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Landscape study on the role of

# Urban Local Bodies in Primary Health Care



#### About Janaagraha Centre for Citizenship and Democracy

Janaagraha is a part of the Jana Group of organisations and is among India's most renowned not-for-profit institutions working towards the mission of fixing India's cities. It was founded by Swati and Ramesh Ramanathan in the year 2001 and presently works across citizen participation and city governance. Its mission is to work with citizens and governments to transform the 'quality of life' in India's cities and towns.

You can read more about Janaagraha at www.janaagraha.org

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### List of Abbreviations

ABDM	Ayushman Bharat Digital Mission	MMR	Maternal Mortality Ratio
AB-HWC	Ayushman Bharat-Health and Wellness Centre	NASSCOM	National Association of Software and Service Companies
AMRUT	Atal Mission for Rejuvenation and Urban Transformation	NCD	Non-Communicable Disease
ANM	Auxiliary Nurse Midwives	NCDC	National Centre for Disease Control
ASHA	Accredited Social Health Activist	NHP	National Health Policy
ARI	Acute Respiratory Infection	NFHS	National Family Health Survey
ASICS	Annual Survey of India's City- Systems	NRHM	National Rural Health Mission
ВВМР	Bruhat Bengaluru Mahanagara Palike	NSS	National Sample Survey
ВМС	Bhubaneswar Municipal Corporation	NUHM	National Urban Health Mission
CAA	Constitutional Amendment Act	NULM	National Urban Livelihoods Mission
СНС	Community Health Centre	ORS	Oral Rehydration Salts
СРНС	Comprehensive Primary Health Care	PCMC	Pimpri-Chinchwad Municipal Corporation
DBT	Direct Benefit Transfers	PHC	Primary Health Centre
DLC	District Level Committees	PICME	Pregnancy and Infant Cohort Monitoring and Evaluation
DH	District Hospital	PIP	Programme Implementation Plan
DHS	District Health Society	РМ-АВНІМ	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
DOTS	Directly Observed Therapy, Short-course	PMASBY	Pradhan Mantri Atmanirbhar Swasth Bharat Yojana
EAG	Empowered Action Group	PMJAY	Pradhan Mantri Jan Arogya Yojana
ENT	Ear, Nose, Throat	PMU	Project Management Unit
FC	Finance Commission	PPP	Public-Private Partnership

FP	Family Planning	PRI	Panchayati Raj Institution
GCC	Greater Chennai Corporation	RCH	Reproductive and Child Health
GIS	Geographic Information System	RKS	Rogi Kalyan Samitis
GNM	General Nursing and Midwifery	SDH	Sub-Divisional Hospitals
HLSC	High-Level Steering Committee	SBM	Swachh Bharat Mission
HR	Human Resources	SFC	State Finance Commission
HRH	Human Resource for Health	SHS	State Health Society
HRIS	Human Resources Information System	SHSB	State Health Society, Bihar
HWC	Health and Wellness Centre	SORR	States' Own Revenue Receipts
IDSP	Integrated Disease Surveillance Programme	SOTR	States' Own Tax Revenue
IHIP	Integrated Health Information Platform	SRS	Sample Registration System
IMR	Infant Mortality Rate	SWM	Solid Waste Management
IPP-VIII	India Population Project VIII	ТСР	Town and Country Planning
JAN	Jan Arogya Samiti	TNMSC	Tamil Nadu Medical Services Corporation
JNNURM	Jawaharlal Nehru National Urban Renewal Mission	TP	Town Planning
JSY	Janani Suraksha Yojana	UD&HD	The Urban Development & Housing Department
KPP	Key Performance Parameter	UHC	Universal Health Coverage
MAS	Mahila Arogya Samiti	UHND	Urban Health and Nutrition Days
МСН	Maternal and Child Health	UHWC	Urban Health and Wellness Centres
M&E	Monitoring and Evaluation	ULB	Urban Local Body
MLSP	Mid Level Service Provider	UPHC	Urban Primary Health Centres
MML	Model Municipal Law	VHSC	Village Health and Sanitation Committee
МО	Medical Officer	WASH	Water, Sanitation and Hygiene
MoHFW	Ministry of Health and Family Welfare	WHO	World Health Organization
MoHUA	Ministry of Housing and Urban Affairs	XV-FC	Fifteenth Finance Commission of India

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# Foreword

This Landscape Study on the Role of Urban Local Bodies in Primary Health Care was conducted by Janaagraha Centre for Citizenship & Democracy as a part of the Project Transforming Governance of Primary Health Care, supported by the Bill & Melinda Gates Foundation.

The Transforming Governance of Primary Health Care in Bihar programme aims to help the government of Bihar & its Urban Local Bodies (ULBs) best plan with, access and deploy grants that the Fifteenth Finance Commission of India (XV-FC) has allocated for it towards improving primary health care in urban areas. This is a necessary first step towards strengthening health care governance in Bihar.

The landscape report is an exploratory study to understand the role of Urban Local Bodies for primary health care, models of implementation through decentralisation at the Urban Local Bodies level, and synergies with the National Urban Health Mission. It looks at Bihar (selected cities from five districts), gives an overview of national policy on ULBs and their role in public health, and then narrows to take the examples of four Indian cities outside Bihar (Bengaluru, Bhubaneswar, Chennai, and Pimpri-Chinchwad) to offer points of comparison.

Primary research was conducted in Bihar and the four benchmark cities between May 2022 to July 2022, which included extensive interviews of key officials in urban

#### **JANAAGRAHA**

governance. The secondary research incorporates a desk review of the Municipal Acts, State Finance Commission Reports, and Town & Country Planning Acts of different states in addition to the other relevant studies. Based on Desk & Field Research, the report has been written with recommendations keeping in mind a 'City Systems' based approach for strengthening the Urban Health System specifically in Bihar. The study is intended for the State to draft a roadmap to strengthen Primary Health Care outcomes through decentralisation.

We, at Janaagraha, believe Urban Local Bodies are best placed to enable greater reach to local communities given their proximity at the 'First Mile' to citizens. Further, cities and towns are complex in nature when compared to rural areas with ever expanding geographical areas due to rapid urbanisation, presence of private sector and therefore need a more nuanced approach in Governance, Systems and Processes. Recent experience during the COVID-19 pandemic have shown us the importance of co-opting ULBs in delivering and managing primary health and public health in general. With this study, we seek to support the state in drafting a roadmap to strengthen primary health care outcomes through Urban Local Bodies (ULBs). We hope the recommendations from this study are implemented not just in Bihar, but across states based on context and the system while our attention on health care remains heightened following the pandemic, and as India's urban population continues to grow.

### **Scope of the Study**

The present landscape study on the Role of Urban Local Bodies in Primary Health Care was conducted with specific objectives, as part of the Transforming Governance of Primary Health Care project focusing on Bihar. During the field visits between May 2022 to July 2022 to the selected cities outside Bihar and within Bihar, we attempted to explore the significant aspects of governance and functioning of primary health care systems. Considering the timing and context, the study has potential limitations, and considerable elements which still need to be explored. Our study is qualitative and non-exhaustive in its areas of coverage, as we intended to provide a view of the landscape in Bihar and our benchmark cities as-is.

In the case of cities within Bihar, there is selective involvement of ULBs in Health Care. Therefore, we interviewed key officials such as Commissioners/ Executive Officers from ULBs and some ex-Councilors, with most discussions held with the health department. Responses recorded in the Focus Group Discussions were mainly on hospital-based health care, as the community cannot differentiate between Primary Health and Secondary/Tertiary Health Care.

However, these limitations of the field research do not influence the findings and recommendations at large. We hope that the learnings, findings, and recommendations from this report are used within and beyond Bihar to empower Urban Local Bodies to take on a more active role in the provision of primary health care.



# **Executive Summary**

A Landscape Study on the 'Role of Urban Local Bodies in Primary Health Care' was conducted by the Janaagraha Centre for Citizenship & Democracy as a part of the Project 'Transforming Governance of Primary Health Care'.





#### **BACKGROUND**



Until two decades ago, urban health was not a pressing matter within public discourse, as most urbanrural comparisons showed that the urban population was faring better on most health indices. There was an assumption that urban populations have better access to resources and access to health care, in addition to the greater presence of private health care. Disaggregating these health indicators by socio-economic criteria brought forth the realisation that the health indicators of the urban poor and marginalised communities are, in fact, worse than their rural counterparts.

A combination of factors is contributing to this, particularly that exposure to certain risk factors to health are unique to urban environments, and access to key determinants of health such as clean drinking water, good air quality, and sanitation facilities is low amongst the urban poor. Recent National Family Health Surveys make it evident that key health indicators in urban areas are either plateauing or declining, and the triple burden of disease (Reproductive and Child Health, Communicable & Non-Communicable Diseases, and emerging diseases) in urban areas requires urgent attention.

#### Of the

### 119 million population of Bihar

### less than 12% is currently urban as compared to about 35% in India.

As per the 2030 population projections for the state, 13.93 million people (12.8%) will be in urban areas. It is timely to now create a blueprint for urbanisation in general, and work on improvements to urban health care in particular.

#### **EFFORTS TO IMPROVE URBAN HEALTH - NATIONAL**



The National Urban Health Mission (NUHM) was launched in May 2013 to focus on the health needs of urban populations, particularly the marginalised populations in state capitals, district headquarters and cities/towns with a population of more than 50,000.

The National Health Policy, 2017 took the agenda of urban health further by prioritising the health needs of the underserved populations living in listed and unlisted slums and other vulnerable populations (such as the homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants), and reiterating the need for a cross-sectoral ecosystem level action to address the determinants of health.





The Ayushman Bharat or 'Healthy Bharat' initiative was launched in 2018 to achieve the vision of Universal Health Coverage (UHC), the **primary care** component being provisioned through Health and Wellness Centres (HWCs), and secondary and tertiary care through strengthening the Public Health Institutions and the **Pradhan** Mantri Jan Arogya Yojana (PMJAY) in both rural and urban areas.

### EFFORTS TO IMPROVE URBAN HEALTH – BIHAR

These national policies have seen varying levels of implementation in different states. Bihar has been making steady progress in improving urban health with NUHM implementation in 25 cities having more than 50,000 population. The Urban Development & Housing Department (UD&HD) has no direct engagement with health care delivery but plays an important role in prevention and control of vector-borne diseases: advancement of civic consciousness of public health; birth and death registration; and eradicating determinants of health. The COVID-19 pandemic brought together all city level stakeholders in managing the pandemic and has demonstrated that the Urban Local Bodies (ULBs) can play an important role in health care.



# Currently, there are 259 ULBs in Bihar

comprising of 18 Nagar Nigams, 83 Nagar Parishads and 158 Nagar Panchayats. 44% of the urban population of Bihar resides in Nagar Nigams, 32% resides in Nagar Parishads and 24% resides in Nagar Panchayats.<sup>1</sup>

<sup>1</sup> As per the 74th Constitutional Amendment Act 1992: Nagar Nigams are Municipal Councils for urban areas with a population greater than one million. A Nagar Parishad is an urban body for a population of 20,000 to 1,00,000; and a Nagar Panchayat is a Notified Area Council, ie. a settlement in transition from rural to urban and therefore a form of an urban political unit comparable to a municipality, for a population of 12,000 to 40,000 people.

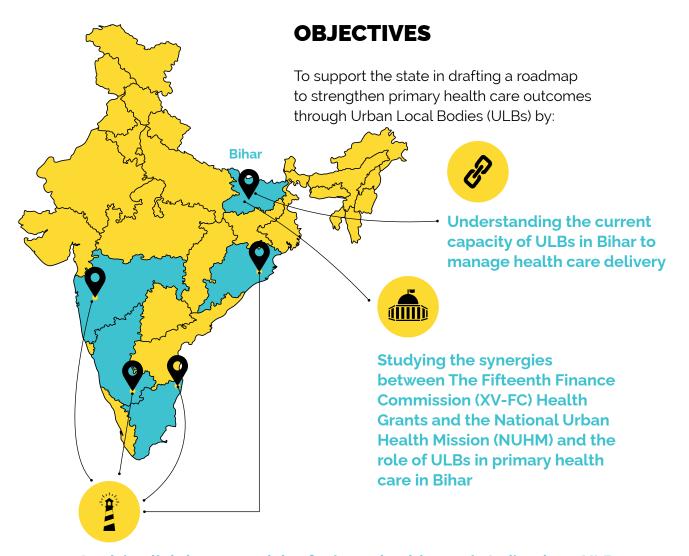


#### **RATIONALE FOR THIS LANDSCAPE STUDY**

The Fifteenth Finance Commission (XV-FC) stressed the need for decentralisation of primary health care to local bodies and allocated a significant amount for this purpose. Additionally, under the Twelfth Schedule of the Constitution, public health functions have been devolved to ULBs. Decentralisation of powers and functions with regard to public health (particularly primary health care) would involve landscaping the current status and drawing up a comprehensive roadmap for attaining this goal.

Given this need to better understand decentralisation and growing urbanisation in Bihar, Janaagraha has undertaken a study of the financial sustainability, accountability, and current capacities of ULBs in Bihar to manage health care delivery. The study also draws lessons from other ULBs in the country that have successfully led health care delivery for the past few decades – in the cities of Bengaluru, Chennai, and Pimpri-Chinchwad; and the ULB of an emerging city making strides in public health provision – Bhubaneswar.





Studying lighthouse models of primary health care in India where ULBs are playing a primary role in access to equitable health care services (in this study – Bengaluru, Bhubaneswar, Chennai and Pimpri-Chinchwad)

#### **METHODOLOGY**

We adopted a two-pronged approach for this study:

- 1. A desk review, evaluating 22 Municipal Acts of 16 states, Town and Country Planning Acts of 10 states, and State Finance Commission reports of 16 states
- 2. Field studies were conducted in four major cities (Bengaluru, Bhubaneswar, Chennai and Pimpri-Chinchwad) and 9 selected cities of Bihar

#### **LEARNINGS & FINDINGS**



#### **Health Policy**

ULBs are largely empowered by municipal acts to handle primary health care. There is provision of public health in core or discretionary functions, standing/subject-matter committees on health, the appointment of health officers, and enabling ULBs to make bye-laws.

In Bihar, community health is a core function and there is a provision for health officers, but their powers are limited to the registration of vital statistics and prevention of dangerous diseases; while in some other states, it is more open-ended.

Town and Country Planning Acts (TCP Acts) do not adequately focus on the important factor of health, but convergent sectors like water and sewerage predominate.

However, the Bihar TCP Act provides for the creation/upgradation of health facilities which are mentioned in the contents of the development plan.

### The ULBs lack adequate and appropriate staff for handling primary health care.

Data available from the Annual Survey of India's City-Systems (ASICS) 2017, indicated the highest vacancy of 65% in municipal corporations. A separate municipal cadre was recommended from JNNURM and continued via AMRUT, and also 5th State Finance Commission - (SFC) of Bihar Cadre was created but still needs to operationalise fully.





