



FRAMEWORK ON CONVERGENCE

MoHFW, MoUD & Others

National Urban Health Mission

**Ministry of Health & Family Welfare
Government of India**



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Nirman Bhavan, New Delhi-110011

Preface

The National Urban Health Mission (NUHM), a sub-mission of National Health Mission recognizes that inter-sectoral and intra-sectoral convergence as essential elements for success of National Health Programmes.

NUHM has taken an important step to promote inter-sectoral and intra-sectoral convergence for accelerating improvements in health outcomes, particularly by addressing social and environmental determinants. The challenges in urban areas are very different from those in rural areas. One significant challenge is that of social inclusion and ensuring that health interventions reach the most marginalized of all. In this regard an integrated approach is crucial by involving all the stakeholders to address the social and environmental determinants for good health with strong planning and co-ordination.

I am happy to see that Swachh Bharat Mission (SBM) and National Urban Livelihood Mission (NULM) have come forward and actively supported the initiative of Convergence. This has resulted in the development of Framework on Convergence between NUHM, SBM and NULM which lays down principles for implementing interventions related to convergence with focus on social and environmental aspects in urban areas. This will help the ULBs, different stakeholders, frontline workers etc at state/city/district levels to maximise health investments and multiply health gains.

The States/UTs are encouraged to adapt the framework to their specific contexts and to work jointly in building upon and refining these to ensure improved coverage and access of the urban poor and in particular, the marginalised, to primary health care.

I commend the efforts undertaken by the Urban Health Division of the Ministry and other experts/partners in bringing out this document, which will be a good resource for all the concerned stakeholders associated with NUHM.




(Preeti Sudan)



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Foreword

The implementation of National Urban Health Mission (NUHM) has benefitted from the experience of National Rural Health Mission (NRHM). The roll out of the NUHM has however, faced challenges because of the target population, their health seeking behaviour, quality of habitation and poor access to basic resources such as water and sanitation.

In the National Health Policy 2017, there is a paradigm shift and emphasis is laid on the importance of achieving convergence among wider determinants of health and improving the environment for health. It is now imperative that we join hands and utilize this opportunity to address the root causes of ill health by providing quality primary healthcare services with prime focus on access to safe water and sanitation to all and an enabling environment for sustainable livelihood.

NUHM has taken sincere steps to promote inter-sectoral and intra-sectoral convergence to strengthen the health system. The main objective of convergence is to enhance the utilization of the system through provision of a common platform and availability of all services at one point. This convergence of activities will not only improve the quality of services but also do away with the duplication of action thereby saving valuable resources and time in the process.

Thus Ministry of Health & Family Welfare in its commitment to build up holistic environment covering health, sanitation and livelihood has endeavoured to develop the Framework on Convergence between National Urban Health Mission (NUHM), Swachh Bharat Mission (SBM) and National Urban Livelihood Mission (NULM).

I believe this document which outlines the objectives, rationale, roles & responsibilities, monitoring indicators etc will help the various stakeholders, officials, ULBs, frontline workers at state/city/district levels to develop convergence plan for better health outcomes.



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Foreword

The National Urban Health Mission (NUHM) aims to improve the health status of the urban population with special focus on the urban poor, disadvantaged and vulnerable population. Providing primary healthcare to the vulnerable and disadvantage groups in the urban area is core focus of National Urban Health Mission (NUHM). Addressing these needs require an understanding of their living conditions, everyday challenges and impact of external environment on the physical and mental wellbeing.

It would require an integrated approach involving different stakeholders to address the social determinants of health, focus on convergence and co-ordination between departments. Keeping, this in view, sincere efforts have been made to develop the Framework on Convergence between the flagship programmes of National Urban Health Mission (NUHM), Swachh Bharat Mission (SBM) and National Urban Livelihood Mission (NULM). The framework systematically provides guidance on the roles & responsibilities, planning process, capacity building and such other areas. The document would be of use to the wide range of stakeholders including officials, planners, executives and also the frontline workers at state, city and district levels in addressing urban health challenges.

I am sure this document will help not only the state officials of National Health Mission (NHM) including National Urban Health Mission (NUHM) & National Rural Health Mission (NRHM) but also the other departments & stakeholders involved in delivering the services to the urban population in a comprehensive manner.

I appreciate the efforts put in by Urban Health Division of MoHFW, NEISRC and other experts in drafting this document which will provide guidance to the states for planning and implementing convergence activities.



Preeti Pant
(Preeti Pant)



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Acknowledgement

Intersectoral convergence is one of the priority areas for successful implementation of primary health care in urban areas. A holistic approach for comprehensive primary health care in urban areas calls for collaboration of activities of various stakeholders. The implementing authorities of NUHM in the states are in need of guidance to develop a platform for Intersectoral convergence activities. It is also felt that an indicative framework would be helpful for the states to engage different stakeholders in a pathway that has a semblance of uniformity. But it is easier to say than to create an appropriate document in this regard. A thorough exercise involving various resource persons has resulted in this document after a long process of vetting and reviewing by the peer bodies.



I am thankful to all those who have supported this attempt and contributed substantially in this endeavour. Experts from SBM and NULM have been embedded in this venture by providing their insights and comments in their areas of expertise. Entire team of NHSRC under the guidance of Dr. Rajani Ved, Dr. J.N. Srivastava and Dr. Himanshu Bhushan have edited and reviewed the entire document and finalised it for submission and publication. My special thanks go to Dr. Ranjini Gopinath and Dr. Sonali Rawal who have taken extra pain to go through the document and provided their valuable inputs into it.

Ms. Sudipta Basa, Senior Consultant, NUHM has been involved in this exercise from the very first and has been the pivotal to create and revise time and again as per the inputs received. The publication would have not been possible but for her relentlessness.

Lastly I must express my gratitude to the Joint Secretaries of Urban Health, NULM and SBM to reach to an agreement to provide a roadmap for convergence. I am thankful to Dr. Rajeswara Rao, the then Joint Secretary and Ms. Presti Pant, the Joint Secretary for guidance they have given to finalise the document. Finally I am thankful to our respected Secretary Health, Ms. Presti Sudan and the AS&MD, Sh. Manoj Thakuri for their encouragement and understanding of the issue at hand and expediting the release of the document.

(Dr. Basab Gupta)

ABBREVIATION

NUHM	NATIONAL URBAN HEALTH MISSION
UD/M&UD	URBAN DEVELOPMENT/MINISTRY OF URBAN DEVELOPMENT
HUPA	HOUSING AND URBAN POVERTY ALLEVIATION
ULB	URBAN LOCAL BODY
SBM	SWACHH BHARAT MISSION
NULM	NATIONAL URBAN LIVELIHOOD MISSION
MAS	MAHILA AROGYA SAMITI
ASHA	ACCREDITED SOCIAL HEALTH ACTIVIST
ANM	AUXILIARY NURSE AND MIDWIFE
IT	INFORMATION-TECHNOLOGY
NHM	NATIONAL HEALTH MISSION
HFW	HEALTH AND FAMILY WELFARE MINISTER
AS&MD	ADDITIONAL SECRETARY & MISSION DIRECTOR
CM	CHIEF MINISTER
CS	CHIEF SECRETARY
DM	DISTRICT MAGISTRATE
UHD	URBAN HEALTH & NUTRITION DAY
HBNC	HOME BASED NEONATAL CARE
ANC/PNC	ANTE/POST-NATAL CARE
U-PHC	URBAN PRIMARY HEALTH CENTRE
RCH	REPRODUCTIVE-CHILD HEALTH
ODF	OPEN DEFECATION FREE
PMU	PROGRAM MANAGEMENT UNIT
IEC	INFORMATION EDUCATION COMMUNICATION
BCC	BEHAVIOURAL CHANGE COMMUNICATION
SHGs	SELF HELP GROUPS
WASH	WATER SANITATION AND HYGIENE
IDCF	INTENSIFIED DIARRHEA CONTROL FORTNIGHT
ALF/CLF	AREA/CITY LEVEL FEDERATION
MO	MEDICAL OFFICER
DPM	DISTRICT PROGRAM MANAGER
CHO/DHO	CITY/DISTRICT HEALTH OFFICER
U-CHC	URBAN COMMUNITY HEALTH CENTRE
JS	JOINT SECRETARY
DC-UH	DEPUTY COMMISSIONER-URBAN HEALTH
MHO	MUNICIPAL HEALTH OFFICER
NGO	NON-GOVERNMENT ORGANISATION
MC	MUNICIPAL COMMISSIONER
ICDS	INTEGRATED CHILD DEVELOPMENT SCHEME
DP	DEVELOPMENT PARTNER
IAPSM	INDIAN ASSOCIATION OF PREVENTIVE AND SOCIAL MEDICINE
IAP	INDIAN ASSOCIATION OF PHYSICIAN
FOGSI	FEDERATION OF OBSTETRICS AND GYNAECOLOGIST OF INDIA
OPD/IPD	OUTPATIENT/INPATIENT DEPARTMENT
SN	STAFF NURSE
AWW	ANGANWADI WORKER



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PARADIGM OF HEALTH: A CONVERGENT ISSUE



National Urban Health Mission is committed to create an enabling environment for delivery of quality, primary health care with equity, sustainability and affordability for urban population with a focus on the vulnerable and marginalised segments. Mandated also to focus on critical public health issues such as sanitation, clean drinking water, vector control etc. and strengthening public health capacity of Urban Local Bodies.

(Frame work for Implementation, NUHM Para1.10)

1.1 Introduction:

Urban localities are characterized by high economic activity, diversity of livelihood opportunities and rapid infrastructure development. These urban-pull factors, together with the rural-push factors (lack of land holdings and economic opportunities lead to high rural to-urban migration rates, causing the population density of cities to surpass the threshold of available resources, which are essential to sustain a safe and healthy living environment.

Since land and good quality housing are limited in cities, migrants are forced to live in slum settings with poor sanitation, water supply and inadequate spaces, exposing them to different kinds of vulnerabilities. Proliferation of overcrowded slums leads to severe competition for basic natural resources like land, water and clean air causing serious implications on population health.

Social Determinants of Health:

Health in urban areas is determined more by factors outside the purview of health, than by health sector itself. All the urban factors like nutrition, housing, education, water and sanitation, physical environment, financial status, social support networks, employment conditions, literacy and education, culture, availability of parks and recreational facilities etc. have significant bearing on shaping the health and lives of people living

in cities. These together are therefore important social determinants which affect the health of urban population, particularly the slum dwellers and vulnerable.

Owing to plethora of aforesaid social determinants, health problems in urban areas calls for active intervention from multiple stakeholders, which needs well co-ordinated convergent actions. National Urban Health Mission was therefore launched in 2013, as a sub-mission under the National Health Mission to cater to these unique and diverse needs of urban areas. NUHM was designed to provide a common platform for all the departments to work in cooperation for improving the livelihood and health conditions in urban areas.

1.2 Convergence & its Objectives:

Convergence is defined as building partnerships with institutions and actors both within the health and across other related sectors through integrated planning at the city level, with the objectives of achieving best utilization of the established system and avoiding duplication of resources. Reducing health inequities and improving the health status of urban population relies on alignment of all the major sectors along with health sector. It has been internationally established as a critical function in Article-II of WHO

constitution" as well as Article-VII(4) of the Alma Ata declaration**

Convergence is one of the key strategies under NUHM, which tries to build partnerships with actors and institution within health and across other related sectors. It has expanded the scope of the program to include management of social determinants along with provision of clinical services, simultaneously addressing the curative, preventive and promotional aspects of healthcare. Hence the program opens ground for Ministries and departments other than Health Ministry, to work collaboratively in urban areas. It can be classified into two types; Intersectoral and Intra-sectoral.

Inter-sectoral:

It is defined as the cooperation or coordination established between different Sectors or Ministries

Urban Health Care: National health policy prioritizes addressing the primary health care needs of the urban population with special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants. Policy would also prioritize the utilization of AYUSH personnel in urban health care. Given the large presence of private sector in urban areas, policy recommends exploring the possibilities of developing sustainable models of partnership with for profit and not for profit sector for urban health care delivery. An important focus area of the urban health policy will be achieving convergence among the wider determinants of health – air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress. These dimensions are also important components of smart cities. Healthcare needs of the people living in the peri urban areas would also be addressed under the NUHM. Further, Non-Communicable Diseases (NCDs) like hypertension, diabetes which are predominant in the urban areas would be addressed under NUHM, through planned early detection. Better secondary prevention would also be an integral part of the urban health strategy. Improved health seeking behavior, influenced through capacity building of the community based organizations & establishment of an appropriate referral mechanism, would also be important components of this strategy.

