and childhood diseases Health Entitlements	Appreciated by workers; capacities not assessed by MTA team; continued hand holding, refreshers and training in managing (as opposed to technical) MCH delivery will be required
	Project front line workers		Effective; front line workers well versed in MCH technical issues; additional efforts will be required to facilitate critical analysis of public health delivery management to strengthen MCH; For example; organizing a place for carrying out antenatal care, identifying absence of chlorine tablets at facility as a deterrent to preventing childhood illnesses. NGO staff highlighted the need to include them in CB efforts as an approach to sustainability.
Health and nutrition days	Implementers from Health and WCD departments ANMs and ASHAs AWWs Project front line workers	Guidelines for carrying out HNDs Comprehensive guidelines covering all anticipated technical areas	Trained workers have the knowledge about components of HND; however face implementation difficulties to comprehensively provider HNDs. Additional hand holding will be required to support capacities in

			management of HNDs NGO staff highlighted the need to include them in CB efforts as an approach to sustainability.
Mother and child tracking	Orientation to health department; Training to providers of urban health centers; project front line workers	Training on using the tracking formats; hand holding support	Analysis of a small sample of filled formats indicates differential capacities in HUP states. Continued hand holding will be required to effectively track children and utilize data. In addition mechanisms for integrating this within health department's HMIS will be required.
Mother and child nutrition	Providers of urban health centers; AWWs, project front line workers	Yet to be implemented	NA
WASH			
Urban health programs	Key stakeholders of the three departments	Cross Learning Visits	Much appreciated by stakeholders and frequently cited as a highlight of UHP during discussions. Palpable understanding of urban health among stakeholders indicates to the success of some of UHP's CB approaches
CB through TA	Government functionaries at all levels	Several efforts – from research, to presentation of evidence, negotiations, workshops, drafting of documents	The capacity building efforts through technical assistance are often unquantifiable and attribution of results difficult. However, MTA team feels that the constant presence and participation of HUP team does contribute to increasing capabilities within government to do things differently.

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