### Financing Provisions

The provision of financing varies across ULBs. Out of 22 municipal acts reviewed, 11 acts empower ULBs to spend on public health or raise money on account of public health. However, the State Finance Commissions hardly mention "Public Health", but sanitation. solid waste management (SWM), water supply, and sewage disposal have attained significance. The 6th State Finance Commission (SFC) of Bihar has recommended that 40% of the development fund be untied. The ULBs will be able to use these untied funds to take up schemes for local level development under the subjects enshrined in the Twelfth Schedule of the Constitution, subject to the overall guidelines of the State Government.

During our field visits, we also found that NUHM funds have been devolved to the UPHCs for Untied Grants, Operational Expenditures and grants to Mahila Arogya Samitis (MASs) (i.e., Women's Health Committees).





#### **Devolution and Community Participation**

Platforms for Community Engagement are very important in public health. There are specific roles in public health, water, and sanitation for elected representatives in terms of zonal committees, ward committees, and area sabhas in 7 acts. In Bihar, the act enables the ward committees to discharge the functions related to "health immunisation services and slum services" subject to supervision and control of the Empowered Standing Committee.

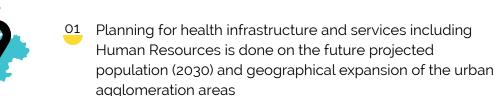
Interestingly, Jharkhand Municipal Act, 2011 has enabled devolution of functions including provision of health and its allied sectors like drainage and sewerage, SWM, disinfection, etc. and and bustee services, provision of lighting, repair of minor roads, maintenance of parks, drains and gullies, and such other functions to the zonal committees, ward committees and area sabhas.

Overall, it was found that relevant provisions have been made in the municipal acts, but the powers and functions of the ULBs need to be defined and clarified so that they can be gainfully engaged with public health.

### HIGHLIGHTS FROM FIELD VISITS OUTSIDE BIHAR

#### Bengaluru

#### Highlights of Key Learnings



- Emphasis on services aimed at Comprehensive Primary Health Care (CPHC) in a phased manner
- O3 Initiative was taken by Bruhat Bengaluru Mahanagara Palike (BBMP) leadership (Executive Officials and Elected Representatives) to prioritise public health delivery and executive orders issued for public health management in 2007
- Robust supply chain mechanism of State Health Department leveraged for drugs, diagnostic consumables, and medical equipment





#### **Bhubaneswar**

#### Highlights of Key Learnings

- O1 Clear mandate from the State Government for the involvement of ULBs in public health
- O2 Strong convergence between Bhubaneswar Municipal Corporation (BMC) and Health Department for providing health services in the city
- Active engagement of the elected representatives in the health care system institutionalised up to the ward level
- Existing health care institutions of BMC as well as Health Department (Urban Health Posts, Urban Family Welfare Centres, and Dispensaries) were upgraded to Urban Primary Health Centres (UPHCs) with the support of NUHM. Emphasis on service delivery, and community outreach and participation
- O5 Specialist clinics in UPHCs are functional on a roster basis with doctors hired on contractual basis from the private sector
- Of Vibrant use of social media for communication on services available





#### Chennai

#### Highlights of Key Learnings

- Chennai has the advantage of being the oldest municipality in the country. Historically, health has been a priority of the policymakers, and therefore a separate cadre of human resources was created for Greater Chennai Corporation (GCC) a few decades ago with a larger share of resource allocation given to health as compared to a majority of ULBs
- O2 Standing Committee on Health at city level was established and activated
- Elected representatives are actively involved in responding to the community needs



#### **Pimpri-Chinchwad**

#### Highlights of Key Learnings

- Selected UPHCs are operational as model UPHCs delivering services as per the CPHC mandate. A shift from focussing only on Maternal and Child Health (MCH) services and some vector control activities to more holistic health care services
- Municipal Corporation is in the process of undertaking household-based Population Enumeration in the city which will also be utilised for all the social sector schemes.
- There are plans to digitise all health care records in the near future





#### **FINDINGS FROM BIHAR**

The findings from our field visits in Bihar are detailed below in three different sub-sections: Health Care Delivery, Community Mobilisation, and Organisational and Financial Governance. Following this, we briefly compare these findings to those from our benchmark cities before moving on to the recommendations of this study.



### Health Care Delivery

- NUHM funding has improved the infrastructure, maintenance and availability of drugs and diagnostics. Service delivery in urban areas has improved; however, there is a need to improve the quality and expand coverage. The initiatives taken by the state to improve the health care delivery system over the past few years were visible during the field visits to the selected Urban Primary Health Centres (UPHCs)
- A majority of the UPHCs are located in rented buildings
- Special Immunisation Corners are set up in UPHCs and they highlight the importance of immunisation in the urban areas
- Some UPHCs have good arrangements for providing privacy for pregnant and lactating women. While the range of services have

expanded to include yoga sessions, hypertension and diabetes screening for patients over 30, the larger focus continues to be on Family Planning (FP) and MCH services

- Recruitment of human resources at the Urban Primary Health Centers (UPHCs) is a perennial struggle with doctors being the most challenging. In the case of Patna, only 8 out of 25 UPHCs were found to be functioning with Doctors. The recruitment takes time, many candidates do not join, and the attrition rate is high. The doctors recruited during the pandemic period have been contracted only for one year. The recruitment of Auxiliary Nurse Midwives (ANMs) from distant places also impacts service delivery and there are issues of absenteeism and lack of accountability
- Most of the UPHCs visited had two lab technicians one recruited under NUHM and the other placed by the Public-Private Partnership (PPP) agency contracted for providing laboratory services. Drugs and supplies are sourced from the district stores, but in some of the Urban PHCs, the drug pharmacies were lacking in storage and systematic upkeep of medicines & supplies i.e. proper labelling, keeping the look alike and sound alike drugs separately to avoid confusion during distribution



#### Community Mobilisation

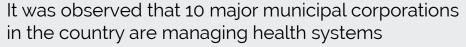
- Jan Arogya Samitis (JASs) are Patient Welfare Committees, which are constituted in UPHCs with the Medical Officer (MO) In-charge as Chairperson, and UPHC MO as Member Secretary for the JAS. Local Councillors are members but their participation is limited. Meetings of JASs are not held at regular intervals
- Councillors are involved in mobilising the community for availing the health care services and enabling access to underserved and vulnerable communities. If ward councillors are also involved prior to any health activity, then the number of people participating will increase and make the activity successful



#### Organisational and Financial Governance

- Role of ULBs in health is currently limited to some vector control measures and community mobilisation activities. The ULBs are part of district level health related committees but their participation is limited
- Elected representatives do not have a clear awareness of their roles and responsibilities for health care services. However, some active elected representatives are playing an important role in supporting the UPHCs, particularly in conducting health camps and improving sanitation services. They also help poor and vulnerable people access basic services
- Most of the health care programmes are implemented based on guidelines from the state and there is little scope for flexibility at the district level
- NUHM funds have been devolved to the UPHCs for Untied Grants, Operational Expenditures and grants to Mahila Arogya Samitis (MASs) (i.e., Women's Health Committees)

#### **SUMMARY OF LEARNINGS**





These cities have evolved the systems within ULBs over a period of time and are able to deliver citizen-centric services including health. Most of the other ULBs have a selected role in the management of health care, wherein they work only on disease prevention and health promotion, and supporting the health department. The capacity of ULBs for managing health systems is limited.

Based on the SFCs reviewed for the study, it was observed that the term 'public health' is only occasionally used in the reports, while its allied sectors receive far more focus. The discourse around healthy living is limited to water supply, sanitation, SWM and access to sewerage facilities. The urbanised states are moving towards a focused approach to tackle public health as a system. In contrast, less urbanised states have just started addressing issues related to public health and its allied sectors.

While immediate recommendations are designed to help move Bihar into Universal CPHC (Comprehensive Primary Health Care), the long-term vision is to move each city towards developing more Comprehensive Health and Wellness Plans and enabling the ULBs to have the infrastructure, skills and resources to manage Healthy Cities (as per the WHO framework)



#### **RECOMMENDATIONS**

The recommendations below are divided into the following categories:



Policy/ Governance



Community Participation



Service Delivery (Planning and Operationalising)



Health Financing



Human Resources



Health Information Systems



#### **Policy/Governance**

#### **Immediate**

- Development & Housing Department (UD&HD) to take a joint decision for the devolution of functions related to primary health care to ULBs in a phased manner; community health is a core function as mentioned in the Bihar Municipal Act, 2007. Consider this provision an enabler for ULBs to take on a greater role in primary health
  - Legislative rules to be promulgated to describe the role of ULBs in health as mentioned under the Bihar Municipal Act, 2007. In the meanwhile, executive order to be passed by the UD&HD enlisting the

role of ULBs in primary health care (proposed roles and responsibilities are given in Annexure No. 1 and 2 as a reference)

- 02 Responsibility of the District Level Committees (DLCs) to be expanded beyond the preparation of the District Health Action Plan, but to include the review and monitoring (at least once a quarter) of the activities approved for the district
- 03 Exposure visit of senior officials of Bihar (Health Department and ULBs) to Bhubaneswar for cross-learning and analysing various practices which can be replicated to strengthen the system suggested
- Keeping in view the significant financial allocations for urban health through XV-FC Health Grants, the governance and management capacity of the State Health Society needs to be enhanced
  - 2 public health professionals to be hired/deputed from the Health Directorate for supporting the Urban Health Cell of the State Health Society
- 05 To showcase and pilot the initiatives for strengthening the role of ULBs in primary health care, 2 ULBs (Patna and another one as per the decision of the state) are to be selected by a special order empowering the ULBs for implementation on a pilot basis
  - As per the mandate of XV-FC Guidelines and Learnings of the Landscape Study, ULBs to take on an increasing role in planning, implementing, and monitoring the Urban Health and Wellness Centres (UHWCs) with technical support from the health department. Health department to depute/ designate senior health official(s) with administrative reporting to the respective Municipal Commissioner for the purpose of providing technical guidance and overseeing the urban primary health initiative as envisaged by XV-FC
  - In Patna city and the other selected cities (ULB), the PMU set up under NUHM to be placed in the Municipal Corporation under the City Health/ Medical Officer for managing urban health in the city, reporting to the deputed health officials functionally and administratively to the Municipal Commissioner
  - Appoint Public Health Managers on a cluster basis, i.e., UPHCs, as per NUHM quidelines in these ULBs. Public Health Managers at City/Circle Level to lead the managerial functions and community processes in the urban areas with funding support from NUHM

#### **Short Term**

To empower the ULBs in taking a leadership role in health, legitimately and adequately through provision of enabling laws/executive orders, some of the steps to be followed are suggested below:

- The Bihar Municipal Act enables the Empowered Standing Committee to constitute ad-hoc committees on the matters it considers significant
  - Constitute a High-Level Steering Committee (HLSC) at the state-level to assess the situation of primary health in urban areas and define the role of ULBs in the medium to long term
  - The HLSC can draft and ratify a white paper on how the transition to ULBs playing an active role in primary health care delivery in urban areas could be a vital step towards improving health in cities and enhancing the accountability of the health care delivery system. Based on the white paper and consultations, a policy/guideline for the roles and responsibilities of ULBs for primary health care in urban areas is to be formulated and implemented
- For effective planning and execution of the initiatives for strengthening urban health in major cities, a decentralised management structure for health will be beneficial
  - Constitution of City Health Society (2 pilot ULBs) for management of urban health programmes at the city level. A governing body under the Chairpersonship of Mayor, and Executive Committee under the Chairpersonship of the respective Municipal Commissioner to be constituted
- Regularly updating the City Health Action Plans will help in consistent planning based on the gap assessment and priorities of the state. State to revisit and update the assessment of urban demography, slums and health facilities, human resources, etc. (an earlier assessment was undertaken in 15 cities in 2013-14)
  - Annual updating of the dynamic data, i.e., Human Resources and Infrastructure; and updating the demographic and slum data every three years to be mandatory
  - Based on this, the annual action plan of NUHM, PM-ABHIM and XV-FC to be prepared

#### Medium/Long Term



To universalise it at the state level, ward committees can be vested with the powers as defined by the rules promulgated under the Act. For example, the Gujarat legislature passed the Gujarat Municipal Corporation's Ward Committees Functions, Duties, Territorial Areas and Procedure for Transaction of Business Rules, 2007 under the Gujarat Provincial Municipal Corporations Act, 1949



#### **Community Participation**

#### **Immediate**

- O1 At the District Level Committees (DLCs), there is low representation of ULBs (only Municipal Commissioner/ Executive Officer is a member) as against Panchayati Raj (where the District Panchayati Raj Officer, elected representatives Zila Parishad Chairperson/Member, Block Samiti, and Mukhiya are members)
  - To ensure that ULBs have equitable representation in DLCs, nominate 1-2 elected representatives of ULBs in the DLCs. State Level Committee to pass an order for inclusion of the elected representatives of ULBs as members of DLCs
  - Review and monitor the activities approved by the district in the District Health Action Plan by DLC
  - Orient and build capacities of the key stakeholders (elected representatives and executives) for the effective functioning of the DLC

#### **Short Term**

To empower the ULBs in taking a leadership role in health, legitimately and adequately through provision of enabling laws/executive orders, some of the steps to be followed are suggested below:

- O1 Strengthening communitisation of urban health by ensuring coverage by Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs) and Mahila Arogya Samiti (MAS). This will help communities to be active participants rather than passive beneficiaries in improving the health of the city. Strengthen community-level committees MAS and Jan Aarogya Samiti (JAS) to achieve better outcomes in preventive and promotive health. The following actions are proposed in this regard:
  - Ensure coverage by ASHAs, ANMs and MASs to empower communities to be active participants in improving health of the city
  - Ensure regular meetings of JASs, discuss and address gaps in service delivery and resources
    - Induct local elected representatives as members of JASs
    - Orient JAS members about their roles and the processes stipulated for the functioning of the JAS
  - Constitute and operationalise Sthaniya Swasthya Sabhas as per the mandate of the XV-FC recommendations
  - Constitute and operationalise ward committees and conduct regular meetings
  - Utilise platforms of National Urban Livelihoods Mission (NULM) and Swachh Bharat Mission (SBM) for community engagement and convergence
- Set up a grievance redressal mechanism and ensure the smooth operation of health centres. TeleHelpline Service Dial '104' is a medical advice helpline number, which is to be expanded for registering community grievances
  - Develop a mechanism for follow-up of the grievances and action taken (timelines and responsibilities for resolving the grievance based on the type of grievance). Feedback to be provided to the complainant regarding the action taken and the solution to the problem
- The Bihar Municipal Act enables the ward committees to discharge the functions related to "health immunisation services and slum services" subject to supervision and control of the Empowered Standing Committee

- A resolution by the HLSC defining the functions of the ward committee regarding primary health to be passed
- 03 "Nominate, Recognise and Reward" best-performing institutions/service providers
  - Mechanisms to be developed for monitoring the performance of the health institutions and service providers based on Key Performance Parameters (KPPs)
  - Based on the KPPs, the best-performing health institutions and service providers to be identified and rewarded

#### Medium/Long Term

- O1 Strengthen the ULBs as per the provision of Bihar Municipal Act, 2007
  - Strengthen ward committees with regular meetings, with emphasis on mechanism of convergence