(Para 3.3.3, National Health Policy 2017)

The policy also speaks of convergence of various sectors/stakeholders to promote preventive and promotive health.

Preventive and Promotive Health: The national health policy recommends the institutionalization of inter-sectoral coordination at national and sub-national levels to optimize health outcomes, through constitution of bodies that have representation from relevant non-health ministries. This is in line with the emergent international "Health in All" approach as complement to Health for All. The policy prerequisite is for an empowered public health cadre to address social determinants of health effectively, by enforcing regulatory provisions.

(Para 3.2, National Health Policy 2017)

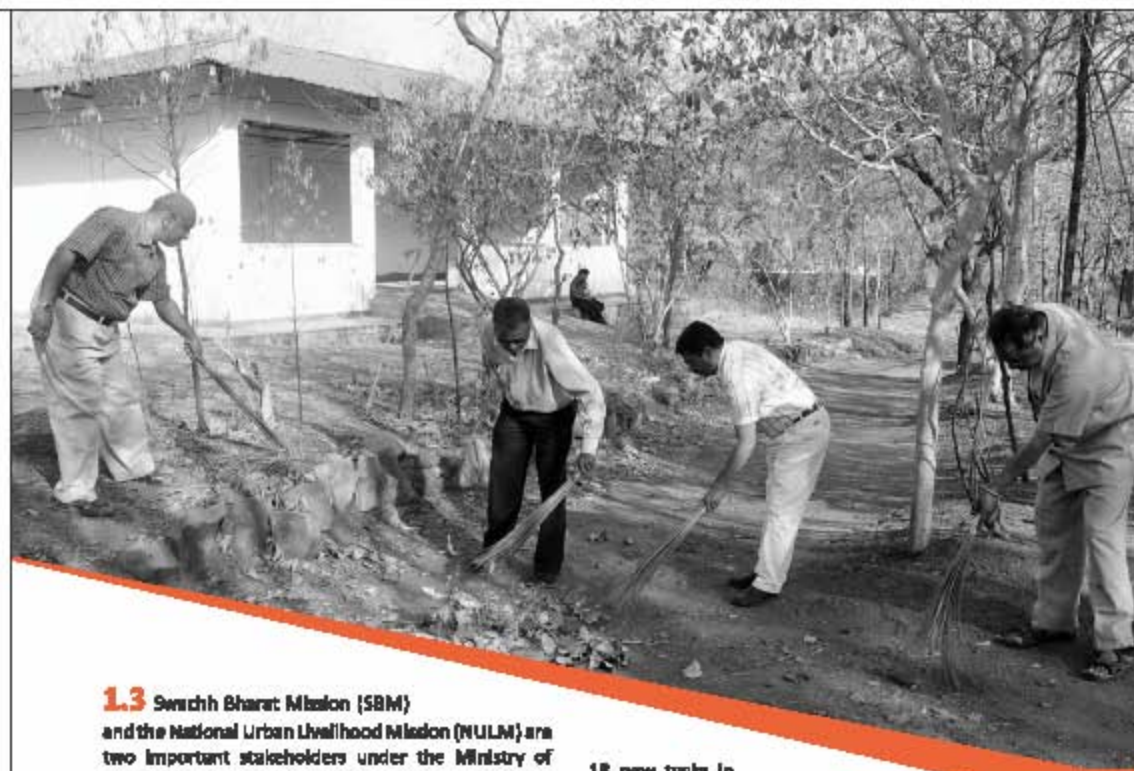
entering to water, sanitation, waste management, housing, nutrition, education etc.

Intra-sectoral:

It is defined as the cooperation or coordination established between different departments/ divisions within the same Ministry, such as TB, vector Borne diseases, Non-communicable diseases, HIV/AIDS, Maternal and Child health, Family Planning etc.

Intra-sectoral Convergence:

In 2017 the NHP has been announced and there is a paradigm shift in Health Policy which emphasizes the importance of achieving convergence between different sectors to manage wider determinants of health and improving the environment for health in urban areas.



1.3 Swachh Bharat Mission (SBM)

and the National Urban Livelihood Mission (NULM) are two important stakeholders under the Ministry of Housing and Urban Affairs, which are committed to achieve cleanliness, sanitation and livelihood for the urban vulnerable population. Among others, cleanliness and sanitation are also the key components for quality health care. It is therefore vital to develop strong convergence between Ministry of Health and Ministry of Urban Development.

ULB has key role in implementation of major missions and programs at the grass-root levels in urban areas, hence the role of ULBs is very important in establishing convergence. An illustrative list of functions that may be entrusted to the municipalities were listed in the Twelfth Schedule of the Constitution which had defined

18 new tasks in the functional domain of the ULB for urban areas, including Public Health as sixth task on the list. (See Chapter-1 for Details)

1.4 Keeping in view of the above, a convergence platform has been developed where in all the three Missions namely NUHM, SBM, and NULM can synergistically play their role through the Urban Local Body structures and institutions, to uplift the health status of the urban population in a holistic manner.



ROLE OF URBAN LOCAL BODIES FOR INTERSECTORAL CONVERGENCE

2.1 The 74th Constitution Amendment 1993 has enabled the municipalities to have self control over the functionality, funding and governance to a large extent and are governed under the State Municipal Act. This amendment also made provision for creation of ward level committees in the municipal mechanism. As per the 12th Schedule of the Article 243w of the Constitution following the 74th Amendment, the following functions are enumerated for Urban Local Bodies:

1. Urban Planning Including Town Planning	10. Slum improvement and Up gradation
2. Regulation of Land use and Construction of Buildings	11. Urban Poverty Alleviation
3. Planning for Economic and Social Development	12. Provision of Urban amenities and facilities like Parks, Gardens, Play grounds
4. Roads and Bridges	13. Promotion of Cultural, Educational and Aesthetic aspects
5. Water Supply Domestic, Industrial and Commercial Purpose	14. Burials and burial grounds, Cremations, cremation grounds and Electric Cremation
6. Public Health, Sanitation, Conservancy & Solid Waste Management	15. Cattle Pounds, Prevention of cruelty to animals
7. Fire Services	16. Vital statistics Including Registration of Birth and Death
8. Urban Forestry, Protection of Environment and Promotion of Ecological aspects	17. Public Amenities including Street Lighting, Parking Lots, Bus stops and Public Convenience
9. Safeguarding the interest of the Weaker section of the society, including the Handicapped and Mentally retarded	18. Regulation of Slaughter Houses and Tanneries

(Schedule 12th, Article 243w, Indian Constitution)

2.2 The above functions of the ULBs, as obligated by the Constitution, show that, ULB has a mandate to fulfill these functions and developing an intersectoral convergence with them, can be beneficial to both the ministries. Ministries of UD, HUPA and the Ministry of Health and Family Welfare are the primary stakeholders to implement their programs through the ULBs in metro cities. Therefore a stable and viable ULB structure becomes beneficial for the program implementation to be successful.

2.3 The role and responsibilities of the ULBs in the context of Health, and under the aegis of the three Mission Programs namely SBM, NULM and NUHM may be summarized as below:-

- Support in situational analysis of urban health and its determinants;
- Supporting in mapping and vulnerability assessment under NUHM
- Coordinated vector control measures; and execution of its core functions of solid waste management and preventive vector control;
- Joint monitoring of program implementation
- Participation in city health planning in terms of infrastructure and human resources; Rationalization of health facilities;
- Provision of budgets for contractual human resources
- Identification of land, its acquisition, or allocation for health facilities;
- Provision of budgets for medicines from ULB budget
- Epidemic planning and management
- Coordinated management of water contamination episodes
- Implementation of urban development programs/ schemes in coordination with NUHM to better target the vulnerable populations



FRAMEWORK OF THE CONVERGENCE: THE MECHANISM

These convergence action points have been articulated after consultation with SBM and NULM during series of meetings and discussions.

3.1 The major convergent action points have been delineated and a draft convergence framework formulated as under:

1. Planning Process For Convergence
2. Capacity Development for Convergence
3. Implementation of Activity based Convergence
4. Monitoring of the Deliverables under Convergence
5. Indicators of Convergence Implementation
6. Way Forward and Time Line (As Annexure)

1. PLANNING PROCESS FOR CONVERGENCE

The institutional mechanism of NHM includes convergence at the highest level by the inclusion of the Ministries of Housing and Urban Affairs, Women and Child Development, Rural Development and Drinking Water and Sanitation as key members of the Mission Steering Group. Similarly, states may institutionalize the planning process for convergence by forming relevant Committees or Convergent teams at each of the levels mentioned below.

Stakeholders	NUHM	SBM	NULM	ULB	OTHERS*
At Ward Level	MO/ANM/ASHA/PHM	Representative	Representative	Ward Councillor Ward Official Sanitary Inspector	PHED, NGOs
At City Level	DPM, MO(UHC/Dispensary/UPHC)	Nodal Officer	Coordinator	Mayor MHO	ICDS, NGOs
At District Level	CHO/DHO/URCHO MO(UPHC), I/C (UHC), Nodal Officer (NUHM)	Project Officer	Project Officer	Mayor/MC/DM AC(Health), MHO, Slum Improvement Officer	NHGOs/DP/ Medical College/ Education/IC DS/PHED
At State Level	Mission Director, NHM State Nodal Officer	Mission Director	Mission Director	Senior most Pr. Secretary-(Health/ UD) Municipal Commissioner	ICDS/Medical College/ NGOs/DPs
At National Level	JS NUHM - Convenor DC-NUHM Director - NUHM	JS SBM-Co Convenor Director SBM	JS NULM-Co Convenor Director NULM	Representation from UD/HUPA	NGOs/IAPSM/ DPs/IAP/FOGSI

*Representation from professional bodies like IAP, FOGSI, IMA to be included at local levels

Members of the committees/convergent teams shall depend upon the availability, relevance and priority as decided by the states. A balance has to be maintained between quality and quantity.

In some cases e.g. Ward Sanitation Committee is envisaged under the SBM. ULBs have Coordination committees at ward and zonal levels. Representative from NUHM/NHM to be included in the committees instead of establishing a parallel structure. State may further decide to establish working groups to ensure convergent actions for a) jointly implementing state specific and national urban programs; b) sanitation; c) and vector/epidemic control¹.

2. CAPACITY DEVELOPMENT

TRAINEE	KEY FUNCTION	TRAINING NEED	TRAINING METHOD
Central and State Leadership Directors, MDs, Additional MDs	<ul style="list-style-type: none"> Policy Strategy Planning Monitoring & Evaluation Financial Accountability 	<ul style="list-style-type: none"> Orientation about Urban Health & NUHM Synergy among the programs Orientation of Technical Resource for Convergence 	<ul style="list-style-type: none"> Workshop Audio Checklist Sharing of Best practices Visit at demonstration sites
State Nodal Officers, Convergence Consultants, Planning Consultants	<ul style="list-style-type: none"> Program Planning Monitoring Financial Management 	<ul style="list-style-type: none"> Mechanism of Convergence under NUHM Orientation about state level schemes and programs for urban poor ULB Function Convergence Planning Techniques PPP Involvement Reporting and Analysis & Monitoring 	<ul style="list-style-type: none"> Induction Training Orientation Training- Creation of Module by compilation of details of schemes/programs in the state Workshop –Group work on Convergence Planning Cross Learning On-line Training facility for reorientation and refresher training (Remote)
HMIS Data Manager & State M&E Manager	<ul style="list-style-type: none"> Data feeding, viability checking, analysing and monitoring 	<ul style="list-style-type: none"> Development of KPI Strengthening of HMIS Data Sharing with stakeholders 	<ul style="list-style-type: none"> Workshop sessions on HMIS Data
District and City level officers of the PMU and the ULBs including Epidemiologist	<ul style="list-style-type: none"> Planning, Monitoring, Financial Management at City level and To support Implementation 	<ul style="list-style-type: none"> Orientation to Convergence needs and mechanism Orientation about ULB functioning Orientation about NUHM Framework and Core Strategy Mapping Data Capturing and Analysing Role of NGOs/Private Players 	<ul style="list-style-type: none"> Induction Training Workshop on related subjects Group Work for Planning Cross Visits On-line Training facility for re-orientation and refresher training (Remote)
All the stakeholders listed as convergent team members at the City level	<ul style="list-style-type: none"> Overall Implementation of Program Micro-planning Monitoring Capacity Building 	<ul style="list-style-type: none"> Orientation about the stakeholders ULB Functioning Training for Convergence Planning Partnership with NGOs and other private players Data capturing, Data Flow and Analysis 	<ul style="list-style-type: none"> Induction Training on the basis of a composite Training module prepared for the convergence purpose Field visits Workshop On-line training facility for reorientation and refresher training (Remote)

¹Refer to D.O no.L.19017/38/2017-NUHM dated 25th July,2017 Issued by MoHFW for additional guidance about possible Institutional mechanisms, their composition and roles.

ACTIVITIES FOR IMPLEMENTATION THROUGH CONVERGENCE ACTIONS

ACTIVITY	NUHM	SBM	NULM
Achieving ODF	As per the population Norms of the UPHC/UCHC ODF to be incorporated into Kayakalp parameters. Prioritize the ODF in NUHM cities.	Make SBM incentives available to participating functionaries of other Missions within the geographically delineated ODF area. Support local health facility with Solid & Liquid Waste Management and attaining score under the Kayakalp thematic area 'Outside boundary wall'	Night shelters, Vending places, migrant/vagrants to be part of ODF movement
Common Resource Pool SWACHHAGRAHI	ASHA, ANM, MAS to be part of the Swachhagrahi movement and also focus on BCC.	Volunteers having eligibility to be ASHA/MAS member would be recognized as Swachhagrahis where ASHA and MAS are weak and also focus on BCC.	SHGs(ALF/CLF) having eligibility to be ASHA/MAS member would be accredited where ASHA and MAS are weak and also focus on BCC
National Programs	NUHM in urban areas to stress on the National Initiatives such as Importance of Deworming and IDCF, WASH programs implemented by NHM	Support the National Programmes which are directly or indirectly influenced by sanitation and cleanliness.	Involvement in integrating the health and sanitation programs among the NULM clientele (support from ALF/CLF)
Vulnerability Mapping	Utilization of mapping done by SBM and NULM for slum and vulnerability mapping	Support NUHM with its data resources	ALF/CLF actively support ASHA/ANM for vulnerability mapping along with their data resources (Pavement dwellers, Night shelters/ vagrant/Vendors)
Outreach Activities	May organise outreach camps at NULM structures such as Night shelters, Homeless Centres, NULM Program Centres; Can disseminate SBM messages during the outreach camps	Outreach platforms can be used by SBM for their message dissemination- Behavioural Change Communication	Avail health care support for the vulnerable group mapped under NULM by creating a systematic per schedule.

ACTIVITY	NUHM	SBM	NULM
Micro-Sanitation Plan	Support the ULBs in identifying vector breeding sites. Catchment area wise plan for each facility; Identification and referral and follow up of malnourished children; Data sharing from household and vulnerability surveys. Plan to be part of the QA exercise	Addressing source reduction through ULBs. Nomination of External Member for Kayakalp External Assessment. Support Health Facility (U-PHC/UJHC) in Improving Kayakalp score. Data sharing of surveys done in terms of non-ODF areas under the UPHC/UJHC catchment areas; Nodal persons to be a part of Kayakalp Award nomination Committee (District & State level)	Sharing of NULM data on vulnerability and gradation of slums on the basis of vulnerability; Collective community action for preventing vector borne diseases; Nodal persons to be a part of QA Committees
Common IEC Platform	MOs, Nurses would utilize the Triggering Platforms of SBM (an exercise of participatory community appraisal followed by guided conversation with members of the community) to disseminate the health message and also about sanitation issues; Community mobilization during UHMDs, Health Mela; Joint Planning for Health, Nutrition and Sanitation	Triggering platform may be used for messages on Immunization, Anemia, Nutrition in urban poor. IEC materials and other logistics to be utilized by all the Missions;	Joint exercise for health services to the vulnerable population in night shelters and sanitation awareness to the poor; Dissemination of IEC materials and sustained joint BCC through SHGs, ASHA and MAS members

The activities may be expanded as per requirements of the states. Above mentioned action points are basic and indicative to observe. Similarly, the stakeholders may be expanded and their convergence activities may be planned and made functional.

Note: The NUHM implementation where is ULB driven such as in seven Megacities / Metros and others e.g. Pune, Nashik etc. The responsibility of co-ordination of convergence activities will be with ULB. But in the States/UTs where it is not ULB driven, the convergent activities responsibility needs to be taken as per respective Mission specific activity.



MONITORING THE DELIVERABLES/ ACTIVITIES UNDER CONVERGENCE

The deliverables for committees/convergence teams at each level as well as their performance indicators are presented here. The indicators should be monitored jointly by the higher level committees/team and reported.

1. Community Level Deliverables-Orientation of MAS members on Convergence benefits; MAS to be linked to the livelihood and financial opportunities; Slum specific Sanitation Plan developed and implemented; Joint IEC dissemination; Triggering Platform used by Swachhagrahis; MAS to be in close communication with ULB officials;

2. Ward Level deliverables-Comprehensive Planning jointly with stakeholders to improve the health and sanitation status; Mobilization of Resources; Target Achieving as per Key Performance Indicators; Minutes of the Half yearly Review and Monthly Coordination Meetings.

3. City Level Deliverables-Comprehensive City Health Plan (Multi-year with Timelines) for Health and WASH; Annual Capacity building Plan with Time lines; Developing a Urban Health Compendium; Minutes of the Half yearly Review and Monthly Coordination Meetings

4. State Level Deliverables- Comprehensive multi-year State Urban Planning for health and WASH (with timelines); Annual Capacity building Plan with Time lines; Minutes of the Half yearly Review and Monthly Coordination Meetings

To serve as a guidance for states, the key convergence activities to be undertaken by

the states have been illustrated in Annexure -4 and a proposed timeline of month-wise

activities has been developed in Annexure - II.





INDICATORS FOR CONVERGENCE IMPLEMENTATION

In order to measure the progress of convergence activities a set of process, output and impact level indicators have been delineated below. The impact indicators focus on the vulnerable, urban poor population. These indicators have been included based on the priorities articulated in the National Health Policy 2017, India's commitment to achieving the Sustainable Development Goals and are in accordance with the framework for implementation of NUHM.

I. PROCESS LEVEL INDICATORS:

1. Formation of Working Groups

- i. National Level Consultative Working Group
- ii. State Level Consultative Working Group
- iii. Vector and Epidemic control Working Group
- iv. ULB Sanitation Working Group

2. Meetings Conducted

- i. Number of Review Meetings conducted at State/ City/District/Ward levels.
- ii. Number of Co-ordination meetings conducted at State/City/District/Ward levels.

3 Convergence Plan (Annual / Quarterly /Monthly)

- i. Number of Committees at(ward/city/state) who have developed convergence plan (Annual/ Quarterly/Monthly)
- ii. Number of convergence plan developed at ward/ city/Dist/State level and implemented
- iii. Number of activities undertaken in functionaries
- iv. Number of triggering platforms used by MO/ SN/ANM

4. Capacity Building

- i. Number of ASHA Percentage trained as Swachhagrahis
- ii. Number of MAS/SHG Percentage trained as Swachhagrahis
- iii. Number of AWW Percentage trained as Swachhagrahis
- iv. Number of ULB/All Committee/team members at state, city, ward level Percentage trained
- v. Number of MO/SN/ANM Percentage trained

5. Biomedical Waste Handling Training for Segregating, Collection and Disposal

- i. Percentage of SHGs trained
- ii. Percentage of ALFs trained
- iii. Percentage of CLFs trained

6. Kayakalp Indicators

- i. Number of UPHC/UCHC in urban areas selected for Kayakalp
 1. Percentage of Facilities completing internal assessment in each Quarter
 2. Percentage of Health Facilities scoring more than 70% on peer assessment
 3. Percentage of Health Facilities scoring more than 70% score on External Assessment
 4. Percentage of districts & metro declaring Kayakalp Awards by 31st Dec and by 31st March in subsequent year.
- ii. Percentage of UCHC/UPHC qualifying for Kayakalp Awards in Metros
- iii. Percentage of UCHC/UPHC qualifying for Kayakalp Awards in Non-Metros
- iv. Percentage of UCHC/UPHC qualifying for Kayakalp Awards in other cities/towns

7. IT enabled services

- i. Number of ANMs using Tablet for reporting

8. Micro-Sanitation Plan

- I. Percentage of ODF Household
- II. Percentage of ODF Community
- III. Percentage of Households practicing Segregation of Waste
- IV. Percentage of change in incidence of Communicable diseases
 - a. OPD
 - b. IPD
- V. Percentage of Household having portable drinking water facility
- VI. Percentage of Household having Individual toilets

- VII. Percentage of Household having regular water facility in the toilets
- VIII. Percentage of Individual Toilets regularly being used
- IX. Number of Community Toilets available
- X. Percentage of Community Toilets having regular cleaning facility
- XI. Percentage of Household having broken Toilets
- XII. Percentage of Household broken Toilets repaired

II. OUTPUT LEVEL INDICATORS

- I. Increase in OPD Attendance related to communicable disease
- II. No. of Diarrhoea/Dysentery cases reported in the OPD and Trend
- III. No. of ORS packet consumed in a specific season and Trend
- IV. No. of Malaria/Dengue/Chikungunya cases reported
- V. No. of Typhoid cases reported
- VI. Other water/air borne diseases reported
- VII. Increase in number of urban health facilities having micro-sanitation plan
- VIII. Increase in number of urban health facilities qualifying for Kayakalp awards
- IX. Increase in number of Swachhagrahis in urban areas
- X. Increase in number of ODF urban areas
- XI. Increase in construction of toilets in households/community
- XII. Increase in participation of SHG in segregation/disposal of wastes
- XIII. Increase participation and accountability of ULB/Municipality etc. in health sector

III. IMPACT LEVEL FOCUS ON URBAN POOR

- I. 100% ODF in urban areas
- II. Reduction in IMR related to sanitation caused diseases by 40%
- III. 100% access to clean drinking water and environment
- IV. Increased participation of SHG/ALF/CLF in segregation/disposal of wastes etc.

(ANNEXURE-I)

WAY FORWARD

1

Formation of institutional mechanisms (committees/convergent teams/working groups) at state and sub-state level

2

Designation of Swachhagrahis and involving members from ASHA, MAS, ALF, CLF and other self help groups.