## Service Delivery (Planning And Operationalisation)

#### **Immediate**

\* A mechanism needs to be 01 developed to strengthen the service delivery specifically to the underserved and vulnerable populations (migrants such as those working on construction sites, or in small habitations along roads and under bridges, non-notified slum areas, destitute and street children). They remain unserved/ underserved and may remain excluded during service delivery planning or statistics. A concerted effort at the local level is required to ensure their access to services. This will help in achieving universal coverage and increasing access for the underserved

- Conduct facility assessment- gap analysis and planning basis 'Design Thinking' by considering socio-demographic profiling and vulnerability assessment of the area
- Conduct Vulnerability Assessments jointly by the departments of Health and UD&H, based on the Vulnerability Mapping and Assessment guidelines and tools developed by MoHFW for Urban Health<sup>2</sup>
- Map all slums (listed and unlisted) in cities and include planning for health care delivery
- Equip the UPHCs/UHWCs for providing services related to MCH, FP, and management of communicable diseases and screening of non-communicable diseases
- Display Citizens' Charter in all facilities including services provided, grievance redressal mechanism and patient responsibility. The staff list and names of drugs and diagnostic tests available at the facility to be prominently displayed
- Designate government academic institutions such as IIM Bodh Gaya or IIT Patna as nodal institutes for maintaining the currency of GIS (geographic information system) maps of the cities. This can also dovetail into the Smart Cities Mission and National Urban Digital Mission
- Decentralised planning of primary health care by co-opting the ULBs will enhance the efficient use of resources
  - Planning based on population projections and geographical expansion to be undertaken for establishing the new health institutions
  - Map the area, assess the existing health infrastructure and identify the sites and buildings for the health centre. ULBs to steer the identification of sites/areas for establishing UPHCs/UHWCs

#### **Short Term**

- Facility level assessment- assessing gaps in infrastructure and availability of services- planning basis 'Design Thinking' (socio-demographic profiling and vulnerability assessment)
  - While selecting the site for UPHCs/UHWCs, easy accessibility (by pucca roads) by the general population, including poor and marginal sections of society, is to be taken into consideration. Health institutions are to be accessible to the community at large. Establishing UPHCs/UHWCs in the middle of a slum will restrict the usage by the periphery area because of the overcrowded slum and adjoining population, as the area is likely to lack

<sup>2</sup> Guidelines and Tools for Vulnerability Mapping and Assessment for Urban Health, 2017, National Urban Health Mission, Ministry of Health and Family Welfare.

- sanitation facilities and an unhygienic environment thereby creating limitations to access.
- Establishing UPHCs/UHWCs within an already existing outpost of a medical college or hospital will not be any value addition for the community
  - Setting up new UPHCs/UHWCs within District Hospitals (DHs), Sub-Divisional Hospitals (SDHs) and/or Community Health Centres (CHCs) to be avoided, so as to increase access by a larger community
- Focus on providing CPHC in a phased manner:
  - 7 services are being provided in the UPHCs. The ambit of services is to be expanded for screening and management of communicable diseases, ENT and elderly care in a phased manner
  - While expanding the services in Bihar, it is imperative that MCH services and communicable diseases continue to be a priority as the state is yet to achieve the desired results in Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR) and control of communicable diseases
  - Specialist services to be provided, at least on a weekly basis, including Medicine, Obstetrics & Gynaecology, Paediatrics and Dermatology (on an honorarium basis) at selected UPHCs which are to function as polyclinics
- Public-private partnership with the not-for-profit sector for facility operationalisation. Models can be:
  - Doctor on hire Doctor to be hired by the department for a limited period/ hourly basis/per case basis. Full-time Paramedical staff to be hired by the department. Service delivery will be as per the in-house model presently operational
  - Selected UPHCs/UHWCs to be operationalised through partnerships with community-based/charity organisations/trusts who have experience in providing health care services. Human resource to be deployed by the organisation. Service delivery including OPD and outreach services to be provided by the organisation. Lump-sum amount for operationalising the UPHCs/UHWCs to the organisation. Supply of drugs and diagnostics by the department. Outreach services of community engagement, public surveillance and health awareness being undertaken by ASHA. This will require robust governance mechanism to oversee the implementation of the Public Private Partnership (PPP) and defined key performance indicators

## Medium/Long Term



# **Health Financing**

### **Immediate**

O1 Track planning, budgeting, and utilisation of financial resources allocated for urban health (State Government, NUHM, XV-FC, etc.)

### **Short Term**

- O1 Institutionalise the financial devolution process to ULBs ensure that the funds flow from State Government is timely and utilised for the intended purpose
- Empower ULBs to enhance their revenue-generating capacity through instruments like bonds, grants, taxes, user charges etc. and utilise these resources to provide social services including primary health

## **Medium/Long Term**

Increase financial allocation for ULBs as part of municipal finance reforms. The 6th SFC of Bihar has recommended that at least 40% of the development fund to be untied. 5th & 6th SFCs of the state have also recommended that activity mapping is to be implemented on priority basis. Activity mapping to identify the priority for sectoral allocation of funds to ULBs

- UD&HD to undertake activity mapping to disseminate the functions for available subjects under the Twelfth Schedule. ULBs are to adapt to the mapped activities, and the pool of funds devolved may be used for their local conditions (Activity mapping undertaken by Maharashtra for Panchayati Raj Institutions can be taken as a reference)
- Institutionalise the financial devolution process to ULBs ensure that the fund flow from State Government is timely and utilised for the purpose
   ULBs to be empowered to enhance their revenue generating capacity and

utilise these resources on providing social services including health

❖ For primary health to be institutionalised as a function of the ULB, the ULBs are to be empowered by the State Government to raise funds to increase the pool of funds available for financing primary health. The example of Pimpri-Chinchwad Municipal Corporation can be followed in this regard that has embarked on raising capital via a Municipal Bond to fund health care infrastructure and services



# Human Resources for Health Institutions

### **Immediate**

- Data and field findings on the availability of Human Resources point to a severe shortage of human resources in the existing urban public health facilities which need to be urgently resolved
  - Rational Deployment of Human Resources – HR assessment already undertaken by the state, this is to be the basis for the rationalisation
  - Conduct walk-in interviews for recruitment of Medical Officers for UPHCs and UHWCs
  - Devolve recruitment of paramedical staff at the district level, which will ensure the availability of local HR and better retention. This will ensure district-level cadre and restrict the

- inter-district transfers, with some exceptions
- If required, at the state level written test may be conducted and thereafter candidates to apply at district level, and further selection process to be undertaken at district level
- Leverage use of telemedicine facilitated by Mid Level Service Provider (MLSP) at the Urban Health and Wellness Centers (UHWCs) and UPHCs to address the shortage of Doctors
- Along with the fixed pay and perks, some financial and non-financial incentives (performance-based incentives, area allowances, leave, higher education opportunities) to be introduced based on the service delivery in the underserved and low-performing districts where retention of Human Resources is a challenge, e.g., additional incentives may be given in cities like Purnia, which is underserved and low performing as compared to Patna

#### **Short Term**

- As is evident from the data and reports compiled on the availability of Human Resources, there is a lack of human resources in public health facilities. Hence, in the short term, the state needs to focus on:
  - Comprehensive assessment of Human Resources (based on population projections) to be undertaken to assess the shortfall, and create new posts within the health department or the urban development department
  - Depute/designate senior health official(s) from the health department to provide technical guidance to the selected ULBs
  - Prioritise recruitment and posting of the cadre of Assistant Health Officers @ Circle/Zonal level in ULBs, which has already been approved by the state
  - Existing Human Resources Information System (HRIS) to be customised to provide city/town-specific information. Retirement planning is already a part of the HRIS
- Multi-skilling of existing Human Resources to meet the specific service delivery requirements would help reduce the gap between the needs and availability of services
  - Capacity building of Medical Officers for management of diseases for special groups, i.e., adolescents, geriatric care, mental health, etc., to be undertaken. For example, in Chennai, all the Female Medical Officers have been trained for conducting ultrasound scans for antenatal cases, thereby addressing the shortage of Radiologists
  - Capacity building of GNM/ANM cadre for counselling services on different health issues and mental health to be undertaken

## Medium/Long Term

- Operationalise Health Cadre (recruit and post Assistant Health Officer @ Circle/Zonal level) within the pilot ULBs. 5th & 6th SFCs in Bihar have strongly recommended a proposal for creating a Municipal Cadre in Bihar to overcome the challenges restricting the development of the urban areas in the state
  - The role of the Health Officer appointed under the act to be expanded to include primary health care in its ambit by a legislative amendment in the act
  - However, since a legislative amendment is a lengthy process, it can be instantly operationalised by passing an executive order, as can be seen in the example of Bruhat Bengaluru Mahanagara Palike in short term for pilot ULBs



# Health Information Systems

## **Short Term**

- o1 Strengthen systems for data collection for urban areas to improve the availability of data for evidence-based planning and implementation of Urban Health Services
  - Recording of disease profile of patients visiting UPHCs/UHWCs, collection, and analysis of OPD, using digital platforms
  - Analysis based on the NFHS and other survey data to be utilised for the implementation of programmatic health facilities
  - As per the mandate of the Integrated Disease Surveillance Programme, capacity building and equipping grassroots workers for disease surveillance to be undertaken

- Involvement of the Community/Councillors in reporting outbreaks will be given emphasis in the capacity building module for ULBs. Awareness among the community to identify and report the inordinate/unusual health incidents in their locality, e.g., fever, diarrhoea or other such conditions in 2-3 families in a locality
- Rapid response to the outbreak/suspected illness by the local health and ULB officials
- Use social media for surveillance; reporting the outbreak for quick responses and containing the outbreak, as well as providing information on health-related issues

## Medium/Long Term

01 Implement Ayushman Bharat Digital Mission.



## **Other Recommendations**

### **Immediate**

- D1 Learning and analysing the Best Practices on the role of ULBs in primary health, which are being followed by other states and which can be replicated, are to be assessed and adopted in Bihar
  - Organise a learning visit to Bhubaneswar Municipal Corporation (representatives from Health Department/State Health Society, Bihar (SHSB), UD&HD, and major ULBs)

## Medium/Long Term

Other recommendations
Create urban health plans based on
WHO Healthy Cities Framework

## AGENDA FOR DISCUSSION

The focus of this study was to support the State of Bihar to draft a roadmap to strengthen Primary Health Care outcomes through ULBs. Although the recommendations are focused on Bihar, they can be adapted by other States, since almost all ULBs do not manage primary health care functions. Therefore, this study may be helpful to a majority of State Governments/Urban Local Bodies and at a National Level to create a plan of action for strengthening the Primary Health Care Systems with the proactive support of Urban Local Bodies, wherein Urban Local Bodies either or are actively co-opted in managing Primary Health Care in the long run.

Based on the learnings from both research and fieldwork, specific recommendations are made as part of each chapter. Some broader points for discussion with respect to high-level initiatives at the national & state levels are:



Using the Model Municipal Law 2003 as a mechanism for strengthening the Urban Local Bodies specifically for Primary Health Care



Creating a typology of the municipal bodies based on their capacities/state government's decisions for managing Primary Health Care through Urban Local Bodies in the long term



Creating Healthy Cities India Report for million plus cities on the line of Healthy States, Progressive India Index



# Using the Model Municipal Law 2003 to strengthen Urban Local Bodies for Primary Health Care

In the Model Municipal Law, health is mentioned across three functions three kinds of functions:

- Core municipal functions Every Municipality shall provide on its own or arrange to provide through any agency, are known as core functions
- Additional functions Each State Government may consider and decide whether the costs for performing such functions which strictly speaking do not belong to the functional domain of the Municipalities shall be underwritten by the sponsoring Government - Central or State

Other functions – Each State Government may consider the various lists in this clause and may add or delete any function

Drainage & Sewerage, Solid Waste Management, Community Health, and protection of the environment are among the functions related to Public Health and its allied sectors falling into the category of Core municipal functions. Curative Health is placed among the additional functions assigned by the state government. At the same time, Public Health and Sanitation is classified into other functions.

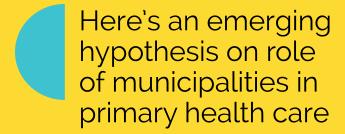
Except for a few major ULBs, most of the ULBs may not be able to manage the Curative Care Systems, i.e. secondary & tertiary care services. But, basic curative services as part of Comprehensive Primary Health Care can be provided at UPHC, which includes management & treatment of basic ailments, communicable diseases (TB, Malaria, and Dengue), non-communicable diseases (hypertension, diabetes, ophthalmic & ENT care and screening of common cancers) can be managed.

In 2003, the Model Municipal Law was circulated as a directive for states to make amendments to the 74th Constitutional Amendment Act, 1992 and include health in these municipal functions. Many states did amend their acts to include Community Health, Curative Health, and Health and Sanitation, but this did not translate into policy and practice on ground. The powers and functions of the ULBs need to be defined and clarified so that they can be gainfully engaged with public health.



# Typology of municipal bodies based on capacity to manage Primary Health Care through ULBs

In light of the preliminary findings from the study and thrust on engagement of ULBs in primary health care, there is a need to closely study a larger number of ULBs. There is an opportunity to engage at the national level to draw upon a policy framework on the progressive involvement of ULBs in primary health care and look at the set of recommendations that can be generalised and replicated across ULBs. This would create a robust typology and a specific roadmap for each set of ULBs. The typology could be based on predefined metrics of involvement, capacity, and performance classifying them into four groups- Small ULBs, Medium sized ULBs-II, Medium sized ULBs-I, and Large ULBs. In the figure below is an emerging hypothesis on the role of municipalities in primary health care.







## Small ULBs

Need handholding for most roles; evolve shared services model

Cluster-based shared services model with role in community engagement, monitoring



## **Medium sized ULBs-II**

Active role in planning, gap analysis, financing, vulnerability assessment, monitoring

Well defined role in planning, financing, community engagement, monitoring



### Medium sized ULBs-I

Own basic primary health care delivery

Comprehensive urban health programming through convergence of all urban development programs

### Large ULBs

Comprehensively own primary health care delivery

# 03

## Creating Healthy Cities India Report for million plus cities

WHO's Healthy Cities framework advocates for a participatory process to respond to health issues that have emerged due to urbanisation. The core principles of the approach included good governance for health, strong political commitment to optimal health, health equity, multi-sectoral collaboration, community participation, monitoring and evaluation, transparency and national and international networking. According to the proposed plan by WHO, for the kick-start to become a healthy city it should commence with the commitment to put people and health at the centre of the urban development agenda. Furthermore, this requires a multi-disciplinary approach that includes urban planning, economic development, social sciences and public health.

Through this study and the workshop around it, we seek to invite community workers, practitioners, researchers, government officials, politicians, and others who are engaged in and/or are active stakeholders in either urban governance or public health to participate in the discussion and engage in a fruitful partnership to strengthen democratic governance at the local level. We, at Janaagraha, believe Urban Local Bodies are best placed to enable greater reach to local communities given their proximity at the 'First Mile' to citizens. Further, cities and towns are complex in nature when compared to rural areas with ever expanding geographical areas due to rapid urbanisation, presence of private sector and therefore need a more nuanced approach in Governance, Systems and Processes. Recent experience during the COVID-19 pandemic have shown us the importance of co-opting ULBs in delivering and managing primary health and public health in general. We hope our recommendations from this study are implemented not just in Bihar, but across states based on context and the system while our attention on health care remains heightened following the pandemic, and India's urban population continues to grow.