3

Identification of infrastructure for use across all three programmes (e.g. NULM-SUH/CLC)

4

Joint Meetings with the stakeholders (NULM, NULM, SMM) at the state and sub-state level

5

Platform for health education

6

Training and Capacity Building through development of a common training Module

7

Development of IT based mechanism for real time data transfer and training/capacity building at every level

8

Development of Monitoring indicators/proxy indicators, impact indicators, outcome indicators etc



PROPOSED TIMELINE

Activities Months	1	2	3	4	5	6	7	8	9	10	11	12
1) Formation of institutional mechanisms at all four proposed levels												
2) Orientation and training of Committees												
3) Enrollment of Swachhagrahis												
4) Orientation and training of Swachhagrahis												
5) Development and finalization of Micro-sanitation plan												
6) Development and finalization of City/Town level plan												
7) Development and finalization of District level plan												
8) Development and finalization of State level plan												
9) Implementation of plan												
10) Data Capturing of indicators												
11) Reporting of indicators												

COMPONENTS OF 3 MISSIONS :
NUHM, SBM & NULM

3.1 NATIONAL URBAN HEALTH MISSION

3.1.1 The National Urban Health Mission was approved in May 2013 as sub-mission under an overarching NHM and aims to improve the health status of the urban population with a focus on disadvantaged and poor population. The mission aims to provide equitable access to quality health care through a revamped public health system, partnerships (public-public and public-private) and community based mechanism. The core strategy of the Mission is mainly as follows:

- Improving the efficiency of the public health system in the cities by strengthening, revamping and rationalizing existing government primary urban health structure and designated referral facilities
- Promotion of access to improved health care at the household level through the community based groups: Mahila Arogya Samitis
- Strengthening public health through innovative preventive and promotive action
- Increased access to health care through creation of revolving fund (for "Rainy Days", thereby minimizing Out of Pocket Expenditure)
- IT enabled Services and e-governance for improving access improved surveillance and monitoring

- Capacity Building of Stakeholders
- Prioritizing the most vulnerable among the poor
- Ensuring quality health care services

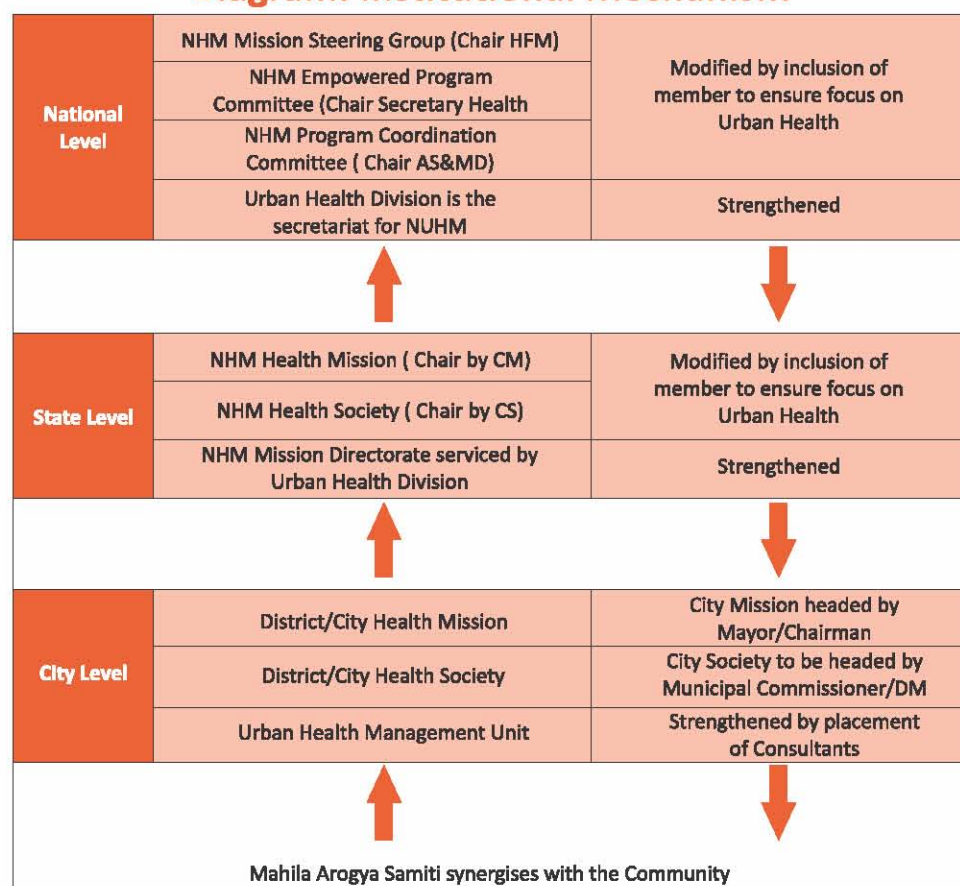
(Framework for Implementation, NUHM)

The framework for implementation envisages Intersectoral coordination as an important convergent activity in order to avoid duplication of resources and efforts under NUHM.

Institutional Mechanism

3.1.2 The institutional arrangement for implementation of the urban health mission is in consonance with the structure of National Health Mission at the national, state and district level. However, in order to undertake a focused approach to the urban issues, the institutional mechanisms will need to be strengthened at various levels of implementation. The unique mechanism, Mahila Arogya Samiti (MAS) at the community level, which has been envisaged under the NUHM, is expected to create demand for quality health and is an opportunity for synergized actions through various self-help groups of urban development schemes at the grass root level.

Diagram: Institutional Mechanism



(Framework for Implementation, NUHM)

3.1.3 Components of Service Delivery under NUHM

3.1.3.1 Community Level:-

1. ANM: Three to five ANMs are posted at each primary health centre depending on the population. The ANMs are responsible for outreach sessions at the community level. The sessions include check-ups, drug dispensing and counselling. Outreach sessions are planned with special attention to bringing services to the vulnerable sections of the urban population such as slum population, rag pickers, sex workers, brick kiln workers, street children and rickshaw pullers.

2. ASHA: Each slum/community has one frontline community worker called ASHA, for delivery of services

at the doorstep (Urban Health Nutrition Days, Home Based Neonatal Care, Ante Natal and Post Natal Care, participation in Disease Control Programs). She covers around 1000-2500 beneficiaries across 250-500 households.

She maintains interpersonal communication with beneficiary families and serves as a link between the health facility (U-PHC) and the urban slum populations. In return for the prescribed activities she receives performance based incentives.

3. Mahila Arogya Samiti: It acts as a community group involved in awareness generation; community

based monitoring; facilitating linkages to services. It comprises of 10-12 women covering 50-100 households and functions as a community group, at the slum level. It focuses on the preventive and promotive health care and it is provided with an untied revolving fund for management and expenditure. Women's or SHG groups wherever present would be encouraged to expand their scope of work to address the health challenges in the community.

3.1.3.2 Urban Primary Health Centre (U-PHC): is functional for a population of 30000-50000 and located in and around slum areas and is expected to work in two shifts for at least 8 hours a day. It is developed with a vision to provide comprehensive primary healthcare to the populace with all its components at the facility and also in the community.

Services which are generally provided are RCH services, NCD services, Communicable diseases lab facility and drug dispensing among others. Expansion of health care services to cover the primary health care comprehensively is the goal of the UPHC under NUHM. The package of 12 services that the UPHC is expected to provide are preventive, promotive, curative, rehabilitative and palliative care for the following areas: (1) Care in pregnancy and child birth (state specific context). (2) Neonatal and infant health care services. (3) Childhood and adolescent health care services including immunization (4) Family Planning, Contraceptive services and other Reproductive Health Care Services. (5) Management of Communicable Diseases and General Outpatient care for acute simple illness and minor ailments. (6) Management of Communicable Diseases : in context of all National Health Programmes.

(7) Screening and Management of Non Communicable Diseases (8) Screening and Basic Management of Mental Health Ailments. (9) Care of Common Ophthalmic and ENT problems (10) Oral Health Care and essential Dental Therapeutic Procedures (11) Elderly and palliative health care services (12) Burns & Trauma Care (that can be managed at this level) and Emergency Medical Services. (Details explained in Framework for Implementation, NUHM)

3.1.3.3 Urban Community Health Centres (U-CHC): acts as a referral unit for the UPHCs and the community level services and have been developed as satellite hospitals for every 5-7 UPHCs. Each caters at least 2,50,000 population. The UCHC is expected to provide in-patient services (30-50 bedded) including medical care, minor surgical services and institutional delivery. The in-patient services may be expanded,

depending upon the resources available.

(Framework for Implementation, NUHM)

3.2 SWACHH BHARAT MISSION (SBM)

3.2.1 As per the SBM guidelines, Urban SBM is functional in 4041 statutory towns across the country. About eight million households don't have access to toilets facilities (Census 2011). However, since the initiation of implementation of SBM there is substantial improvement and as per latest report on Urban SBM website, 2145 towns have become ODF zone as on 11th May, 2018.

3.2.2. To improve citizen's access to sanitation, seven key mission objectives have been identified under SBM. They are:

1. Elimination of open defecation;
2. Eradication of manual scavenging;
3. Modern and scientific municipal solid waste management;
4. Behavioural change regarding healthy sanitation practices;
5. Generate awareness about sanitation and its linkage with public health;
6. Capacity augmentation for urban local bodies (ULBs);
7. Enabling environment for private sector participation in capital expenditure and operation and maintenance.

SBM has a three-tier mission management structure as follows:-

At National Level:

3.2.3 National Advisory and Review Committee (NARC) is headed by the Secretary, MoUD and comprises of representatives from relevant line ministries. Main functions of NARC are overall monitoring and supervision of SBM (Urban); and monitoring outcomes and performance of projects sanctioned under SBM (Urban).

3.2.4 SBM National Mission Directorate is headed by National Mission Director and supported by a dedicated Project Management Unit (PMU). It acts as a support structure for the State Mission Directorates and issues appropriate guidelines /advisories to states from

time-to-time. The PMU covers four verticals – Programme management, IEC & Media, Information Technology, and Monitoring & Evaluation.

State Level:

3.2.5 High Powered Committee (HPC) under the chairpersonship of the State's Chief Secretary, and with members drawn from concerned departments (including a MoUD representative), the HPC is responsible for the management of SBM-U. It is entrusted with development of State Sanitation Strategy, sanctioning of projects related to Solid Waste Management (SWM), planning the fund flow, reviewing and monitoring outcomes of the program for issues and challenges.

3.2.6 SBM State Mission Directorate is headed by a State Mission Director, to create / notify a uniform structure across the state for the planning, designing, project preparation, appraisal, sanction and implementation of sanctioned projects under the mission at the ULB level.

Urban Local Body (ULB) Level

3.2.7 ULBs are entrusted to elicit the active participation of the Ward Committees, Area Sabha, Resident Welfare Associations (RWAs), NGOs and Civil Society Groups for the implementation of SBM activities.

(Guidelines for Swachh Bharat Mission, December 2014), (<http://www.swachhbharaturban.in>)

3.3 NATIONAL URBAN LIVELIHOOD MISSION (NULM)

3.3.1 NULM was launched to decrease poverty and susceptibility of the urban poor households by empowering them to access rewarding self-employment and skilled wage employment opportunities. Strong grassroots level institutions have been built for the poor to facilitate appreciable improvements in their livelihoods on a sustainable basis. The mission provides shelter equipped with essential services to the urban homeless. In addition, it also addresses livelihood concerns of the urban street vendors by facilitating access to suitable spaces, institutional credit, social security and skills to the urban street vendors for accessing emerging market opportunities.

3.3.2 KEY STRATEGIES

The strategies adopted by the program are:

1. Build capability of the urban poor, their establishments and the machinery involved in the implementation of livelihoods development and poverty alleviation programmes through hand holding support
2. Enhance and expand existing livelihoods options of the urban poor
3. Building skills to enable access to growing market-based job opportunities offered by emerging urban economies
4. Training for and support to the establishment of micro-enterprises by the urban poor – self and group
5. Ensure availability and access for the urban homeless population to permanent 24-hour shelters including the basic infrastructural facilities like water supply, sanitation, safety and security
6. Cater to the needs of especially vulnerable segments of the urban homeless such as the dependent children, aged, disabled, mentally ill, and recovering patients, by creating special sections within homeless shelters and provisioning special service linkages
7. Establish strong rights-based linkages with other programmes which cover the right of the urban homeless to food, healthcare, education; and ensure access for homeless populations to various entitlements, including to social security pensions, feeding programmes, drinking water, sanitation, identity, financial inclusion, school admission and affordable housing
8. Address livelihood concerns of the urban street vendors by facilitating access to suitable spaces, institutional credit, social security and skills to the urban street vendors for accessing emerging market opportunities.

(Mission Document, NULM, MoHUPA)



Dr. K. Rajeswara Rao
Joint Secretary (NHM)
Government of India
Department of Health & Family Welfare
Ministry of Health & Family Welfare
Nirman Bhawan



Shri Pravleen Prakash
Joint Secretary (SBM)
Government of India
Ministry of Urban Development
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Shri Sanjay Kumar
Joint Secretary (DAY-NULM)
Government of India
Ministry of Housing & Urban
Poverty Alleviation
Nirman Bhawan

Dear Colleagues,

We are writing to you with regard to the convergence plan between National Urban Health Mission (NUHM), Swachh Bharat Mission (SBM) and National Urban Livelihood Mission (NULM) to develop a holistic environment covering health, sanitation and livelihood. As we are aware that NUHM works towards providing equitable and quality primary health care services to urban population with special focus on slum and vulnerable population, an integrated approach is needed involving all the stakeholders to address the social determinants for good health with convergence of ideas and co-ordination between activities as the key philosophy with support from SBM whose prime focus is on elimination of open defecation & generation of awareness about sanitation and its linkage with public health and NULM whose strategy is to reduce poverty & vulnerability of the urban poor by enabling them to access gainful self-employment & skilled wage employment opportunities, resulting in an sustainable significant improvement in their livelihoods, through building strong grass root level institutions for them.

There is a paradigm shift in the National Health Policy (2017) which emphasizes also on the importance of achieving convergence among wider determinants of health and improving the environment for health. It is now imperative that we join hands and utilize this opportunity to address the root causes of ill health by providing quality primary healthcare services with prime focus on access to safe water and sanitation to all and an enabling environment for sustainable livelihood. The main objective of convergence is to enhance the utilization of the system through provision of a common platform and availability of all services at one point. In this regard, please recall the Joint Video Conference held with HUPA, MoUD and NUHM on 3rd Feb, 2017 where all the states/UTs shared their areas of activities for urban health and expressed their commitment to work in collaboration for better urban health outcomes.

Keeping the above in view, some key action points for joint implementation of urban health initiatives are planned as follows:

1. State initiative to develop a road map in consultation with their counterparts in the state on convergence activities under NULM, SBM and NUHM with regular state level reviews at the Urban Local Bodies and State Health Departments.
2. Formation of Common Coordination Committee (CCC) at state, district, city and ward level to implement convergence through proper planning, activity and monitoring.
3. Sanitation drives with focus on importance of sanitation in areas around the urban health facilities and in accordance to the SBM norms for every fifty thousand population covered by the facility involving the urban health mechanism.

Contd...

4. Involvement of all the community level workers like Mahila Arogya Samiti, Self Help Groups, Area Level Federation, City Level Federation etc., through christening them as "Swachhagrahis" through adequate capacity development and training (MEPMA model).
5. Leveraging these community level groups through social entrepreneurship by incentivizing them to participate actively in improving not only sanitation in area but also improvement in resultant health indicators.
6. Utilization of NULM infrastructure like night shelters & city livelihood centres and also community SHM infrastructure to provide community level health care like outreach services; utilization of NUHM-BBM combined triggering platform for sustained behavioral change counseling.

The way forward for this convergence mechanism has been envisaged as under:

1. Joint Meetings with the stakeholders (NUHM, NULM, SHM) at the state and sub-state level.
2. Formation of CCC at state and sub-state level.
3. Formation of Swachhagrahis involving members from ASHA, MAS, ALR, CLF and other self help groups.
4. Identification of infrastructure for use across all three programmes (e.g. NULMSUH/CLC).
5. Triggering Platform for health education.
6. Training and Capacity Building through development of a common Training Module.
7. Development of IT based mechanism for real time data transfer and training capacity building at every level.
8. Development of Monitoring Indicators-processing indicators, impact indicators, outcome indicators etc.

In addition to the above, States/UTs may develop their own mechanism of convergence between these committees based on local needs. The success of convergent action would depend largely on all the stakeholders who would come and work together for the benefit of vulnerable and poor people in urban areas so as to achieve common goal of a healthy and improved urban life within the framework of guidelines/instructions of respective schemes.

With Warm Regards,


(Sanjay Kumar)

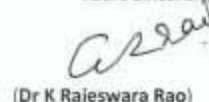
To

Principal Secretary Health/Urban Development-All States/UTs
Municipal Commissioners of 7 Metros & 76 Million Plus Cities
Mission Directors DAY-NULM/BBM/NUHM- All States/UTs
PS to Chief Minister of all States
PS to Minister -Urban Development/Health- All States

Copy for information to:

Secretary H&FW / Add. Secretary & MD-NUHM
Chief Secretaries (All States/UTs)
PS to Minister for Health & Family Welfare/ Minister for Urban Development

Yours Sincerely,


(Dr K Rajeswara Rao)

Concept Note on Convergence

1. National Urban Health Mission (NUHM) was approved by the Union Cabinet on 1st May, 2013 as a sub-mission of National Health Mission (NHM) for providing equitable and quality primary health care services to the urban population with special focus to vulnerable/slum population.

2. Implementation of NUHM in States is heterogeneous and varies from state to state and city to city. Whereas in Seven Metros NUHM is being implemented through Municipal Corporations, in some States like West Bengal and Maharashtra, the implementation is through Municipality and Nagar Palika. In most of the States NUHM is implemented through State Health departments as the ULBs are either not strong enough to provide the required services or the mandate is not for health.

3. Health outcomes are more defined by the other social determinants than by the just health itself. Addressing the other determinants entail building partnerships with institutions and actors both within the health and across other related sectors. Reducing health inequalities for sustainable improvement in health status of urban populations requires alignment of all sectors together with health sector; thus making Inter Sectoral Convergence is one of the main core strategies under the NUHM. The National Health Policy, 2017 also emphasize the importance of achieving convergence among the wider determinants of health and improving the environment for health. Monitoring of the programme reveals that the platform of NUHM requires integration and coordination of health and health related social determinants in order to provide a equitable, easily accessible, quality primary health care which includes preventive, promotive and curative health services deliverable to the target population i.e. the vulnerable urban population mainly slum dwellers.

4. This convergence of activities will not only improve the quality of services but also do away with the duplication of action thereby saving invaluable resources and time in the process.

5. Convergence may be viewed in the following areas:-

- (i) Convergence with the National Disease Control Programmes
- (ii) Convergence with other departments of Ministry of Health and Family Welfare
- (iii) Convergence with other Ministries

6. The main objective of convergence is to enhance the utilization of the system through provision of a common platform and availability of all services at one point. Convergence among wider determinants of health has been minimal thus far emphasizing the need for creating common institutional arrangements such that the same community organization, under the umbrella of urban local body, is responsible for all the wider determinants such as water, sanitation, nutrition, health care, education, skill development, housing, etc. Effective institutional mechanisms for convergence of urban primary health care services with other government run schemes responsible for health determinant is critical considering the massive burden that the poor state of these determinants imposes on the health of our population. Therefore the mechanisms for convergence with health related non-medical services (water, sanitation, and waste-disposal) should be strengthened. For example, 4 lakh annual diarrhoeal deaths of children below 5 in the country are due to severe lack of Sanitation facilities. World Malaria Report (2012) estimates that over 2.4 crore episodes occurred annually in India, again the chief reason in urban areas being poor sanitation and lack of behavioural change counselling.

Formation of committees at different levels

7. To ensure convergent actions of health and social determinants of health, the formation of common committees at City/State/District/ Ward level is very important. It needs to be ensured that the members of

coordination committee expected to be formed at different levels from National level to Ward level must include the Nodal Officers / Concerned Officials of the National Health Programme e.g. (IDSP/RNTCP etc). It is proposed that the members of Coordination Committee especially at district level must have access to all data related to health and social determinants of health for ensuring timely decision making.

The National Health Mission provides for an executive level headed by Chief Secretary as per the Gazette Notification on NUHM dated 26th June, 2013 which directs that at the City level the States may either decide to constitute a separate City Urban Health Mission/City Urban Health Society or use the existing structure of the District Health Society/Mission under NRHM with additional stakeholder members. The notification also articulates the need for Urban Health Committee headed by the Municipal Commissioner/District Magistrate/Deputy Commissioner/District Collector/Sub-divisional Magistrate/Assistant Commissioner based on whether the city is a district headquarters or sub-divisional headquarter. This would help ensure better coordination with other related departments such as Women & Child Development, Water Supply & Sanitation etc as the administrative heads of these departments are the same officials.

Mechanisms of Convergence at different levels of implementation:

It is envisaged that three-tiered level of mechanisms can be put in place under NUHM, which are as under:

- Ward level committees including UPHC/UCHC functionaries and community level workers;
- City level committees for planning, monitoring and reporting; and
- State level committees for planning, monitoring and provisioning

City Level Coordination Committee (CLCC)- to be constituted to address and resolve the day to day activities related to Health Department such as Water & Sanitation, Biomedical Waste Management, sewerage, involvement of frontline functionaries, etc.

Ward level Coordination Committee (WLCC)- Ward is the smallest administrative unit in a city and is recognized as the unit for planning and monitoring. Each ward is politically represented by the elected member (Ward Councillor) in Municipal Corporation. The key departments like Department of Health and Family Welfare, Women and Child Development (WCD), Urban Development Department, Public Health Engineering Department (PHED) and other related departments also often respect the ward division and plan accordingly.

WLCC will serve as the nodal body for the planning and monitoring service delivery at the community level and effectively link the communities and may be utilized to address the health and other issues by involving the UPHC/UCHC functionary of the concerned area and also the community level workers, elected & other department representatives.

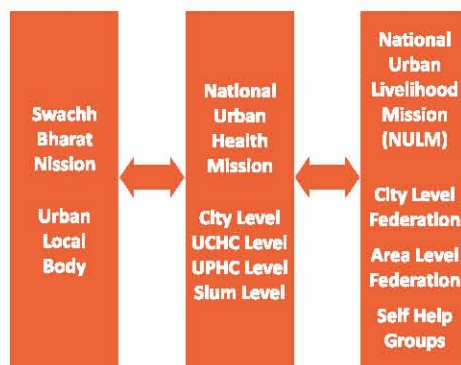
Convergence of activities among different departments under ULBs which are looking after the social determinants of health such as Water, Sanitation, Waste disposal, Food adulteration is essential to provide a quality holistic health care even if the ULBs are not implementing NUHM.

The convergence with these agencies/divisions of the health service providing agencies (ULBs/State Health Department) is another paradigm of coordinated activity.

Numbers of Missions are underway under the aegis of the Urban Development department whose activities have direct and indirect implication on the health care quality. It is now envisaged that a convergence model is to be planned to integrate the activities of these missions in order to leverage the performance and experiences of these missions. The foci of the Missions' activities are Swachhata (Cleanliness) and development of the urban poor. These parameters are complementary to the achievement of NUHM goals as health is intricately associated with cleanliness and socio-economic status of the population. Therefore we expect the proposed convergence model facilitates reaching NUHM goals in an accelerated manner.

8. Convergence Model

In this context, realizing the importance of wider determinants of health, NUHM seeks to adopt a convergent approach for interventions planned under the umbrella of SBM & NULM at the City/State/District/Ward level.



The model above would define the steps to be taken for various convergence activities at the City, District, UCHC and UPHC levels and also the rationalization of manpower and resources being deployed by the various Missions. This will impact the status of social determinants of health and maximize efficiency of all the Missions,

9. The synergy with different departments within/outside the health department i.e. intra-sectoral/inter-sectoral convergence plays a key role for rolling out of the convergence vehicle.

NUHM would aim to provide a system for convergence of all communicable and non communicable disease programmes at the city level through integrated planning - both annual and prospective, sharing of funds and human resources and joint monitoring and evaluation.

1. Convergence with the National Disease Control Programmes

All the disease control programs such as RNTCP, IDSP, NVBDCP, NPCDCS etc. are to be brought under the umbrella of City/District Health Plan so that preventive, promotive and curative aspects are well integrated at all levels.

Similarly, the NACP which ensures early detection of HIV/AIDS, effective surveillance and Universal HIV screening will be made an integral part of the ANC check-up. The health and nutrition days would be utilized for rapid blood tests and positive cases would be referred to ICTCs for confirmation. Counsellors, ANMs and ASHA/Link workers at the U-PHC would be trained for counseling on RTI, PPTCT, ANC, nutrition and spacing between births. The training for RTI and PPTCT counseling will be provided by the respective State AIDS Control Society. Testing kits should be made available at the Urban PHCs/CHCs by NACO. All HIV positive patients will be tested for T.B. and vice-versa.

* Initiatives under the RCH programme such as Intensive Diarrheal Control Fortnight (IDCF), National Deworming Day (NDD), WIFS, PMSMA etc. need to converge at the UPHC level to ensure health is addressed comprehensively. Similar convergence mechanisms can be developed for other initiatives through integrated plan and support of concerned officials.