# 01

# Background

The epidemiology of health is clearly different in urban and rural areas as evinced by largescale surveys.





# **STATUS OF URBAN HEALTH** 1.1 INDIA AND BIHAR



Until about two decades ago, urban health was not a pressing matter within public discourse, as most urban-rural comparisons showed that the urban population was faring better on most health indices. There was an assumption that urban populations have better access to resources and access to Health Care, in addition to the greater presence of private Health Care. This analysis ignored that data collected for urban areas cannot be representative of urban populations across socio-economic lines. Disaggregating the health indicators for urban populations by socioeconomic criteria brought forth the realisation that the health indicators of the urban poor and marginalised communities are, in fact, worse than their rural counterparts. 3

Further, disease epidemiology, Health Care-seeking behaviour, and exposure to risk factors to health, are unique in urban environments.4 Determinants of health are poor in the urban areas, and haphazard urbanisation without expansion of civic amenities has worsened the situation<sup>5</sup>. The epidemiology of health is clearly different in urban and rural areas as evinced by large-scale surveys.

- https://www.who.int/health-topics/urban-health#tab=tab\_1 Salgado M, Madureira J, Mendes AS, Torres A, Teixeira JP,
- health in urban settings. A systematic review. BMC Public Health. 2020 Jun 3;20(1):853. doi: 10.1186/s12889-020-08905-0. PMID: 32493328; PMCID: PMC7271472.

WHO's Healthy Cities framework advocates for a participatory process to respond to health issues that have emerged due to urbanisation. The core principles of the approach included good governance for health, strong political commitment to optimal health, health equity, multi-sectoral collaboration, community participation, monitoring and evaluation, transparency and national and international networking.



# According to the proposed plan by WHO,

for the kick-start to become a healthy city it should commence with the commitment to put people and health at the centre of the urban development agenda. Furthermore, this requires a multi-disciplinary approach that includes urban planning, economic development, social sciences and public health.

Table: 1.1 Health indicators in urban bihar and india - srs and nfhs<sup>6</sup>

	2018 (SRS)				2019 (SRS)			
	Bihar	Urban (Bihar)	India	Urban (India)	Bihar	Urban (Bihar)	India	Urban (India)
Infant Mortality Rate	32	30	32	23	29	27	30	20
Under-five mortality rate	37	32	36	26	34	31	35	23
Maternal Mortality Ratio	149	NA	113	NA	130	NA	103	NA
	2016-18 (SRS)			2017-19 (SRS)				

Sample Registration System (SRS), National Family Health Survey (NFHS-4 and NFHS-5)

	Urban	Rural	Total	Urban	Rural	Total	
Maternal Health							
Mothers who had at least 4 antenatal care visits (%)	32.4	24.0	25.2	26.3	13.0	14.4	
Institutional births (%)	84.1	75.0	76.2	74.3	62.6	63.8	
Institutional births in public facility (%)	47.4	58.3	56.9	42.7	48.2	47.6	
Home births that were conducted by skilled health personnel (%)	3.6	6.5	6.1	5.7	8.5	8.2	
Average out-of-pocket expenditure per delivery in a public health facility (₹)	3,511	2,771	2,848	1,835	1,778	1,784	
Marriage and Fe	Marriage and Fertility						
Total fertility rate (children per woman)	2.4	3.1	3.0	2.4	3.6	3.4	
Unmet Need for	Family Plar	nning (curre	ently married v	women age	15-49 year	s)	
Total unmet need (%)	11.5	13.9	13.6	19.1	21.4	21.2	
Unmet need for spacing (%)	5.0	6.3	6.1	8.1	9.6	9.4	
Delivery Care (for births in the 5 years before the survey)							
Institutional births in public facility (%)	47.4	58.3	56.9	42.7	48.2	47.6	
Treatment of Childhood Diseases (children under age 5 years)							
Prevalence of diarrhoea in the 2 weeks preceding the survey (%)	12.6	13.9	13.7	8.0	10.7	10.4	
Children with diarrhoea in the 2 weeks preceding the survey who received oral rehydration salts (ORS) (%)	56.7	58.4	58.2	62.1	43.8	45.2	

NFHS-5- Bihar (2019-20)

NFHS-4-Bihar (2015-16)

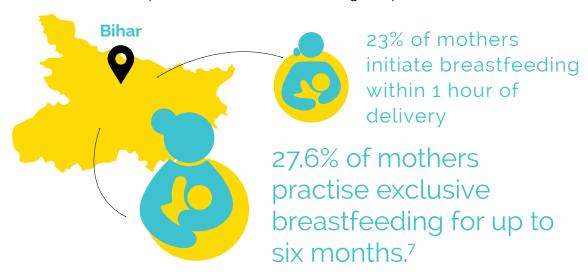
Indicators

Indicators	NFHS-5- Bihar (2019-20)		NFHS-4-Bihar (2015-16)			
	Urban	Rural	Total	Urban	Rural	Total
Children with diarrhoea in the 2 weeks preceding the survey who received zinc (%)	25.3	25.6	25.6	27.2	19.5	20.1
Children with diarrhoea in the 2 weeks preceding the survey taken to a health facility or health provider (%)	63.2	64.9	64.7	56.3	54.7	54.9
Prevalence of symptoms of acute respiratory infection (ARI) in the 2 weeks preceding the survey (%)	3.0	3.6	3.5	1.7	2.6	2.5
Child Vaccinatio	ns					
Children age 12-23 months who received most of their vaccinations in a public health facility (%)	91.1	97.4	96.6	87.0	96.4	95.5
Children with fever or symptoms of ARI in the 2 weeks preceding the survey taken to a health facility or health provider (%)	67.8	69.6	69.4	57.0	60.1	59.8
Anaemia among	Children a	nd Adults				
Children age 6-59 months who are anaemic (<11.0 g/dl) (%)	67.9	69.7	69.4	58.8	64.0	63.5
All women age 15-49 years who are anaemic22 (%)	65.6	63.1	63.5	58.7	60.5	60.3
All women age 15-19 years who are anaemic22 (%)	67.2	65.4	65.7	NA	NA	NA
Blood Sugar Level among Adults (age 15 years and above)						
Women						
Blood sugar level - high (141-160 mg/dl)23 (%)	7.2	6.3	6.4	5.0	4.1	4.2

Indicators	NFHS-5- Bihar (2019-20)		NFHS-4-Bihar (2015-16)			
	Urban	Rural	Total	Urban	Rural	Total
Blood sugar level - very high (>160 mg/dl)23 (%)	8.0	4.9	5.4	2.3	1.8	1.9
Men						
Blood sugar level - high (141-160 mg/dl)23 (%)	10.2	7.8	8.3	8.0	6.4	6.7
Blood sugar level - very high (>160 mg/dl)23 (%)	9.2	6.5	7.0	4.0	3.1	3.3
Hypertension an	nong Adults	s (age 15 ye	ars and above	s)		
Women						
Mildly elevated blood pressure (Systolic 140- 159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	9.0	8.6	8.7	4.2	4.5	4.4
Men						
Mildly elevated blood pressure (Systolic 140- 159 mm of Hg and/or Diastolic 90-99 mm of Hg) (%)	11.7	11.0	11.2	10.4	7.1	7.7
Screening for Cancer among Adults (age 30-49 years)						
Women						
Ever undergone a screening test for cervical cancer (%)	0.6	0.9	0.8	10.9	12.3	12.1
Ever undergone a breast examination for breast cancer (%)	0.4	0.3	0.3	3.8	4.6	4.5
Ever undergone an oral cavity examination for oral cancer (%)	0.4	0.3	0.3	7.7	5.5	5.8
Men						
Ever undergone an oral cavity examination for oral cancer (%)	1.3	0.8	0.9	NA	NA	NA

Based on the NFHS-4 and 5 data for the State, it is evident that certain key health indicators of the urban areas are either stagnant or have worsened.

While larger surveys provide overall trends in urban health indicators, the smaller but more focused urban health research also highlights unfavourable epidemiological patterns, which are a cause for concern. In a recent study conducted in urban slums in Bihar, it was found that only 23% of mothers initiate breastfeeding within 1 hour of delivery and 27.6% of mothers practise exclusive breastfeeding for up to six months.<sup>7</sup>



A community-based study on the urban community in Katihar, Bihar found that 21% of adolescents were overweight or obese with a significant association between less consumption of healthy foods and socio-economic status.<sup>8</sup> A study on schoolgoing adolescents of Patna estimated a prevalence of prehypertension at 10.9% and hypertension at 4.6%, while the prevalence of overweight/obesity was 1.5%. The proportion of children who had ever consumed tobacco was 5.3%, cigarette smoking 4.3%, alcohol consumption 2.1%, and excess salt intake 22.3%.

Only 49.1% of children were doing physical activity at least one hour a day in the past seven days for maintenance of good health.9



- Kazmi S, Akparibo R, Ahmed D, Faizi N. Prevalence and predictors of exclusive breastfeeding in urban slums, Bihar. J Family Med Prim Care. 2021 Mar;10(3):1301-1307. doi: 10.4103/jfmpc.jfmpc\_2000\_20. Epub 2021 Apr 8. PMID: 34041169; PMCID: PMC8140268.
- Ghosh A, Sarkar D, Pal R, Mukherjee B. Correlates of overweight and obesity among urban adolescents in Bihar, India. J Family Med Prim Care. 2015 Jan-Mar;4(1):84-8. doi: 10.4103/2249-4863.152261. PMID: 25810995; PMCID: PMC4367012.
- Kumar P, Kumar D, Ranjan A, Singh CM, Pandey S, Agarwal N. Prevalence of Hypertension and its Risk Factors Among School Going Adolescents of Patna, India. J Clin Diagn Res. 2017 Jan;11(1):SC01-SC04. doi: 10.7860/ JCDR/2017/23886.9196. Epub 2017 Jan 1. PMID: 28274012; PMCID: PMC5324457.

Studies among adolescents in schools in an urban area of Patna city have shown a prevalence of depression in approximately 50% of the cases studied, with as many as 7.7% being severely depressed.<sup>10</sup> <sup>11</sup> A study among children residing close to an informal lead battery manufacturing unit near Patna found that all the children had detectable lead concentrations in their blood.<sup>12</sup> These studies raise concerns about the triple burden of disease in urban Bihar, and that requires urgent attention. The term "triple burden of disease" has been used to refer to the combination of communicable diseases, non-communicable diseases and emerging infectious diseases.

Of the 119 million population of Bihar, less than 12% is currently urban as compared to about 35% in India.<sup>13</sup>

As per the population projections of 2030 for the state,

# 13.93 million people (12.8%) will be in urban areas.14

This provides an opportunity for creating a blueprint to start planning for urbanisation in general, and improving urban health care in particular.



Jha KK, Singh SK, Nirala SK, Kumar C, Kumar P, Aggrawal N. Prevalence of Depression among School-going Adolescents in an Urban Area of Bihar, India. Indian J Psychol Med. 2017 May-Jun;39(3):287-292. doi: 10.4103/0253-7176.207326. PMID: 28615762; PMCID: PMC5461838.

Bharati DR, Kumari S, Prasad N, Choudhary SK, Kumar S, Pal R. Correlates of depression among school going adolescents in the urban area of Patna in eastern India. J Family Med Prim Care. 2022 May;11(5):1702-1709. doi: 10.4103/jfmpc\_jfmpc\_125\_21. Epub 2022 May 14. PMID: 35800564; PMCID: PMC9254754.

Ansari JA, Mahdi AA, Malik PS, Jafar T. Blood Lead Levels in Children Living Near an Informal Lead Battery Recycling Workshop in Patna, Bihar. J Health Pollut. 2020 Feb 28;10(25):200308. doi: 10.5696/2156-9614-10.25.200308. PMID: 32175179; PMCID: PMC7058140.

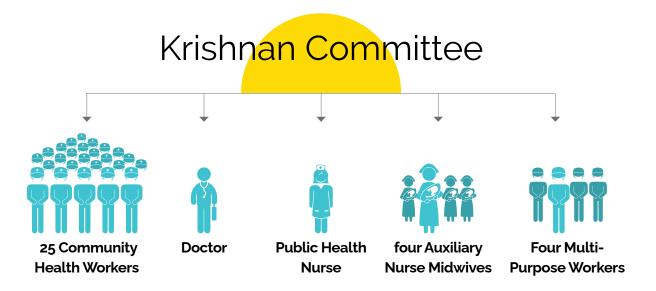
Population projection from census of India 2011

Population Projections for India and States 2011 – 2036, Report of the Technical Group On Population Projections
June 2020, MoHFW

# 1.2 EFFORTS TO IMPROVE URBAN HEALTH IN INDIA AND BIHAR

# 1.2.1 Efforts to improve Urban Health in India

While Health Care delivery for rural populations was planned soon after independence, the focus on Health Care delivery for urban populations started with the appointment of the Krishnan Committee in 1982. The committee recommended the establishment of a health post with a Doctor, a Public Health Nurse, four Auxiliary Nurse Midwives, four Multi-Purpose Workers, and 25 Community Health Workers, for a population of 50,000 and called it the Urban Revamping Scheme.



The National Health Policy (NHP) in 1983 stipulated the need to deliver Health Care to both rural and urban populations and stated that municipal and local authorities should be able to lead in urban areas. The National Health Policy, 2002 recognised the lack of an organised Health Care delivery system in urban areas, the increasing risk of deaths due to accidents, and the possible contribution of the private sector in urban areas. It also envisaged that the funding for the urban primary health system could be jointly borne by the Urban Local Bodies (ULBs) and state and central governments. 16

National Health Policy 1983, Ministry of Health and Family Welfare, Government of India.
 National Health Policy 2002, Ministry of Health and Family Welfare, Government of India.



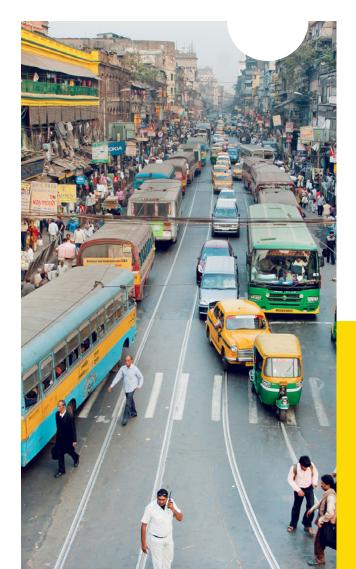
# by the World Bank in the cities of Bengaluru, Delhi, Hyderabad and Kolkata.

The project was focused on reducing infant, child and maternal mortality rates in urban slums by expanding the service delivery system to the slum population through the construction of additional facilities. These facilities created under the IPP-VIII are still the bedrock of urban health infrastructure in these cities and have been supported under different government programmes after the project ended. The facilities built on an enormously large piece of government land provide the perfect opportunity to upgrade to HWCs in these cities.