The objective of convergence would be optimal utilization of resources (i.e. common pool for funds, human resources, consumables, infrastructure etc) and ensuring availability of all services at one point (U-PHC) thereby enhancing their utilization by the urban

population. The existing IDSP structure would be leveraged for improved surveillance.

2. Convergence with other Ministries

At present NUHM is focusing on inter-sectoral convergence with Ministry of Urban Development/HUPA for the programmes (SBM & NULM) in improving the social determinants related to health (water, sanitation, food & nutrition etc), the following may be looked upon:

Convergence with SBM — Urban Local Body plays an important role in delivering urban development programmes at the city level. This is vital for SBM as well as the NUHM programmes. The convergence with SBM can be facilitated as per the following roadmap:

- Developing a micro-sanitation plan for each catchment area of UPHCs/ UCHCs (total population coverage) needs to be developed by ULBs. Correspondingly, the State Health Department will ensure adherence of quality guidelines of the micro-sanitation plan for the earmarked PHCs/CHCs. The ward office will coordinate with UPHCs and UCHCs so that sanitation and Open Defecation Free (ODF) areas in urban localities can be promoted.
- ASHA, ANMs, MOs and Directors (Municipal Administration) are to be involved in community triggering exercise by the ULBs especially near identified OD Spots to generate awareness about the oro-fecal transmission route and trigger demand for toilets among the communities. The triggering platforms may be utilized for dissemination of NUHM messages like immunization, ANC, Anaemia control and other related National Health Programmes
- Registration of health workers (ASHA/ANM/AWW) and members in Mahila Aarogya Samitis as Swachhagrahis for Health Promotion and dissemination of SBM related messages. Recognition of Swachhagrahis by giving non incentives items such as caps, T-shirt, sari, bags, badges etc.
- Incentives for Swachhagrahis (ASHA/ANM/AWW) as individual or group incentives.
- 1-2 days training under Swachh Bharat Mission for ensuring proper management of waste and maintenance of hygiene standards in public health facilities and on triggering techniques.
- Swachh Bharat Mission officials should also be involved in Quality Assurance assessment of UPHC/UCHC facilities at different levels by incorporating their membership in the committee.

- Dissemination to and utilization of collaterals which are available with the State Mission Directors of SBM at the UPHC/UHC and slum levels.
- While implementing the IDCF and National Deworming Day initiative at the ward/district levels, support of the Swachh Bharat Mission can be sought through the Swachhagrahis, common pool of funds, key health messages, declaration of ODF etc in the form of integrated plan of action.

Convergence with NULM

NULM can provide support in strengthening the community processes as well as improving the socio-economic status of the population which impacts the health in urban areas through convergence within its existing structures,

(DAY-NULM) envisages universal social mobilization of urban poor women in three tiered structure of Community Institutions viz. Self-Help Groups (SHGs), Area Level Federations (ALFs) and City Level Federations (CLFs). ALF provides handholding support to SHGs, facilitate SHG bank linkage, negotiate with higher level Institutions for benefitting urban poor and facilitate member of SHGs in accessing benefits under various government programmes and schemes.

One time revolving fund of Rs. 10,000 for two years is provided to the SHGs and used for internal lending to its members. Registered ALF is provided with revolving fund of Rs. 50,000 per ALF for onward lending of its member SHGs.

The convergence with NULM can be strengthened in the following manner:

- Target population of both the programs viz NUHM and NULM is same in terms of community participation. It would thus be appropriate to develop linkages between Mahila Arogya Samities (MAS) under NUHM and Self -Help -Group (SHG)/Area Level Federations under DAY-NULM.
- The convergence of ALF and MAS could be made in such a way that the Chairperson for both of the committees (MAS & ALFs) is common. The list of MAS state-wise under NUHM has been shared with NULM.
- Three strategies which can be adopted for better linkages between MAS and ALF depending on the level of implementation in the States/Towns.

Option 1: Cities/States, where ALF exists but MAS is not formed

- A subcommittee of 10-12 representatives from existing ALFs can be identified as MAS.

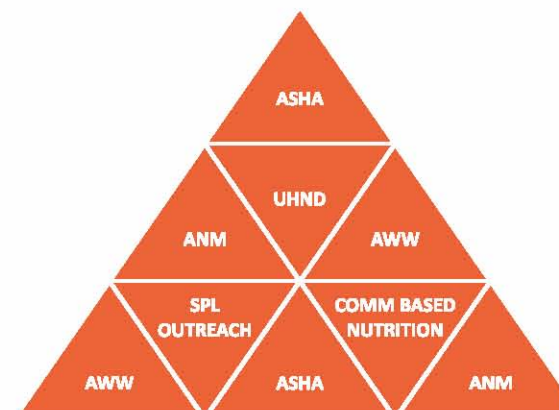
Option 2: Cities/ States where both ALF and MAS exist

- MAS members can be included into SHGs and further be included in ALF

Option 3: Cities/States where MAS is formed but ALF doesn't exist

- MAS members who are not part of SHGs will be encouraged to join existing SHGs and will further be represented in ALFs.
- ALFs will support all community process activities under NUHM through MAS including preparation of plan as per the needs of urban poor and mobilization of community to increase access to health related schemes. ALFs can also facilitate identification of ASHA as per guidelines of MoHFW where they have not been identified.
- Once the MAS members will come into SHGs/ALFs, they may avail the benefit of revolving funds and bank linkage and get skill training under DAY-NULM.
- SHGs along with MAS can mobilize the population to access outreach programs and generate health awareness including for UHND, Immunization drive, health melas among others.
- Joint Monitoring of health services at community level by ALF/MAS.
- Vulnerability mapping of slum/urban areas; data sharing between both the programmes; updating; and developing common consensus.
- NULM can play key role by rendering unused structures/ Shelters for homeless/ City Livelihood Centers for NUHM programme to address lack of infrastructure facilities in urban areas for conduction of UHND, Special Outreach session, for functioning of UPHC where land availability is difficult.
- NULM conducts regular surveys of street dwellers and provides them with support through night shelters. Since the street dwellers are one of the vulnerable groups that NUHM caters to, the NULM survey data can help ANMs and ASHAs target this population better. This population group can also be targeted at the night shelter level by developing an appropriate mechanism like UHND, Special Outreach session etc.
- In addition to the above, States/UTs may develop their own mechanism of convergence between these committees based on local needs.

Figure 1-Intersectoral Convergence under NUHM between Frontline Workers



Convergence with Women & Child Development Department (WCD)

There is a close relation between the activities of ICDS and NUHM as in most States/UTs, the NUHM outreach activities i.e. UHND and special outreach sessions take place at the AWC. A service delivery mechanism by involving ASHA-ANM & AWW (3 A's) is being envisaged. Hence a convergence mechanism is to be planned on the same line.

Actionable Points

Therefore the following actionable points are suggested to strengthen convergence to accelerate the achievement of urban health goals:

Identify state, district, city and ward level institutional mechanisms for coordinating and _ converging with relevant stakeholders in urban health and development.

- Develop terms of reference for the committees to ensure convergent activities are planned, implemented and monitored effectively.
- Ensure the integration of all national health programmes, specific initiatives and state health programmes at the UPHC level.
- Convergence with SBM for developing micro-sanitation plan for urban health facilities with focus on ODF, trigger demand for toilets by community, involvement of health workers as Swachhagrahis, proper solid waste management disposal, proposal for incentives for Swachhagrahis.
- Convergence with NULM for strengthening of community processes at slum level, vulnerability mapping, joint monitoring of health services, support for infrastructure needs, UHND, Special Outreach session through ICDS infrastructure wherever applicable.
- Community based monitoring of nutritional status of vulnerable children in convergence with NUHM/NHM. The linkage with NRC and similar structure under NHM are to be maintained.
- Develop mechanisms to use NULM data on street dwellers and develop outreach actions at the NULM night shelters improve access of health to the most vulnerable homeless population.
- Any state specific convergence area.

The success of convergent action would depend on the quality of the Public Health Planning process. The City/State/District Health Action Plans should reflect integrated action in all section that determine good health — drinking water, sanitation, women's empowerment, adolescent health, education, female literacy, etc. At the time of appraisal of City/State/District Health Plan, care should be taken to ensure that the entire range of wider determinants of health have been addressed through the convergent action approach.

Convergence is aimed at improving the effectiveness and efficiency of all national health programmes. Thus promoting Inter-sectoral convergence for promotive and preventive health care is of prime importance.

ANNEXURE VI

FREQUENTLY ASKED QUESTIONS(FAQ) ABOUT CONVERGENCE

PERSPECTIVE OF THE HEALTH DEPARTMENT

1. Why is convergence important under the National Urban Health Mission?

Convergence is one of the main core strategies under the NUHM. Monitoring of the programme reveals that the platform of NUHM requires integration and coordination of health and health related social determinants in order to provide a equitable, easily accessible, quality primary health care which includes preventive, promotive and curative health services deliverable to the target population i.e. the vulnerable urban population mainly slum dwellers. Therefore convergence will help to enhance the utilization of the system through provision of a common platform and availability of all services at one point. Convergence among wider determinants of health has been minimal thus far emphasizing the need for creating common institutional arrangements so that the same community organization, under the umbrella of urban local body, is responsible for all the wider determinants such as water, sanitation, nutrition, health care, education, skill development, housing, etc.

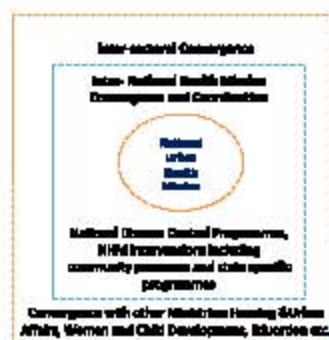
2. What is the scope of convergence under the National Urban Health Mission?

The synergy with different departments within/outside the health department, in other words intra-NHM and inter-sectoral convergence plays a key role for rolling out of the convergence vehicle.

Convergences may be viewed in the following areas:-

- Convergence with other Ministries
- Convergence with other departments and efforts of the National Health Mission of Ministry of Health and Family Welfare
- Convergence with the National Disease Control Programmes

The objective of convergence would be optimal utilization of resources (common pool for funds, human resources, consumables, infrastructure etc) and ensuring availability of all services at one point (U-PHC) thereby enhancing their utilization by the urban population. For example "The Red Ribbon Express project of National AIDS Control Organization presents one successful model of partnership comprising of Government (Ministries of Railways, Social Welfare, AIDS Control Organization) and Non-Governmental stakeholders and intergovernmental bodies".



3. What Convergence can be applied within National Health Mission?

Convergence as an administrative process which facilitates different Divisions / Units within the Department can be applied to work in synergy e.g. Health Department. All programmes such as

1. Disease control programs (RNTCP, IDSP, NVBDCP, NPCDCS, NACP etc) among others must be brought under the umbrella of City/District Health Plan so that preventive, promotive and curative aspects are well integrated at all levels.
2. Initiatives under the RCH programme such as Intensive Diarrhoeal Control Fortnight (IDCF), National Deworming Day (NDD), Weekly Iron Fertilization Supplementation (WIFS), Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) and others need to converge at the UPHC level to ensure health is addressed comprehensively.
3. Regular Intra-NHM meetings need to be institutionalized. The existing different program heads should be responsible for implementing the different program related activities with respect to NUHM concurrently with NHM programs.

List of Important Intra-Health Departments for Urban Health

- Immunization Task Force Involving Immunization Division & NUHM
- Reproductive and Child Health
- HIV - NACO
- TB- RNTCP
- Vector Borne Diseases - NVBDCP
- Non-Communicable Diseases - NPCDCS
- Surveillance - IDSP
- National Prevention and Control of Blindness
- National Prevention and control of deafness
- National Mental Health Programme
- Tuberculosis Control
- IEC cell

Note: List is not exhaustive it is indicative

4. Who are the important stakeholders for urban health?

The key stakeholders and their core functions which influence health have been presented in the table below.

Stakeholder	Relevant Core Functions
Ministry of Women and Child Welfare	ICDS interventions pertaining to nutrition and health, SHG formation, women empowerment and prevention of domestic violence and early marriage.
Ministry of Housing and Urban Poverty Alleviation	Urban poverty alleviation through gainful self employment and skilled wage employment under DAY-NULM, housing, shelter for homeless, livelihood, implement programs such as Sreech Bharat Mission and DAY-NULM, through ULBs and parastatals implement Solid waste management, water supply/quality, sanitation, preventive vector control and food hygiene
Ministry of Drinking Water and Sanitation-(MDWS)	To provide safe drinking water and better sanitation. In state the department is called - Public Health Engineering Department.
Ministry of Education	Primary, secondary and higher education; mid day meal schemes; support to school health schemes/nutritional programmes
Ministry of Social Justice & Disability Department	Focus on vulnerable and disabled persons including their pension.
Ministry of Food & Civil Supplies	Focus on subsidized ration.
Elected representatives	MPs, MLAs, MLCs and ward representatives play an overarching role in monitoring welfare and developmental activities of the urban areas.
Intergovernmental organizations and donors	Demonstrate innovations and models of health; provide technical assistance and knowledge management
Private Sector Providers	Curative and specialist care; diagnostics and health insurance
NGOs and CBOs	Community mobilization, capacity building and support to implementation
Communities	Adoption of healthy behaviors, service utilization and participation

5. What are the areas for convergent actions with key stakeholders?

At present NUHM is closely working with Swachh Bharat Mission and DAY-NULM

SBM	DAY-NULM	WCD
Developing a micro-sanitation plan for each catchment area of UPHCs/ UCHCs.	Sharing of DAY-NULM survey data of vulnerable groups with NUHM; provision of health outreach to shelter for urban homeless.	Assigning administrative linkages between AWWs and ASHAs (as there are fewer AWCs than ASHAs).
Promotion of Open Defecation Free (ODF) areas in urban localities.	Developing linkages between Mahila Arogya Samitis (MAS) under NUHM and Self-Help Group (SHG)/Area Level Federations under DAY-NULM.	Joint planning of Urban Nutrition and Health Days.
Registration of health workers (ASHA/ANM/AWW) and members in Mahila Arogya Samitis as Swachhagrahis for Health Promotion and dissemination of SBM related messages – Incentives and collaterals.	Common chairperson for MAS and ALFs; Sub-committee of ALFs can function as MAS; MAS members can be included in SHGs.	Presence of AWW in health sector meetings.
Training under SBM for waste management, hygiene, point of use care.	Involvement of SHGs, ALFs in health planning, community mobilization, dissemination of information, UHNDs, health melas, vulnerability mapping and joint monitoring of services.	Reporting of IDSP related Information.
Support from SBM for IDCF activities.		Identification and referral of malnourished children to NRCs.
		Sharing of data pertaining to household surveys and utilization.
		Joint dissemination of health information and IEC.

6. What are the envisaged roles for the Urban Local Body under the NUHM?

The 74th Constitutional Amendment Act (1993) lays down the provisions for the devolution of funds, functions and functionaries to enable Urban Local Bodies (ULBs) to perform their duties. The Model Municipal Law (MML) provides guidance to states towards implementation of the provisions under the 74th CAA. The MML classifies municipal functions into three categories - core, additional and other functions. Community health, curative health and health and sanitation are listed under these categories of functions.

Primary core functions are provision of safe drinking water, environmental sanitation, air pollution, licensing of butchers and slaughterhouses and preventive vector control. Among the larger ULBs with further devolution curative care at primary, secondary and tertiary levels are also among the primary functions. There has been an expansion of roles being performed by the Municipal Health teams under NUHM. The municipal health teams in some cities are participating in carrying out health assessment; developing city health plans; and in many cities supporting the identification of infrastructure for health facilities as well as monitoring the implementation of the program.

Envisaged Roles of the ULB

- Support to situational analysis of urban health;
- Participation in city health planning in terms of infrastructure and human resources; Rationalization of health facilities;
- Co-ordination and support to CPMU/DPMU.
- Joint monitoring of program implementation;
- Identification of land, its acquisition, or allocation for health facilities;
- Provision of budgets for contractual human resources, if the city plan demands for additional centres which are not approved under the NUHM;
- Provision of budgets for medicines from ULB budget;
- Epidemic planning and management;
- Coordinated management of water contamination episodes;
- Execution of its core functions of solid waste management and preventive vector control; and
- Implementation of urban development programs/schemes in coordination with NUHM to better target the vulnerable

7. What are the proposed institutional mechanisms for convergence at each level?

To ensure convergent actions of health and social determinants of health, the formation of common committee at City/State/District/ Ward level is very important. It needs to be ensured that the members of coordination committee expected to be formed at different levels - from National level to Ward level must include the Nodal Officers / Concerned Officials of the National Health Programme e.g. (IDSP/RNTCP etc).

The 3 tier system which can be followed are as follows:

- WARD LEVEL-Ward Level Coordination Committee
- CITY LEVEL-City Level Coordination Committee
- STATE LEVEL-State Level Committee

In six mega city corporations the above three tiered mechanism for convergence is followed.

The above committees are expected to facilitate convergent planning and implementation with ULBs and other critical stakeholders. This coordination is to be delivered through the platform of the district health societies in smaller towns. Various inter-sectoral convergence structures currently exist in different forms at the city, and ward levels either as a part of the Urban Local Bodies administrative structure or through national programmes such as Swachh Bharat Mission.

In addition to the committees it will be important to establish working groups of key functionaries involved in operational activities. These working groups could meet more frequently than the committees.

8. What are the existing platforms under various programmes that can be leveraged at each level for constituting the committees?

Programme/ Body	State Level	District/City Level	Ward Level	Community Level
NUHM	State Level Executive Committee	District Health Society	Ward Level Committees (these have not been established everywhere)	Mahila Arogya Samitis
DAY-NULM	Executive Committee (includes Secretary Health)	Executive Committee (Includes Chief Medical Officer) Common District level Committee	Area Level federations of SHGs	Self Help Groups/ Area Level federations of SHGs
SBM	High Powered Committee	Advisory & Monitoring Committee	Ward sanitation committee	Swachhagrahis
ULBs	NA	City Council Area Sabhas	Ward Committees	NA

9. Is there any existing examples of Convergence in States /UTs, if yes, provide details?

Some Examples of Existing Convergence Structures in States/UTs are as follows:

- Ward Kalyan Samitis (ward welfare committees) were established in Chattisgarh under the Mukhya Mantri Shahari Swasth Karyakram and Odisha under HUP program. They are composed of representatives of health, ULB, ICDS, schools and elected officials
- Formalized platform in West Bengal at UHC, ward and higher levels with structured interactions; Presence of SUDA structures at all levels.
- Mandated interaction of the NGO managed UHCs in Telangana with other stakeholders; leveraging MEPMA for strengthening community processes
- Ward level multi-sectoral committees which are addressing health and beyond.
- Informal ward level groups in Madhya Pradesh, leverage existing ICDS ward level nutrition committees and SJSRY neighbourhood committees
- Informal coordination of UPHCs in Mysuru, Karnataka with elected officials

10. What are the suggested objectives, functions and composition of the State Level Committee?

The State Level Committee is envisaged as a multi-sectoral platform for ensuring various urban stakeholders to be involved in planning and executing all policies, programmes and schemes which target the urban poor with a coordinated approach. The objectives of establishing a state level committee are:

- Provide a forum for convergence of state level stakeholders for the delivery of Urban Health and WASH services to the urban poor.
- Serve as nodal body for planning and monitoring of Urban Health and WASH service delivery to the urban poor.
- Provide a forum for identifying gaps and convergent solutions, and innovations to address the Urban Health and WASH service delivery to the urban poor.

Proposed Members

Designation	Options*
Chairperson	Senior most Principle Secretary (Health/Urban Development)
Convener	MD NHM
Member – Health	State Nodal Officer/SPM(NUHM)/Relevant SPOs under NHM
Member – ICDS	Principle Secretary/Director WCD
Member - Municipal Corporation	Municipal Commissioner of the Capital City
Member Education	Principle Secretary/Director Education
Member – Missions – NULM, Swachh Bharat Mission or similar such urban bodies	Mission Directors
Member - Medical College/ Professional Bodies	SPM Department/ IAPSM/ IAP/ FOGSI
Member - Development partners	WHO-NPSP/ CARE/ UNICEF/ UNFPA etc
Member – NGOs	Representatives from NRHM recognized NGOs/ Resource Organization under NULM

* This is an Indicative /suggested list. State to discuss and decide the final list of members at the state level.

Proposed Functions

1) Planning:

- Develop and formally approve a multi-year city health plan (MNCHN, Vector control, NCD & WASH) with budget estimates, based on current situation analysis and the prevalent national and state policies.
- Identify and assign fixed responsibilities to member departments/ organizations based on the needs identified in the state health plan.
- Mobilize existing resources from the member departments/ organizations to meet the requirements as per the plan.
- Identify gaps in resources, infrastructure and manpower based on the health plan.
- Develop an annual capacity building plan for member departments/ organizations on urban health issues.

2) Monitoring and review:

- Monthly monitoring of progress based on fixed indicators, as decided by the committee, with appropriate feedback to concerned members.
- Quarterly review meetings with analysis of progress made and recommendations for mid-course corrections if necessary.

3) Fostering partnerships:

- Explore the possibilities for entering into Public-Private Partnerships to meet the gaps identified in the city health plan.
- Review and approve proposals for PPP interventions to improve services delivery among the urban poor.

4) Knowledge and communication:

- Dissemination of current urban health guidelines among all stakeholders.
- Develop a compendium of guidelines, letters and research material on urban health for dissemination to all stakeholders.
- Identify and disseminate best practices in other cities to all members through review of literature.

11. What are the suggested objectives, functions and composition of District/City Level Committees?

The City Coordination Committee is envisaged as an Apex Body at city level for the convergence of various stakeholders involved in the delivery of urban health and Water, Sanitation and Hygiene (WASH) services to the urban poor which will function with the following objectives:

- Provide a forum for convergence of city level stakeholders for the delivery of Urban Health and WASH services to urban poor.
- Serve as the nodal body for the planning and monitoring of Urban Health and WASH service delivery to the urban poor.
- Provide a forum for exploring, reviewing and approving Public-Private Partnership initiatives and innovations to address the gaps in Urban Health and WASH service delivery to the urban poor.

Proposed Members

Designation	Options
Chairperson	Mayor/Municipal Commissioner /DM in District based cities
Convener	City Health Officer/ District Medical Officer/ Urban RCH Officer
Member – Health	MO UPHC/City/District Urban Health Consultant
Member – Health	NUHM nodal officer
Member – ICDS	Urban CDPO/ DPO ICDS
Member - Municipal Corporation	Assistant Commissioner Health, ULB Municipal Health Officer Slum Improvement Officer
Member – PHED	Executive/superintendent engineer
Member Education	Principals of Municipal and government schools
Member – DUDA, NULM, SBM or equivalent	Project Officer
Member - Medical College/ Professional Bodies	SPM Department/ IAPSM/ IAP/ FOGSI
Member - Development partners	WHO-NPSP/ CARE/ UNICEF/ UNFPA etc
Member – NGOs	Representatives from NRHM recognized NGOs/ ROs engaged under NULM & 2 Representatives from City level Federations

* This is an indicative /suggested list. State/City to discuss and decide the final list of members

Proposed Functions

1) Planning:

- Develop and formally approve a multi-year city health plan (MNCHN, Vector control, NCD & WASH) with budget estimates, based on current situation analysis and the prevalent national and state policies.
- Identify and assign fixed responsibilities to member departments/ organizations based on the needs identified in the city health plan.

- Mobilize existing resources from the member departments/ organizations to meet the requirements as per the city health plan.
- Identify gaps in resources, infrastructure and manpower based on the city health plan.
- Develop an annual capacity building plan for member departments/ organizations on urban health issues.

2) Monitoring and review:

- Monthly monitoring of progress based on fixed indicators, as decided by the committee, with appropriate feedback to concerned members.
- Quarterly review meetings with analysis of progress made and recommendations for mid-course corrections if necessary.

3) Fostering partnerships:

- Explore the possibilities for entering into Public-Private Partnerships to meet the gaps identified in the city health plan.
- Review and approve proposals for PPP interventions to improve services delivery among the urban poor.