The National Urban Health Mission (NUHM) as a submission of the National Health Mission (NHM) was launched in May 2013 to focus on the health needs of urban populations, particularly marginalised populations in state capitals, district headquarters and cities/towns with a population of more than 50,000.

The NUHM, therefore, aims to address the health concerns of the urban poor by facilitating equitable access to available health facilities by rationalising and strengthening the existing capacity of health delivery. This endeavour will help in improving the health status of the urban poor<sup>17</sup>.





The NUHM acknowledged the need for cross-sectoral convergence to address the wider determinants of health such as Drinking water, Sanitation, School education





Drinking water



Sanitation



School education

Every Municipal Corporation, Municipality, Notified Area Committee, and Town Panchayat was envisioned as a planning unit<sup>18</sup>. While the allocation to NUHM has increased over the last three financial years, i.e., 2019-20, 2020-21 and 2021-22 from 850 crores, 950 crores and 1,000 crores, respectively, it has remained at about 3% of the NHM budget.<sup>19</sup>

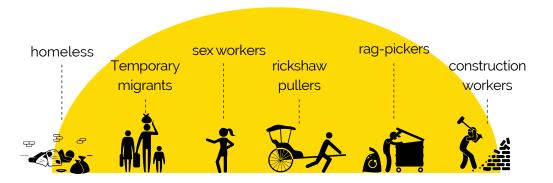
# The National Health Policy, 2017 (NHP)

NHP focuses on health and well-being for all, through promotive and preventive Health Care, health in all developmental policies, and providing universal access to quality Health Care services to the community, without any financial hardship.

https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=970&lid=137

Demand for Grants 2021-22 Analysis: Health and Family Welfare. PRS Legislative Research. https://prsindia.org/budgets/parliament/demand-for-grants-2021-22-analysis-health-and-family-welfare

National Health Policy took the agenda of urban health further by prioritising the health needs of poor populations living in listed and unlisted slums, other vulnerable populations such as (such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants) and reiterating the need for a cross-sectoral ecosystem level action to address the determinants of health. The policy advocated scaling up NUHM to cover the entire urban population of the country<sup>20</sup>.





# The Ayushman Bharat or 'Healthy Bharat' initiative

was launched in 2018 to achieve the vision of Universal Health Coverage (UHC). The Primary Care component of the Ayushman Bharat is being provisioned by the establishment of Health and Wellness Centres (HWCs) in both rural and urban areas. These centres will provide Comprehensive Primary Health Care (CPHC) which is universal, affordable, and closer to the community. In rural areas, the sub-centres and/or Primary Health Centres are being converted to Health & Wellness Centres. In urban areas, the existing health facilities such as Urban Primary Health Centres (UPHCs) and/or dispensaries are being converted to Health & Wellness Centres or new facilities are being set up. The paradigm shift is from selective PHC covering maternal and child health, to an expanded range of services for noncommunicable diseases including free essential drugs and diagnostics.

# The Pradhan Mantri Jan Arogya Yojana (PMJAY)

PMJAY is a health insurance scheme under the Ayushman Bharat Yojna that provides a health cover of 5 lakhs per family per year for secondary and tertiary care hospitalisation to poor and vulnerable families. The PMJAY provides coverage to both the rural and urban poor and vulnerable populations.

The Ayushman Bharat Digital Mission (ABDM) serves as the backbone for universal coverage with CPHC by using integrated digital health infrastructure of the country and linking providers, patients, payers and regulators.







# 1.2.1 Efforts to improve Urban Health in Bihar

Under the National Rural Health Mission (NRHM), the Empowered Action Group (EAG) States (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand and Uttar Pradesh, as defined in 2010-11) as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh, were given special focus to ensure greatest attention where needed.<sup>21</sup>

Bihar being one of the EAG States was given more focus in terms of resource allocation and health systems strengthening. Funding to the EAG States was 1:1.30 as compared to non-EAG States.

The State Health Society, Bihar (SHSB) under the Health Department was set up in 2005 to lead the implementation of NRHM in the state.



Under NRHM there was not much focus on system strengthening in the urban areas. Only the component of urban Reproductive and Child Health (RCH) supports the provision of Auxiliary Nurse Midwives (ANMs) and outreach activities in selected slum areas. Like in most other states, the focus on urban health was limited in Bihar and became more emphatic as the attention to and funding for urban health increased at the national level.

The NUHM implementation began in Bihar in the financial year 2014-15. The SHSB created an urban health cell responsible for implementing the NUHM activities in the 15 cities with more than 50,000 population. In order to make UPHCs function effectively and for conducting monthly Urban Health and Nutrition Days (UHNDs) along with providing antenatal care (ANC) and immunisation services, Special Outreach Health Camps were started in each UPHC area.<sup>22</sup>

Reports of the Common Review Missions and other reports highlighted that by 2018, out of 100 UPHCs sanctioned in the state, 89% were functional and 85% of these had their own accounts.

210th Common Review Mission 2016, Ministry of Health and Family Welfare.



Out of the target of 843 Mahila Arogya Samitis (MASs), 75% had been achieved, consequently resulting in the formation of the MASs, and bank accounts have been opened for 48%. Also, 79% of the targeted 562 Accredited Social Health Activists (ASHAs) had been selected by the state and each ASHA was catering to about 4,000 people.<sup>23</sup> Facility mapping had been completed in Bihar in 15 cities by 2019, and mapping for vulnerable populations had been started manually. In order to improve access for the urban community, the state changed the OPD timings of urban facilities to be operational from 11:00 am to 7:00 pm and some of the UPHCs are also providing the services on Sundays. Approximately 95% of the state's UPHCs have now been converted to HWCs for provision of CPHC to the urban vulnerable population.<sup>24</sup>

The current status of infrastructure and human resources in the urban health system in Bihar is detailed in Table 1.2 below.

Table 1.2<sup>25</sup> Urban Health Infrastructure in Bihar

Total UPHC - Functional	105
UPHCs in private buildings (rental)	82

- 🛮 12th Common Review Mission 2018, Ministry of Health and Family Welfare. Government of India.
- 🔟 13th Common Review Mission 2019, Ministry of Health and Family Welfare. Government of India.
- 5 Data from SHSB, Department of Health and Family Welfare, Government of Bihar.



Presently, 105 UPHCs have been established in 25 cities, out of which 82 (78%) are in private buildings. At many places, the owner does not permit major renovation/alteration for making the UPHCs patient-friendly. Most of the UPHCs are functioning by deploying Medical Officers from other health institutions from rural/periphery areas.

The Urban Development & Housing Department (UD&HD) has no direct engagement with Health Care delivery but plays an important role in managing vector control, advancement of civic consciousness on public health, birth and death registration, and improving determinants of health.

The COVID-19 pandemic brought together all city level stakeholders in managing the pandemic and has demonstrated that the ULBs can play an important role in health.



through ULBs

# 1.3 RECENT EFFORTS TO INCREASE FUNDING FOR MANAGING URBANISATION

Recently, efforts have been made to focus on Health Care delivery in urban areas, and financial allocations have been made separately for urban health. The most recent allocations made have been under the Fifteenth Finance Commission (XV-FC) and Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM).

# 1.3.1 Fifteenth Finance Commission Recommendations

A Finance Commission is constituted by the President every five years to give its recommendations on the distribution of tax revenues between the Union and the states and amongst the states themselves. The XV-FC<sup>26</sup> has advocated for decentralisation of primary Health Care and the involvement of local bodies in planning, budgeting, delivery, and monitoring of primary Health Care. The Commission observed that strengthening the local governments in terms of resources, infrastructure and skills can enable them to play a catalytic role in achieving universal health coverage.

It has earmarked Health Sector Grants of

70,051 crores total

100,051 crores total

10

Bihar's share of these grants amounts to 6,016.92 crores, a fifth of which, i.e., 1,214.07 crores will go to urban areas as against 2.7% share of NUHM in NHM.

Institutions (PRIs) over five years.

<sup>🍱</sup> Finance Commission in COVID Times, Report for 2021-26. XV Finance Commission, Volume-I, Main Report, October 2020.

The dedicated allocation under the XV-FC provides an opportunity to bring in decentralised planning and governance of the primary Health Care services. The proposed allocation will require focused planning to address the gaps in the Health Care provision in both infrastructure and quality of care. This also provides an opportunity to engage the ULBs in improving health outcomes for the urban populations, especially the poor and vulnerable. However, engaging ULBs would need to be accompanied by building capacities of the elected representatives as well as the executive officials.

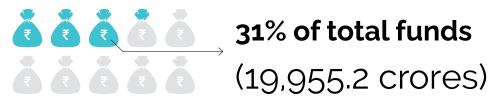
The XV-FC observes that the local elected representatives and officials know the local conditions better, are more accessible, closer and accountable to their constituents, and have the means and the incentives to be more responsive. This in turn leads to higher economic efficiency, better accountability and higher satisfaction of the local population. The XV-FC also recognises that the implementation of XV-FC grants needs coordinated effort at different levels, especially departments of health, local government Panchayati Raj, and UD&HD.

The Ministry of Health and Family Welfare has issued the Technical and Operational Guidelines for Implementation of XV-FC Health Grants through Local Bodies. This brings to the fore the need for policies, devolution of powers, governance, and improving capacities of ULBs in delivering primary Health Care.



# 1.3.2 Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM)

Earlier known as Pradhan Mantri Atmanirbhar Swasth Bharat Yojana (PMASBY), PM-ABHIM was announced as a long-term health infrastructure development scheme in the Union Budget 2021-22 with an outlay of 64,180 crores over five years.



under PM-ABHIM is earmarked for Urban Primary Health Care. There is a major push and emphasis on the involvement of ULBs to manage primary Health Care.

The key elements supported under PM-ABHIM are Health and Wellness Centres (AB-HWCs), Sub-Health Centres, Block Public Health Units, Integrated District Public Health

Laboratories, Critical Care Hospital Blocks, Metropolitan Surveillance Units, Regional NCDCs (National Centre for Disease Control), Integrated Health Information Platform (IHIP) and strengthening Disaster and Epidemic Preparedness.

The committed support for the urban areas is for HWCs, but many of the other elements supporting infrastructure will be housed in urban geographies and spin-off benefits for the urban population also. One clear benefit of rural health infrastructure strengthening will be by decongesting the urban Health Care centres.

# 1.4 DECENTRALISATION OF URBAN GOVERNANCE IN INDIA AND BIHAR

# 1.4.1 74th Amendment of the Constitution

The 74th Amendment to the Constitution, also known as Nagarpalika Act, came into force on 1st June 1993<sup>27</sup>. It gave constitutional status to the municipalities and states were put under constitutional obligation to constitute municipalities. **The 74th Constitutional Amendment Act of 1992 in its Statement of Objects and Reasons sought to make institutions of local urban governance work as "vibrant democratic units of self-government".** It mandated the constitution of local governments and made certain provisions compulsory like regular elections, reservation of seats for socially disadvantaged groups, and constitution of sub-local representative bodies like ward committees.

There are three kinds of municipalities:



Nagar Panchayat for areas transitioning from rural to urban areas



Municipal Council for smaller urban areas



Municipal corporation for larger urban areas.

A ULB comprises elected and nominated members. Each ward (municipal constituency) elects a member to the ULB. Some people with special knowledge and experience may be nominated to the ULB. Lok Sabha and Vidhan Sabha members may also be nominated to the ULB. Only elected members have voting rights on ULB decisions. ULB seats have the following reservations:

- 01 At least one-third of the total seats for women
- O2 SCs and STs in proportion to their population in the municipal area
- O3 Backward class of citizens if so provided by the legislature of the state.
- 04 At least one-third of SC/ST seats are reserved for women
- We will refer to this through the study as the 74th Constitutional Amendment Act of 1992, as both the 73rd and 74th amendments of the Constitution were passed by Parliament On 22/23 December 1992. After securing the endorsement of half the States of the Union and the consent of the President, as required by the Constitution, Part IX ('The Panchayats') was notified in the Gazette of India on 24 April 1993. Part IX A ('The Municipalities') followed a month later.

The duration of the municipality has been fixed at 5 years from the date appointed for its first meeting.

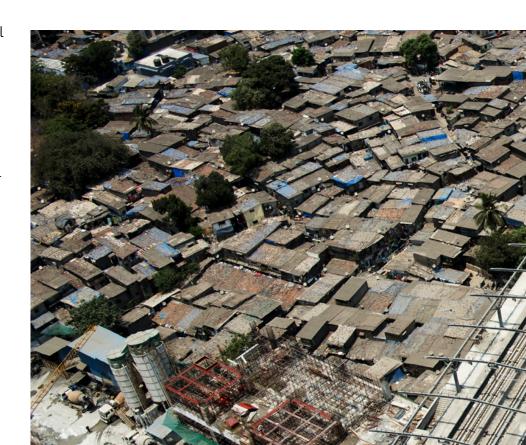
The Twelfth Schedule of the Constitution, inserted by the Amendment, enlists the functions that may be devolved to the Municipalities by the State Government (Article 243W).

This schedule defines 18 new tasks in the functional domain of the ULBs, including slum improvement and upgradation, urban poverty alleviation, planning for economic and social development, water supply, public health, sanitation conservancy and solid waste management, vital statistics including registration of births and deaths, safeguarding the interests of weaker sections of society, including the persons with special needs.

The impetus of decentralisation has gained momentum by providing statutory recognition to local bodies' institutions under the 73rd and 74th Constitutional Amendments Act of 1992. Despite the credit, the local bodies are highly dependent on the higher tier of government for resources. The Constitution of a State Finance Commission (SFC) is mentioned under Article 243-I (1) and 243-Y (1) of the 73rd and 74th Constitutional Amendment Act (CAA), 1992.

## 1.4.2 State Finance Commission

SFCs are the constitutional peers of the Finance Commission (FC). They must advise state governments on the principles to be applied in determining the allocation of funds to local governments and the range of taxes and non-taxes to be devolved to them.

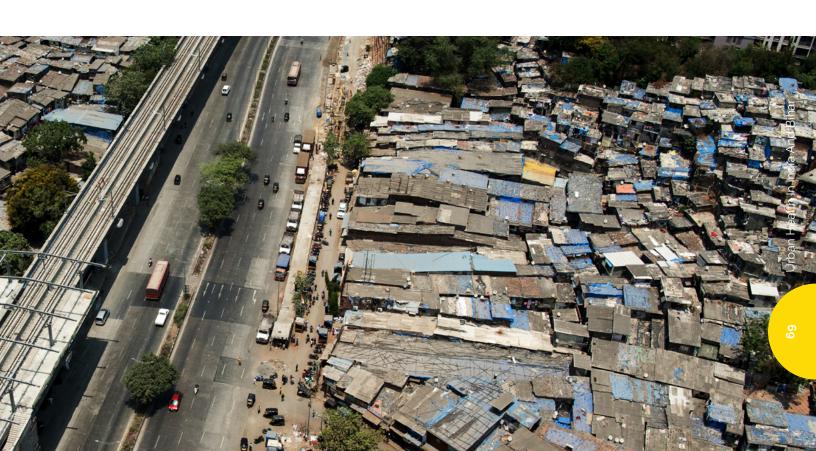


# 1.4.3 Decentralisation of urban governance in India

We will assess the extent of decentralisation of urban governance in India using the Annual Survey of India's City-Systems (ASICS).

Jana Urban Space Foundation and Janaagraha collaborate to conduct an annual survey, the ASICS, that evaluates the quality of governance in cities by assessing the quality of laws, policies, institutions and institutional processes, which together help to govern them.

ASICS evaluates urban governance using Janaagraha's City-Systems Framework consisting of four distinct but interrelated components that help to govern the city and deliver good quality of life to all citizens. The ASICS score of a city is an indication of the health of its governance system and therefore its ability to deliver good quality of life. In the medium to long-term, it aims to push the envelope on transformative reforms in city governance.





The City-Systems framework is a new way of thinking about lingering challenges that plague our cities in three specific ways.



Focuses on root causes rather than symptoms



Recognizes the need for a systems approach



Facilitates periodic measurement of progress In Table 1.3 below, the status of devolution of 18 functions in the Twelfth Schedule is provided as found in the <u>ASICS study</u>, <u>2017</u>. Some items in the Twelfth Schedule have multiple functions, if one of those functions is devolved it is considered 0.5.

Table 1.3 Ten best cities and states with devolution of power on the 18 functions that can be devolved<sup>28</sup>

City	Number of functions devolved	State	Number of functions devolved	
Bengaluru	18.0	Himachal Pradesh Municipal Corporations	18.0	
Vijayawada	13.5	Himachal Pradesh Municipalities	18.0	
Visakhapatnam	13.5	Jharkhand	18.0	
Hyderabad	13.5	Tripura	18.0	
Guwahati	9.0	Uttar Pradesh Municipal Corporations	16.0	
Panaji	9.0	Uttarakhand Municipal Corporations	16.0	
Mumbai	9.0	Goa Municipalities	15.0	
Kolkata	7.5	Gujarat Municipal Corporations	15.0	
Madurai	3.5	Kerala	15.0	
Chennai	3.5	Odisha Municipal Corporations	15.0	

In terms of public health, the cities with the most devolved power are Delhi, Panaji, Bengaluru and Mumbai. States doing well on devolving power to ULBs are Gujarat, Himachal Pradesh, Jharkhand, Kerala, Maharashtra, Rajasthan, Telangana, Tripura, Uttar Pradesh and Uttarakhand.

# 1.4.4 Decentralisation of urban governance to ULBs in Bihar

Currently, there are a total of

259 ULBs in Bihar

comprising

18 Nagar
Nigams

83 Nagar
Parishads

158 Nagar
Panchayats<sup>29</sup>

44% of the urban population
of Bihar resides in the Nagar
Nigams

32% resides in
Nagar Parishads

Bihar state scores an overall 11 in the Janaagraha ASCIS survey in 2021 in devolving power to the ULBs, as compared to 15-18 of some of the cities in Table 1.3.31

24% resides in

Nagar Panchayats.30

<sup>As per the 74th Constitutional Amendment Act 1992: Nagar Nigams are Municipal Councils for urban areas with a population greater than one million. A Nagar Parishad is an urban body for a population of 20,000 to 1,00,000; and a Nagar Panchayat is a Notified Area Council, ie. a settlement in transition from rural to urban and therefore a form of an urban political unit comparable to a municipality, for a population of 12,000 to 40,000 people.</sup> 

http://sec.bihar.gov.in/ForPublic/NagarPalikaEntryReport.aspx#

Janaagraha's Annual Survey of India's City-Systems, in turn, based on the assessment of 67 municipal acts across 28 states and Delhi, 2021.

The Bihar Municipal Act, 2007 describes the following core functions to be performed by the ULBs- planning for economic and social development; roads and bridges; water supply for domestic, industrial and commercial purposes; sanitation conservancy and solid waste management; fire services; urban forestry; protection of the environment and promotion of ecological aspects; urban poverty alleviation; provision of urban amenities and facilities such as parks, gardens, playgrounds; promotion of cultural, educational and aesthetic aspects; vital statistics including registration of births and deaths; public amenities including street lighting, parking lots, bus stops and public conveniences; and regulation of slaughterhouses and tanneries.

The Chief Municipal Health Officer or the Municipal Health Officer can take or recommend action on any aspect of city governance in matters that may be harmful to the health of the citizens.



# 02

# Objective And Methodology Of The Study

## 2.1 STUDY OBJECTIVES

Decentralisation of powers and functions with regard to public health (particularly primary healthcare) would involve landscaping the current state of devolution. In addition, it is essential to draw up a comprehensive roadmap for attaining this goal. An equally critical aspect is ensuring financial sustainability (adequacy of funds), financial accountability and transparency (accountability for outputs and eventually citizen outcomes) for primary health care in Urban Local Bodies (ULBs). This would require a detailed study of existing fund flow and accountability mechanisms for the proposed Fifteenth Finance Commission (XV-FC) grants to ULBs. Key attributes of such a system would include a high degree of digitalisation, elimination of discretion to the extent possible, "observability" (i.e., full transparency in the status of fund flow and utilisation), and correlation between funds and outputs/outcomes at the ULB and state levels.





Against this background, Janaagraha has undertaken this study to understand the current capacities of ULBs in Bihar to manage healthcare delivery, and also to draw lessons from some of the ULBs in the country that have successfully led healthcare delivery for the past few decades.

The objectives of this study are to support the state in drafting a roadmap to strengthen primary healthcare outcomes through Urban Local Bodies (ULBs) by:

- O1 Understanding the current capacity of ULBs in Bihar to manage healthcare delivery
- O2 Studying the synergies
  between The Fifteenth
  Finance Commission (XVFC) Health Grants and the
  National Urban Health
  Mission (NUHM) and the
  role of ULBs in primary
  healthcare in Bihar
- O3
  Studying lighthouse
  models of primary
  healthcare in India where
  ULBs are playing a primary
  role in access to equitable
  healthcare services (in
  this study Bengaluru,
  Bhubaneswar, Chennai and
  Pimpri-Chinchwad)

## 2.2 AREAS OF

The areas of enquiry in the study are organised by four themes: Strategy, Innovation, Operational and Governance. The themes are organised to explore the area where action is required to move ULBs in Bihar to take leadership in delivering healthcare for urban populations.

In our study, we used these categories to inform the questions we sought to answer, both from our research and fieldwork. Similarly, we have used these areas of enquiry and the subcategories listed below to present our recommendations.



### Strategy

policy on devolution and public health provision







### Governance

organisational and financial



### Innovation

health information systems



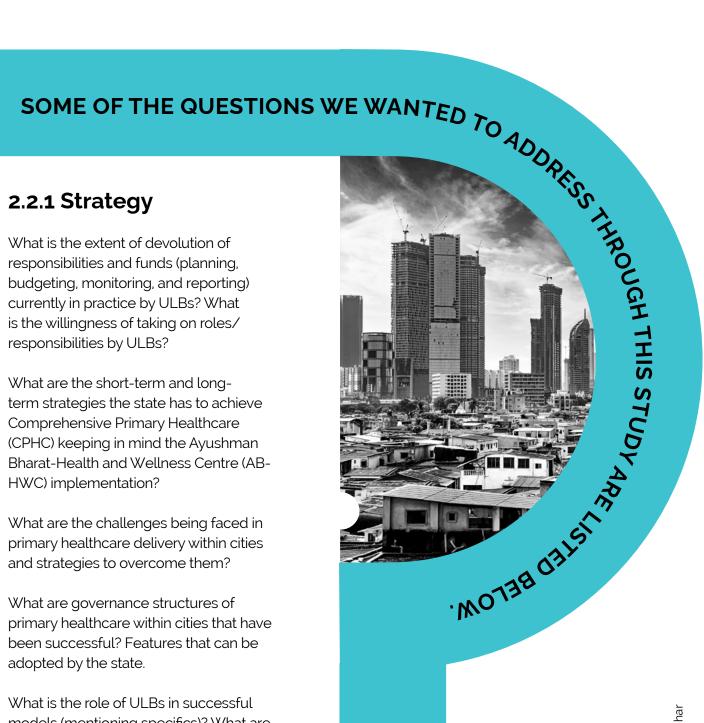
### Operational

service delivery, human resources, and community participation





- O1 What is the extent of devolution of
- O2 What are the short-term and long-
- O3 What are the challenges being faced in
- O4 What are governance structures of
- 05 What is the role of ULBs in successful models (mentioning specifics)? What are the models which can be adopted by the state?
- O6 What is the role of ULBs and coordination mechanism for implementation of NUHM? What are the practices which can be replicated/adopted by the state?



### 2.2.2 Governance

### Organisational

- O1 What is the structure of governance and devolution of powers that have been implemented? What are the practices which can be replicated/adopted by the state?
- What are the strategies/practices adopted by ULBs for building capacities in successful models? What are the practices which can be replicated/adopted by the state?

### **Financial**

- What are the practices for the mechanism of planning, budgeting, drawdown, disbursement, reporting, and utilisation of funds to ULBs?
- What is the flexibility allowed to adapt to the guidelines based on local needs?





### 2.2.3 Operational

This theme also explores lessons around improving coverage and quality of healthcare services, particularly for the underserved communities in urban areas. Our recommendations in this area cover service delivery, human resources, and community participation.

### **Service Provision**

01

What are the successful models of disease surveillance and integration with IDSP (Integrated Disease Surveillance Programme)? What are the practices which can be replicated/adopted by the state?

02

What are the successful models of WASH (Water, Sanitation and Hygiene) implementation done by ULBs? What are the practices which can be replicated/adopted by the state?

03

What are the successful models of operationalising/implementing CPHC through AB-HWC? What are the practices which can be replicated/adopted by the state?







### **Community Participation**

01

What are the successful models of community engagement practices adopted by NUHM/ULBs? What are the practices which can be replicated/adopted by the state?

02

What are the successful models for intersectoral coordination for communicable diseases by ULBs? What are the practices which can be replicated/adopted by the state?

### 2.2.4 Innovations

- What is the extent of technology the state is willing to adopt in the delivery of primary healthcare (MedTech, Point-of-care devices, Artificial Intelligence-based tools)? What are the successful models which can be replicated/adopted?
- What is the extent of considering public-private partnership (PPP) delivery models which have been successful, and the willingness of the state to replicate/adopt the model?
- What are the best practices/models/reforms focussing on urban health to improve the service delivery, which can be replicated/adopted by the state and successfully implemented?





2.3 STUDY METHODOLOGY

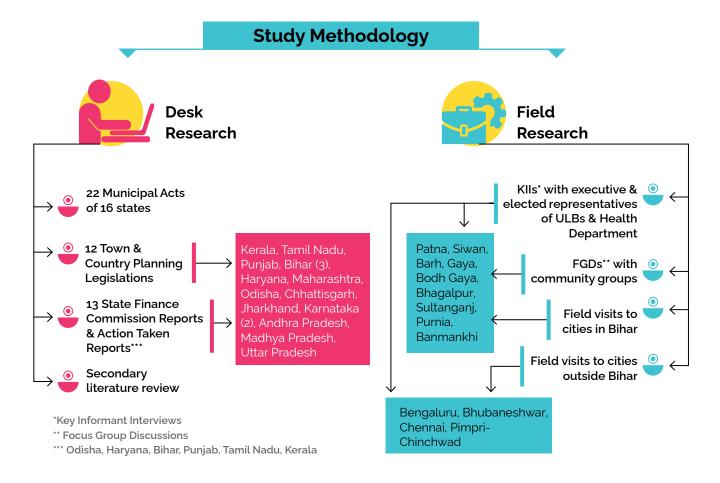


Desk Research



Field Research –
within Bihar and other
states in India

Figure 2.1 Study Methodology



### 2.3.1 Desk Research

### Landscape legislation and literature in public domain to understand empowerment of ULBs in Bihar

- O1 Undertook a detailed review of municipal and town and country planning acts to diagnose the state of governance in Bihar's ULBs in general, and with specific reference to the degree of empowerment and enablement on public health. Janaagraha's City-Systems Framework was applied for this purpose
  - Benchmark with other states specifically on public health related powers and functions<sup>32</sup>

O2 Undertook a detailed review of the following State Finance Commission reports:

- 2nd SFC: Jharkhand
- 3rd SFC: Chhattisgarh
- 4th SFC: Andhra Pradesh and Karnataka
- 5th SFC: Bihar, Haryana, Maharashtra, Odisha, Punjab, Tamil Nadu,
- 6th SFC: Bihar and Kerala



03 Undertook a literature review of studies done on ULB involvement in public health and synthesised the findings and recommendations

### 2.3.2 Field Research in Bihar and Cities outside Bihar

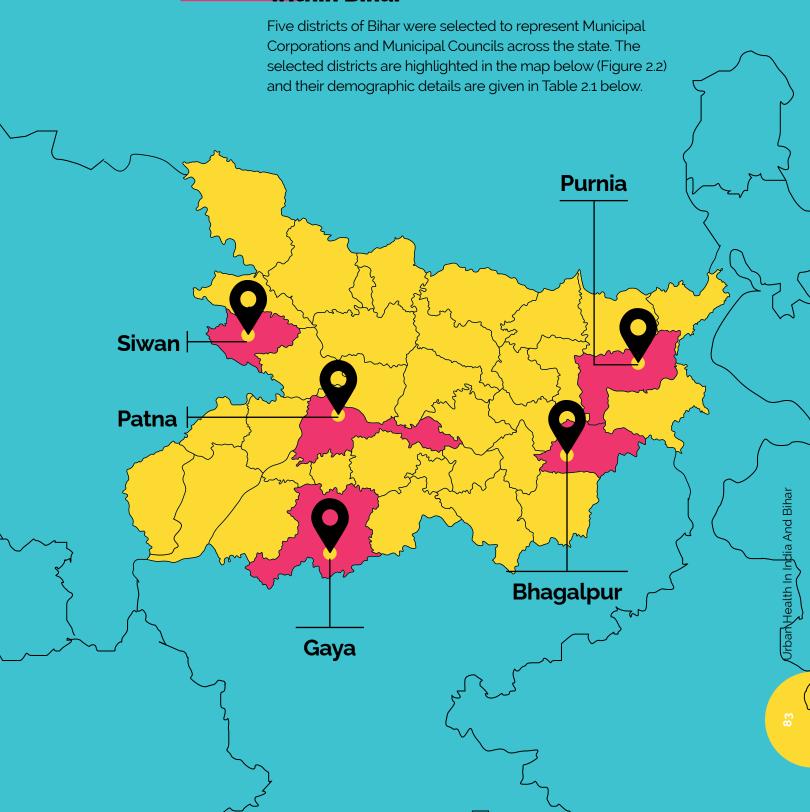
### Key Informant Interviews with regard to ULBs handling public health

We undertook field visits to Bengaluru, Bhubaneswar, Chennai and Pimpri-Chinchwad to understand the existing models where ULBs are taking a lead role in service delivery and community engagement in primary healthcare, sanitation, and other adjacencies. In each of these cities and our selected cities in Bihar, we visited Urban Primary Healthcare Centres/Health and Wellness Centres (1-2 UPHCs) to understand operating practices, processes, and systems. We ascertained which specific policy measures and practices were being undertaken at state and ULB levels, and the impact thereof.