4) Knowledge and communication:

- Dissemination of current urban health guidelines among all stakeholders.
- Develop a compendium of guidelines, letters and research material on urban health for dissemination to all stakeholders.
- Identify and disseminate best practices in other cities to all members through review of literature.

12. What are the suggested objectives, functions and composition of Ward Level Committees?

The urban wards are cohesive units in the otherwise disparate cities. They form the node for convergence of all developmental programs. It establishes linkage between service provider and community by virtue of their rights through policy level influence for decision making. The 74th Amendment of the Constitution (1992) emphasizes the Constitution of Wards Committees in all municipalities with a population of 3 lakhs or more. The Ward Level Coordination Committees may either be established formally or other similar structures such as the Ward Sanitation Committees of the Swachh Bharat Mission or ULB ward committees may be leveraged as ward committees for health as well. They are expected to serve as the nodal body for the planning and monitoring service delivery at the community level and effectively link the communities with all relevant services which impact health and its social determinants.

Objectives

- Provide a forum for convergence of ward level stakeholders for the delivery of Urban Health and WASH services to the urban poor.
- Serve as the nodal body for the planning and monitoring of Urban Health and WASH service delivery to the urban poor.
- Provide a forum for reviewing implementation of multi-sectoral health and WASH activities targeted towards the urban poor.

Proposed Members

Designation	Options
Chairperson	Ward Councilor
Convener	ANM of the ward/Medical Officer of the UPHC
Member – Health	Lady Health Visitor; ANM ; Two ASHAs by rotation/Public Health Managers
Member – ICDS	Anganwadi Supervisors (ICDS)- Two supervisors as representatives by rotation
Member - Municipal Corporation/ Municipality	Ward official, Sanitation Inspector
Member – PHED	Junior Engineer
Member – DUDA, DAY-NULM, SBM or equivalent	Community Organizers
Member - Development partners	WHO-NPSP/ CARE/ UNICEF/ UNFPA etc
Member - Education	School principals and teachers of the school in the ward (one private /government)
Member – NGOs	Representatives from NRHM recognized NGOs
Member- Private Sector	Private Medical Practitioner- One representative by rotation
Community representative	President of MAS/ALF groups – two members by rotation, Representative of the Basti Vikas Manch

Proposed Functions

The Ward Coordination Committee will perform the following functions:

1) Planning:

- Devise a monthly and quarterly convergence plan with all relevant stakeholders and display for general information.
- Develop and formally approve a micro plan for effective delivery of envisaged services in their designated area.
- Assign fixed responsibilities to representatives of different departments and other stakeholders for improving health status and living conditions of the urban poor.
- Mobilize existing resources from the member departments/ organizations for joint activities as per micro plan.
- Utilize community structures such SHGs /ALFs formed under DAY-NULM, DUDA etc for promotion of behaviours related to health and health determinants.
- Utilize the provisions under SBM to advocate with the local authorities for construction of community based health centres, community toilets), storm water drains, desalination plants, sewerage, drainage and disposal system in their area.

2) Monitoring and review

- Monitor the quality of services health nutrition & WASH services in their area.
- Monitor every month progress based on fixed indicators, as decided by the committee, with appropriate feedback to representatives of concerned departments.
- Conduct quarterly review meetings with analysis of progress made versus the plan and recommendations for mid-course corrections if necessary.

3) Fostering partnerships

- Explore partnerships with private service providers for delivery of outreach health care services in urban slums.
- Explore opportunities for resource leverage for urban health and health determinant issues with charitable organizations, trusts, NGOs, CBOs, Social clubs like Rotary etc.

4) Knowledge and communication

- Provide platform for sharing the information on various government schemes and

entitlements with the community.

- Dissemination of the minutes of meeting to community with proposed outcome in the month.
- Discussion on the community issues raised by community with the Ward Councilor.

13. What are the budgetary provisions for implementing convergent actions?

The following Line items under each programme and the ULBs can be leveraged to carry out convergent actions:

- Administrative costs (meetings, workshops, exposure visits etc)
- Training costs
- Joint IEC/BCC activities
- Untied Fund for MAS

FREQUENTLY ASKED QUESTIONS(FAQ) ABOUT CONVERGENCE



PERSPECTIVE OF THE URBAN LOCAL BODIES (ULB) AND OTHER STAKEHOLDERS

1. Why is it important for the ULB to establish convergence with the National Urban Health Mission?

The 74th Constitutional Amendment Act (74 CAA) enacted in 1993, contains the Twelfth Schedule of municipal functions which are 18 in number. The Act (74 CAA) has transferred the management of health care facilities in urban areas to Urban Local Bodies (ULB) since then. However the capacity of the ULB to lead, plan and manage Urban Health Programme is not only limited in most cases but varies from state to state.

While health may not be perceived as a core function by the ULBs, the impact of ill health on urban development is immense. Therefore by coordinating and converging with the NUHM the ULBs stand to ensure that the urban developmental activities meet with success as well as optimal solutions are identified to ensure productive populations, especially in resource poor contexts.

2. What are the traditional health roles of the ULB?

The Model Municipal Law (MML) circulated by Ministry of Urban Development provides guidance to states towards implementation of the provisions under the 74th CAA. The MML classifies municipal functions into

three categories, namely 'core', 'additional' and 'other' functions.

'Community health', a role listed under the 'core' functions of an ULB, is defined as follows:

- Inspection, supervision, regulation, and control of premises to ensure proper environmental sanitation
- Regulation of public bathing and washing
- Provision and maintenance of public conveniences
- Licensing of animals and control of stray animals
- Licensing of butchers and slaughterhouses
- Control of nuisances (which includes prevention of transporting pollutants, burial of corpses in unauthorized locations, sound and air pollution)

Provision of curative care which is listed under 'additional' roles (as assigned by the state government) is self-explanatory. 'Health and sanitation' which is listed under 'other' functions entails the following:

- Mass inoculation campaigns for eradication of infectious diseases
- Construction and maintenance of slaughterhouses and their regulation
- Reclamation of unhealthy localities, removal of noxious vegetation and abatement of all nuisances
- Maintenance of all public tanks and regulating the re-excavation, repair and up-keep of all private tanks, wells and other sources of water-supply
- of civic consciousness of public health and general

welfare by organizing discourses, seminars and conferences

- Measures for eradication of addiction of all kinds including addiction to drugs and liquor

The eighteen areas of participation for ULBs under the 74th CAA may or may not lie with the ULBs depending on the state level policies.

3. What is the envisaged role of the ULB under the Convergence Plan?

NUHM framework envisages that the Urban Local Bodies (ULB) will implement NUHM in the seven mega cities, namely Delhi, Mumbai, Kolkata, Chennai, Bengaluru, Hyderabad and Ahmedabad. For the remaining cities, health department would be the primary implementation agency for NUHM. However, for cities/towns where capacity exists with the ULBs, the states have the flexibility to hand over the management of the NUHM to the ULBs.

The States / UTs need to guide the ULBs on NUHM Convergence Plan there by strengthening their service delivery system.

Level	Convergence Platform	Suggested Participants
State	State convergence committee	Principle Secretary Urban Development as chair Municipal Commissioner of the Capital City as member
District/City	City/District convergence committee	Mayor Assistant Commissioner Health, ULB Municipal Health Officer
Ward	Ward convergence committee	Ward Councillor/ Corporator as chair Ward official Sanitation Inspector Junior Engineer Community Organizers DAY-NULM

In addition to the committees it will be important to establish working groups of key functionaries involved in operational activities. These working groups could meet more frequently than the committees.

Please refer to the FAQs on state, city and ward level committees for further information on objectives, functions and composition of each committee.

4. What are the institutional mechanisms for coordinating with the health department?

In Six Mega City Corporations the three tiered mechanism for convergence are as follows:

The 3 tier system which can be followed are as follows:

- WARD LEVEL-Ward Level Coordination Committee
- CITY LEVEL- City Level Coordination Committee
- STATE LEVEL-State Level Committee

The establishment of institutional mechanisms under the NUHM, such as state and city level committees, is expected to facilitate convergent planning and implementation with ULBs and other critical stakeholders. This coordination is to be delivered through the platform of the district health societies in smaller towns. Various inter-sectoral convergence structures currently exist in different forms at the city, and ward levels either as a part of the Urban Local Bodies administrative structure or through national programmes such as Swachh Bharat Mission.

5. How can community processes under the Housing & Urban Affairs and health programs converge to create enhanced community actions?

While Urban Development programmes such as the DAY-NULM have building institutions such as the self help groups and slum level federations at the community level, the NUHM is mandated to establish a Mahila Aarogya Samiti for every 50–100 households in slums and among vulnerable communities.

The SHGs are provided with financial linkages, livelihood opportunities, skill training under the DAY-NULM to partner with local self governments, public service providers, banks, private sector and other mainstream Institutions to facilitate delivery of social and economical services to poor. Similarly under Swachh Bharat Mission all the frontline health workers at community level will be "Swachagrahis" delivering services.

In addition the ICDS functionary – Anganwadi worker (AWW) and the Accredited Social Health Activist (ASHA) of the NUHM are also providing preventive and promotive nutrition and health services to the vulnerable groups. Coordinated and convergent actions of these community based structures have the potential of exponentially increasing the magnitude of outcomes that can be achieved by the urban development and health programmes alike.

Please refer to D.O letters G.21011/3/2016-UH (Part-1) dated 8th Feb,2017 and L.19017/38/2017 dated 19th June,2017, and the same is also available on (<http://nhm.gov.in/nhm/nuhm/nuhm-orders-letters.html>).

6. What is the role that can be played by the elected representatives?

Through D.O. letters dated 19th Nov,2016, the Joint Secretary (NUHM) has written to Mayors across the country seeking their support in strengthening NUHM in their respective cities. As the elected leaders of their cities the Mayors and Chairpersons can ensure convergence of urban development and health activities through policy decisions at the level of the City Councils.

The suggested common roles for the Mayors/Chairpersons, Municipal Councilors/Corporators, Ward Councilors/Corporators are as follows:

- Chair the city level multi-sectoral coordination committees
- Review the implementation of NUHM activities
- Facilitate inter-sectoral resolution of identified problems
- Visit facilities and review the provision and quality of services
- Advocate for utilization of health services from the urban facilities among the communities
- Advocate for promotion of positive behaviors of Water, Sanitation and Hygiene (WASH), open defecation free communities and collective community actions

Beside the above the other suggested roles are also follows:

Suggested Roles for the Mayors/Chairpersons

- Chair the City level multi-sectoral Coordination Committees
- Review the financial information, including allocation and utilization of funds received by Municipal Corporations and Municipalities from NUHM
- Ensure allocation of municipal budgets to bridge financial gaps to implement identified health interventions
- Encourage the development of multi-sectoral city health plans

Suggested Roles for the Municipal Councilors/Corporators

- Review the implementation of NUHM activities in their areas
- Support the identification of specific health issues and their inclusion in the multi-sectoral city health plans

Suggested Roles for the Ward councilors/Corporators

- Chair the Ward level multi-sectoral Coordination Committees
- Review the implementation of NUHM activities
- Review the support being provided to the ASHAs, including incentives and supervision
- Review the implementation of school health and ICDS activities
- Review the implementation of SBM, water stagnation, solid waste and water quality issues
- Represent ward level health issues at the city council meetings and facilitate allocation of municipal budgets to bridge financial gaps to implement identified health interventions
- Ensure Ward level issues are represented in the multi-sectoral city health plan

Note: May vary depending on the ground reality of the States/UTs.

7. What are the budgetary provisions for implementing convergent actions?

The following Line items under each programme and the ULBs can be leveraged to carry out convergent actions:

- Administrative costs (meetings, workshops, exposure visits etc)
- Training costs
- Joint IEC/BCC activities
- Untied Fund for MAS

NOTES

This image shows a full page of blank handwriting practice paper. It features a series of evenly spaced, horizontal red lines across the entire width of the page. The background is white, providing a clear contrast for the red lines. There are no margins, text, or other markings present.



*When there is both
inner and outer
cleanliness, it
approaches godliness.*

Mahatma Gandhi

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