### Field visits in Bihar

- Discerned the factors of success, risks, and replicability in the Bihar context
- Identified good practices in Bihar and other states with regard to engagement in primary healthcare or other allied aspects such as convergence across sanitation, XV-FC, etc., and determinants of success; reflected on strategies for adaptation and scale
- Studied implementation and synergies with NUHM and role of ULBs
- Interviewed the elected representatives, municipal officials and health officials using an in-depth interview guide to understand opportunities and challenges; views on public health; and involvement of ULBs, the role they envisage for ULBs, and the operating constraints
- Understood the mechanism of funding from XV-FC, central schemes and missions, state schemes and missions, and convergence oriented towards health and wellness of citizens
- Interviewed Primary Health Centre staff to understand the service delivery, ULB engagement, areas of support, areas and pathways for collaboration, etc.

# 2.4 City Selection within Bihar



ULBs in Bihar selected for the Study Table 2.1

Division	District	ULB			
		Municipal Corporation	Projected Population 2025	Municipal Council	Projected Population 2025
Patna	Patna	Patna	2,307,384	Barh	84,214
Magadh	Gaya	Gaya	642,001	Bodh Gaya	52,661
Purnia	Purnia	Purnia	386,680	Banmankhi	41,560
Bhagalpur	Bhagalpur	Bhagalpur	607,978	Sultanganj	72,462
Saran	Siwan	Not applicable	Not applicable	Siwan	185,040

O1 The selection criteria is laid out below:

- Bihar is administratively divided into 9 regions. Out of 9 administrative regions of the state, 5 regions were considered (>50% sample) based on geographical location.
- One district out of each selected region was identified based on population, current urbanisation, and/or potential of urbanisation
- Districts ranging from good performing to poor performing were selected on the following basis -
  - Patna being the largest city and also the State Headquarter of Bihar. Performance based on the NFHS is in the average category. Most highly urbanised district - 46%
  - Gaya being a historical district with high urban population and good performance based on the NFHS data
  - Purnia being the poorest performing district in the state based on NFHS data
  - Bhagalpur being one of the Medical Hub Districts in the state and with good health indicators. Moreover, it is adjoining Purnia but doing better. This will give a better insight and will be more comparable
  - Siwan being a district with low urban population (6%) with only one 1 ULB (Municipal Corporation and no Municipal Council or Nagar Panchayat)
- O2 In the selected districts, one municipal corporation and one municipal council with the largest projected population of 2025 were selected
- O3 Selected health Indicators of NFHS-5 in comparison to NFHS-4 (National Family Health Surveys) were analysed - Maternal and Child Health, and Prevalence of Non-Communicable Diseases

Five districts of Bihar were selected to represent Municipal Corporations and Municipal Councils across the state. The selected districts are highlighted in the map below (Figure 2.2) and their demographic details are given in Table 2.1 below.

### 2.5.1 Respondents from Bihar

29 respondents from the state including Municipal Commissioners, Executive Officers, Civil Surgeons, officers from the health department and ex-councillors, were interviewed based on the interview schedule and formal discussions.

In Table 2.2 below, the number of respondents from the Health Department and ULBs is given.

Respondents from Health Department and ULBs in Table 2.2 Bihar (Annexure 8)

District	Health Department	ULB	Total
Patna	5	1	6
Gaya	3	0	3
Purnia	6	2	8
Bhagalpur	5	2	7
Siwan	2	3	5
Total Respondents	21	8	29

9 Focus Group Discussions (one in each city) were organised wherein 15-20 members including ward councillors (ex), ASHAs, representatives of Mahila Arogya Samitis, Rogi Kalyan Samitis, community organisations, and civil society participated.

Respondents	Number	
TOTAL RESPONDENTS	46	
Selected Ward Councillors- (2-3 Councillors) –Meeting/	9 FGDs (one in	
FGD with all	each ULB)	
Service Providers (Medical Officer-1, Pharmacist/Lab	9 FGDs (one in	
Technician - 1 and ANM (at least one)	each ULB)	
ASHA, MAS, Citizen Groups/Community-Based	9 FGDs (one in	
Organisations (at least one person from each category)	each ULB)	

### 2.5.1 Respondents from Bihar

29 respondents from the cities of Bengaluru, Bhubaneswar, Chennai and Pimpri-Chinchwad were interviewed. The respondents included elected members, Commissioner/Additional Commissioner/Deputy Commissioners, Health Officers at ULBs/Zones, and others. The citywise break-up of respondents is given in Table 2.3.

Table 2.3	List of Respondents from				
Table 2.3	cities outside Bihar				

Bengaluru	7
Bhubaneswar	8
Chennai	9
Pimpri-Chinchwad	5

## 2.6 PATA ANALYSIS AND REPORT WRITING

Themes have been developed for analysis based on the areas of enquiry, in-depth interviews and field visits. The themes are mentioned above in Section 2.2 of this chapter.





# 2.7 CREATE A

Based on the above, the Project Monitoring Unit (PMU) will support the state to create an immediate, short-term and medium-term roadmap for ULB engagement in primary healthcare.

- Report will be shared with the stakeholders.
- Consultations with the Health and Urban Development & Housing Departments will be undertaken.
- Based on the discussions, the Programme Management Unit will extend support for creating a roadmap.





# 03

### Strategy: Learnings and Recommendations

In the following sections, the learnings and corresponding recommendations from the study have been laid out thematically, as per the areas of enquiry. This chapter covers existing strategy and recommendations for policy change on devolution of powers to ULBs and public health provision.





# 3.1 LEARNINGS FROM THE DESK RESEARCH



Literature available in the public domain was reviewed to understand good practices encompassing local self-governance, particularly the availability of resources to Panchayati Raj Institutions (PRIs) and Urban Local Bodies (ULBs.) The 74th Constitutional Amendment and the state legislations related to ULBs were studied in detail to understand prioritisation of health as an area of action.

To understand the legislative context, it is important to comprehend the constitutional structure in relation to the local governments.

The Constitution of India originally provided for a two-tier system of government-Central and State Government. The legislative powers of the government were distributed in three lists- Union list, State list, and Concurrent list. Only the Central Government can make laws on items in the Union list, and the State Government on matters in the State list. Both the Central and State Governments can make laws on the subjects in the Concurrent list. 'Local government' was placed in the State list. Thus, the organisation and administration of local governments varied from state to state till 1992 and many states passed laws for urban governance. Further, some large cities had city-specific Municipal Acts. A major step towards decentralisation of state functions and streamlining of local governments in urban areas was taken in 1992 with the addition of a third-tier of government through the Constitution (74th Amendment Act, 1992)

### 3.1.1 Analysis of Municipal Legislations/Acts

### **O1** Introduction

To understand the prescribed role of local governments in public health, water, sanitation, and solid waste management,

# 22 municipal legislations/acts of 13 states were reviewed

(8 municipal corporation acts, 2 city-specific municipal acts, and 4 state-wide municipality acts). States that have a robust system of municipal governance and also ones similar to Bihar in terms of socio-economic indicators were included.



There are different types of municipal acts in the country – state-wide municipality acts, separate acts for municipal councils, separate municipal corporation acts, and acts for specific municipal corporations. In most states, there is a Municipal Act that governs all municipal bodies. In a few states, there is a Municipality Act for smaller municipal bodies; and a Municipal Corporation Act for larger municipal bodies. In a couple of states, in addition to Municipality Acts and Municipal Corporation Acts, there are separate acts for larger cities.

The functions which a municipality has to perform are divided into core (obligatory) and secondary (other) functions. Core functions draw the first charge on the municipal fund. Some acts also have sectoral functions.

### O2 Defining 'Public Health' and related terms in the Act

To understand the treatment of public health in these acts, the interpretation clause which provides a glossary to the act was referred to. It defines important terms and concepts used in the act. Defining a concept is also a way of providing significance to a concept, at the same time it clarifies the meaning of the term.

### Defining Public Health and the Role of the Health Officer



'Public health' was defined only in the Orissa Municipal Act, 1950. However, out of 22 legislations/acts reviewed, 'infectious or dangerous disease' is defined in 14 legislations/acts. Nineteen acts have defined the term 'nuisance'. This proves that municipalities have been dealing with health in one form or another. All the legislations/acts provided for a Health Officer or Medical Officer. However, the role of the officer varied from state to state. In Bihar, the role was limited to the registration of vital statistics and prevention of infectious diseases.

The Chhattisgarh Municipalities Act, 1961 provided that every Council having an annual income of 500,000 or more shall have a Health Officer for the efficient discharge of its duties. The Chennai City Municipal Corporation Act, 1919 empowers the Corporation to appoint a Special Health Officer. Under the Madhya Pradesh Municipal Corporation Act, 1956, the role of the Health Officers is mentioned but their appointment is not specified. In Haryana, the responsibilities of the Health Officer include powers to deal with matters related to burial and burning grounds, tracking information on infectious diseases, moving patients suffering from infectious diseases to a hospital, and disinfection of buildings and articles. The presence of a health officer provides scope to expand the ambit of their responsibilities and the opportunity to realise the vision of the Fifteenth Finance Commission (XV-FC).



# It should be noted that 12 states provide for committees on health.

In Kerala, there is a provision for a Managing Committee for public health institutions transferred to the Municipality.

### 03 Financial Provision

It is important that municipalities have their sources of revenue for public health. These provisions acknowledge the importance of local governments in the context of public health and motivate local governments to prioritise public health needs.

Eleven legislations/acts contain financial provisions with regard to public health in terms of application of corporation fund, utilisation of "Services to Poor Fund", finance rules, expenditure authorised, imposition of taxes, fees, user charges, etc.

The Orissa Act of 1950 provides for the application of funds on matters related to health, empowers municipalities to incur expenditure beyond the limits of the municipality to promote health, and provides for the imposition of taxes for health.

The Andhra Pradesh Municipalities Act of 1965 has a provision for obligatory medical expenditure to be incurred from the municipal fund or by grants-in-aid. This includes expenditure on (a) a hospital or dispensary where the sick, and poor of the municipality shall be entitled to receive medical and surgical advice and treatment free of charge; and (b) a hospital for the treatment of patients suffering from infectious diseases in the municipality.

In some legislations/acts, such as those of Kerala, hospitals are exempt from paying property tax.

It is pertinent to note that the municipal legislation/act of Bihar does not have any specific financial provision for public health.





### **Power to Enact Bye-laws**

Bye-laws are promulgated by the municipality to regulate itself or define its functions and procedures. However, the subjects on which these bye-laws can be made are provided for in the legislation.

12 legislations/acts have a provision for bye-laws on health.

The power to make bye-laws is important as it gives the municipality the opportunity to define its roles and responsibilities, and the procedures to fulfil them.

In Bengaluru, the municipality has the power to make bye-laws for regulating the measures to be taken in the event of the outbreak of any disease, for the regulation and licensing of hospitals and nursing homes, for the prevention of dangerous diseases of men or animals, and for the enforcement of compulsory vaccination.

Under the Haryana Municipal Act, 1973 the municipality has the power to make byelaws for the control of malaria in municipal areas. In Kerala Municipality Act, 1994 and Orissa Municipal Corporation Act, 2003 the bye-laws can be enacted for the training and licensing of dais and midwives, the prevention of dangerous diseases of men or animals, and the enforcement of compulsory vaccination.

Under the Maharashtra Municipal Corporations Act, 1949 the bye-laws include the following clause: Regulate admission to, and use by members of the

public of, municipal hospitals, dispensaries, infirmaries, homes, and similar institutions and the levy of fees therein.

In the Madhya Pradesh Municipal Corporation Act, 1956, the State Government has the power to issue directions for the implementation of welfare measures.

The Bihar Municipal Act, 2007 does not have a specific power to make bye-laws with regard to public health.

The power to make bye-laws is important as it gives the municipality the opportunity to define its roles and responsibilities, and the procedures to fulfil them.



### 05 Core Functions

As mentioned earlier, core or mandatory or obligatory functions are those which have to be fulfilled by the municipality and have the first charge on the municipal fund. 17 legislations/ acts have public health as a function in one form or another.



### In Bihar, community health is a core function.33

In Bengaluru, in addition to public health, safeguarding the interests of persons with physical and mental disabilities is included in the core functions.

Under the Uttar Pradesh Municipal Corporation Act, 1959, the core functions include the establishment, maintenance or support of public hospitals and dispensaries including hospitals for the isolation and treatment of persons suffering or suspected to be infected with a contagious or infectious disease and carrying out other measures necessary for public

33 Community health takes a non-clinical approach to improving the health of a community at a local level, engages different stakeholders, and addresses the wider social determinants of health, rather than an exclusively disease-prevention approach, which is often how public health is defined. https://nhm.gov.in/images/ pdf/guidelines/iphs/iphs-revised-guidlines-2022/02-CHC\_IPHS\_ Guidelines-2022.pdf



medical relief, preventing and checking the spread of contagious, infectious and dangerous diseases, provision for anti-rabies treatment, maintenance of ambulance service, and establishing and maintaining a system of public vaccination.

In Maharashtra Municipal Councils, Nagar Panchayats and Industrial Townships Act, 1965, along with establishing and maintaining public dispensaries, and providing public medical relief, organising family planning centres and promoting population control, family welfare, and small family norms is also enlisted in the mandatory functions.

In some acts like the Madhya Pradesh Municipalities Act, 1961, "Duties of the Council" are also defined. In Bihar, monitoring of pollution levels and undertaking health risk assessments are provided under the Duties of the Council.

### Discretionary, General Functions, and Sector Functions

The discretionary functions are those which have to be performed after fulfilment of the mandatory functions. In some legislations/acts, there is a sector-wise distribution of these functions. 18 legislations/acts mention public health or its components as discretionary or general functions.

Under the Madhya Pradesh Municipalities Act, 1961, the discretionary functions include contributing towards the construction, establishment, or maintenance of hospitals and dispensaries, treatment of "lunatics and lepers", anti-rabic treatment, and establishing ashrams for destitute, "blind, crippled, lame disabled" and old persons.

In Kerala, the sector functions include running dispensaries, primary health centres and sub-centres under all systems of medicine, conducting child welfare centres and mother care homes, organising remedial and other preventive measures against disease, implementing family welfare programmes, implementing sanitation programmes, sanctioning and distributing pension to destitute, widows, handicapped and agricultural labourers, and natural calamity relief.



In Bengaluru and Jharkhand, Public Health and Sanitation are mentioned as sector functions. In some acts, for example, Maharashtra Municipal Corporations Act, 1994 public health is mentioned in a residual manner ("any measure not hereinbefore specifically named, likely to promote public safety, health, convenience or instruction").. In the Punjab Municipal Corporation Act, 1976, the discretionary functions include the organisation or management of chemical or bacteriological laboratories for the examination or analysis of water, food, and drugs for the detection of diseases or research connected with the public health or medical relief, and the provision for relief to destitute and disabled persons.

Under the Uttar Pradesh Municipal Corporation Act, 1959, the discretionary function includes the organisation, maintenance, or management of institutions including "lunatic asylums, leper homes, orphanages, and rescue homes for women, within or without the City for the care of persons who are infirm, sick or incurable; or for the care and training of blind, deaf, mute or otherwise disabled persons or of handicapped children".

In the Orissa Municipal Corporation Act, 2003 along with other functions, the discretionary functions include the maintenance of an ambulance service.

The findings on some of the parameters discussed above have been summarised in Table 3.1.

Table 3.1 Analysis of Municipal Legislations/Acts on Operational Provisions

Act has a relevant provision Act does not have a relevant provision

Act has a different provision, and is explained in the preceding description\*

Act	Health/ Medical Officer	Committee on Health	Mandatory Function	Discretionary/ General Function	Power to make Bye-laws	Financial Provision
Andhra Pradesh Municipalities Act, 1965						
Bihar Municipal Act, 2007						
Bruhat Bengaluru Mahanagara Palike Act, 2020						
Chennai City Municipal Corporation Act, 1919						
Chhattisgarh Municipal Corporation Act, 1956						
Chhattisgarh Municipalities Act, 1961						

Act	Health/ Medical Officer	Committee on Health	Mandatory Function	Discretionary/ General Function	Power to make Bye-laws	Financial Provision
Gujarat Provincial Municipal Corporations Act, 1949						
Haryana Municipal Act, 1973						
Jharkhand Municipal Act, 2011						
Karnataka Municipal Corporations Act, 1976						
Karnataka Municipalities Act, 1964						
Kerala Municipality Act, 1994						
Madhya Pradesh Municipal Corporation Act, 1956						
Madhya Pradesh Municipalities Act, 1961						
Maharashtra Municipal Corporations Act, 1949						
Maharashtra Municipal Councils, Nagar Panchayats and Industrial Townships Act, 1965						
Orissa Municipal Act, 1950						
Orissa Municipal Corporation Act, 2003						
Punjab Municipal Act, 1911						
Punjab Municipal Corporation Act, 1976						
Tamil Nadu District Municipalities Act, 1920						
Uttar Pradesh Municipal Corporation Act, 1959						

<sup>&</sup>lt;sup>\*</sup> The Punjab Municipal Act, 1911, and the Chennai City Municipal Corporation Act, 1919 do not have core functions as such but make a provision for public health in the power and authorities of the municipalities that may be endowed by the State Government.

Overall, it was found that relevant provisions have been made in the municipal acts, but the powers and functions of the ULBs need to be defined and clarified so that they can be gainfully administered and engaged with public health.



06 Water Supply, Sanitation and Solid Waste Management



There are elaborate provisions regarding the same in the legislations/acts. If public health is envisioned in a larger context, these components would be subsumed in its definition.

Water supply being a conventional function, 'water course' or 'waterworks' is defined by most states. Similarly, 'drain', 'filth', 'municipal drain', 'offensive matter', 'rubbish', 'sewage', and 'sewage connection' are defined in most legislations/acts.

It is the responsibility of the municipality to provide for drains and privies; discharge sewerage; lay or carry wires, pipes, drains, or sewers; arrange for the removal of rubbish and filth and for the preparation and sale of compost; close dangerous tanks, wells, holes, etc., exercise functions in relation to urban environmental management; and submit a report on the environmental status of the municipal area, etc.

Similarly, the municipalities have the responsibility of supplying water to connected premises for domestic, industrial, and commercial purposes; making connections with municipal waterworks; giving notice to the owner of waste water plants; securing buildings, wells, tanks, etc., providing for troughs and pipes for rainwater; regulating dangerous, stagnant or unsanitary sources of water supply; etc. The municipalities have to appoint committees and earmark authorities to regulate water supply. They are empowered to make bye-laws in this regard. They can also impose taxes and user charges for providing water. Andhra Pradesh Municipalities Act, 1965 provides for levy and collection of pipeline service charges. Under the Punjab Municipal



Corporation Act, 1976, there is a provision for a charge by measurement (flat rate for water supplied - as per the consumption slab) in lieu of water tax in certain cases. Similarly, the Bihar Municipal Act, 2007 has a provision for levying water tax.

In summary, no clear differences emerge amongst states, and the legislations/acts offer opportunities that can be accessed to understand the current and potential role of ULBs in Public Health, Sanitation and Solid Waste Management. At the same time, it must be pointed out that policy and practice are not binaries and public health should be approached holistically at the level of the city. Relevant linkages which are interoperable in different ULBs, and within different departments in the ULBs, should be identified. From the analysis, it was observed that all municipalities have a role in Public Health, Sanitation and Solid Waste Management. However, their role in health differs from state to state. In some states, the role of municipal bodies is conventional and pertains only to dangerous diseases and vaccination. However, this is also important given the context of the COVID-19 pandemic. There exists a solid foundation in terms of the legal architecture for municipalities to delve into public health. Specific provisions might need revision, reinterpretation or even amendment, but overall, there is a steady system to facilitate public primary healthcare.

### 3.1.2 Analysis of Town and Country Planning Acts

The Town Planning Schemes (TP) can be used as a basis to plan a healthy city. The term 'public health' finds no mention in the town planning acts of the selected states; however, allied sectors such as water supply, sanitation and solid waste management are well incorporated. By and large, the convergent sectors find recognition in the planning documents.

Also, various aspects of infrastructure development contribute to the healthy lifestyle of the citizens, such as open spaces, drainage management, disaster management, etc., which need to be planned at the outset. Town planning acts have been amended from time to time to cope with the increasing urbanisation, and that is visible in the states leading the nation in urban development.

The TP Scheme has been used predominantly in Gujarat and Maharashtra, while a few other states are endeavouring to catch up. The states of India aspiring to use the TP Scheme for urban land expansion include Karnataka, Andhra Pradesh, Madhya Pradesh and Odisha.<sup>34</sup> The term 'public health' is not used in the town planning act of the selected states, though convergent sectors like water and sewerage facilities are covered. The town planning acts recognise disaster mitigation; the need to allocate spaces for open areas, parks, gyms, green spaces, and green belts; better traffic management; etc., and these indirectly support the health of urban residents. The town planning acts have also mentioned mapping vulnerable and disaster-prone areas and a plan for pre-disaster, disaster mitigation and post-disaster requirements for a speedy recovery to everyday life as an influential content of planning and supporting a healthy and decent life.

MEXAMINING THE TOWN PLANNING SCHEME OF INDIA AND LESSONS FROM LAND READJUSTMENT IN JAPAN, ADBI working paper series

The Kerala Town and Country Planning Act<sup>35</sup> and Maharashtra Regional and Town Planning Act<sup>36</sup> include integrated infrastructure development covering water, energy, sanitation, education, health, recreation, communication and other utilities, facilities and services; and conservation of the environment, forests, ecologically sensitive areas and heritage zones; among other frameworks in their Prospective Plan for different districts/regions. The states leading the urbanisation in the country have also mentioned health and convergent sectors in their execution plan along with other matters.

The Maharashtra Regional and Town Planning Act<sup>37</sup> and Tamil Nadu Town and Country Planning Act<sup>38</sup> show the importance of public health by addressing the issues related to public health and convergent sectors in their detailed town planning scheme proposals. While Tamil Nadu has also mentioned the sanitary principles as one of the rules and a significant area of concern in drawing up any development plan, this shows the inclusion of health-related aspects as a very vital consideration during town planning.

States like Odisha<sup>39</sup> recognise 10 frameworks for the master plan, out of which a drainage and sewerage disposal scheme and a water supply scheme play a significant role. Odisha also recognises the mention of "any other proposal bearing on the health, comfort, convenience and general betterment of the inhabitants of the locality".

Karnataka's Board Improvement Act, 1976 has incorporated hospitals and dispensaries, among other amenities, as prerequisites to be provided in a development scheme or improvement scheme; thus, the state has taken a significant stride towards enhancing the health of the population.

In the Haryana Development and Regulation of Urban Areas Act, 1975, there is a clause in the Bilateral Agreement by the owner of land intending to set up a Group Housing colony, which mentions "That the owner shall be responsible for the maintenance and upkeep of all roads, open spaces, public parks and public health

- 35 Kerala Town and Country Planning Act , CHAPTER III DISTRICT PLANNING COMMITTEE AND PLANS FOR THE DISTRICT
- Maharashtra Regional and Town Planning Act CHAPTER II PROVISIONS RELATED TO REGIONAL PLANS
- Maharashtra Regional and Town Planning Act, CHAPTER VII DETAILED TOWN PLANNING SCHEMES: Matters that may be dealt with in a Detailed Town Planning Scheme proposals for natural hazard prone areas; (j) control of air and water pollution; (n) provision of healthcare, religious, cultural and educational facilities; (o) provision of water supply and electricity; (p) provision of sanitary arrangements including construction of drains and public conveniences etc., disposal of sewage, solid waste.
- 38 TAMIL NADU TOWN AND COUNTRY PLANNING ACT, 1971
- 39 THE ORISSA TOWN PLANNING & IMPROVEMENT TRUST ACT, 1956

services for a period of five years from the date of issue of the completion certificate under rule 16 unless earlier relieved of this responsibility, when the owner shall transfer all such roads, open spaces, public parks and public health services free of cost to the Government or the local authority, as the case may be".

Bihar Urban Planning and Development Act, 2012, The Bihar Urban Planning and Development Act, 2012, acknowledges

water supply, drainage and sewerage, and waste disposal, among other sectors in the preparation, contents and approval development plan.

The act also cites the creation/upgradation of health facilities among twelve other programmes.<sup>40</sup>

The Area Development Scheme gives space to the allotment or reservation of land for roads, open spaces, gardens, parks, recreation grounds, schools, markets, residential purposes, industrial and commercial activities, green belts and dairies, transport facilities and public purposes of all kinds, the portion of land which can be acquired for drainage, sewerage, surface or subsoil drainage and sewage disposal and water supply, among others. The mentioned utilities contribute towards the healthy lifestyle of citizens.

The State Government recently set up the Bihar Urban Arts and Heritage Commission<sup>41</sup>, representing, among others, Urban Planning, Visual Arts, Architecture, Indian History or Archaeology, Tourism and Environmental Sciences. The commission strengthens the overall development of the space contributing to the wholesome life of the residents.

Bihar Urban Planning and Development Act, 2012, CHAPTER-V PREPARATION, CONTENTS AND APPROVAL OF DEVELOPMENT PLAN

<sup>41</sup> Bihar Urban Planning and Development Act, 2012, CHAPTER-VII AREA DEVELOPMENT SCHEME

This progress in Bihar in implementing the Bihar Urban Planning and Development Act, 2012, is encouraging and may serve as the groundwork for creating comprehensive health and wellness plans for cities in future, aligning to the WHO Healthy Cities framework.

### 3.1.3 Status based on the Desk Review- 4 selected Cities

The study team visited four cities outside Bihar where the ULB is taking the lead in managing the healthcare of the urban residents: Bengaluru, Bhubaneswar, Chennai and Pimpri-Chinchwad. The four cities are very dissimilar in the way their ULBs have evolved to their current role in healthcare.

The demographic details of the cities covered in the field visits are provided in Table 3.2 below:

Table 3.2 Cities Covered for field visit-Administrative Structure & Health Institutions

	Bengaluru	Chennai	Pimpri- Chinchwad	Bhubaneswar
Population	13.19 million	11.50 million	2.0 million	1.08 million
Zones	8	15	8	3
Wards	198	140	128	67
UPHCs	170	140	21	18
Other Secondary Health Institutions	26 Maternity Homes 6 Referral Hospitals 1 General Hospital	3 Maternity Homes 6 Dialysis Centres 1 Communicable Disease Hospital	4 Multi-speciality Hospitals 3 Maternity Homes	1 District Hospital 1 *BMC Hospital

NOTE: \*BMC - Bhubaneswar Municipal Corporation

There is variation in the State Municipal Acts in the devolution of power to the ULBs, and this also varies by the type of ULB in the four states visited. Irrespective of the larger mandate to devolve the health function to the Municipal Corporations as per the state municipal laws, there are mandates from the state health departments (and the State Health Society, in particular) and the Municipal Corporation leadership that have enabled the ULBs to take the lead for health in the city.

The devolution of Public Health Function as per the State Municipal Law is given below in Table 3.3.

Table 3.3 Devolution of Public Health Function as per the State Municipal Law

State/City/ULB Type	Devolution of Public Health Function	
Bihar	Discretionary	
Karnataka Municipal Corporations	Not Done	
Karnataka Municipalities	Discretionary	
Bengaluru	Not Done	
Maharashtra Municipal Corporations	Done	
Maharashtra Municipalities	Discretionary	
Odisha Municipal Corporations	Discretionary	
Odisha Municipalities	Discretionary	
Tamil Nadu Municipalities	Not Done	
Chennai	Not Done	

A major contributing factor to the success of ULB involvement in healthcare provision in Bengaluru, Chennai and Pimpri-Chinchwad is that the role of ULBs in healthcare provision precedes the launch of National Urban Health Mission (NUHM) in 2013. All three city corporations have health personnel in all cadres working as employees of the Municipal Corporations, and all three of them are allocated a significant share of funds from the ULB corpus for healthcare. Many of the urban healthcare facilities are housed on government land. As indicated earlier in the introductory section on Background, in many cases the land and building were provisioned in the early 1990s under the India Population Project VIII (IPP-VIII). The leadership role of the Bhubaneswar Municipal Corporation (BMC) has expanded recently with the launch of NUHM and availability of NUHM funds. Being one of the best planned cities of the country, there is ample space for health facilities in Bhubaneswar. All four Corporations lead the planning, budgeting, implementing, monitoring and reporting for healthcare in the city. The Health Divisions of the Municipal Corporations develop the Programme Implementation Plan (PIP) for NUHM.

The major strategy challenge for urban healthcare delivery is the decision to make provision of health services for unnotified/unlisted slums. The decision tends to be more trying for ULBs as the commitment to cover unnotified/unlisted slums may be interpreted as recognising them in terms of land tenure and the right to basic civic amenities.

All four cities studied have defined a clear mandate to cover unnotified/unlisted slum populations for healthcare. The COVID-19 pandemic has clearly proven that

 $\rightarrow$ 



for the health of the city, the planning process needs to take into consideration the city as a whole, as missing pockets of residents can serve as the perfect passage for spread of communicable diseases. Further, the left-out population, in any case, is circulating across the city for livelihood and other purposes. The emerging infectious diseases make universal coverage in a city a public health imperative, apart from a basic moral one for any government agency.

Another complexity tends to be the lack of accurate information about the number and population of slums as they tend to change with migration. Different cities have used different mechanisms to address this challenge.



### 3.1.4 Initiatives undertaken by the Municipal Corporations



### **Pimpri-Chinchwad**

The Pimpri-Chinchwad Municipal Corporation (PCMC) has initiated a GIS (geographic information system) mapping of all residential areas which will be dovetailed into the land records and property tax transactions.<sup>42</sup> There are plans to create a population-based registry over the next year to ensure universal coverage.



### **Bhubaneswar**

Bhubaneswar city was covered under the Health of Urban Poor Project, which had undertaken extensive slum mapping. Jaga Mission is one of the largest slum land settlement initiatives of the Government of Odisha, Department of Housing and Urban Development.

The mission aims to empower slums and transform them into a liveable habitat. In addition, due to the presence of a very vibrant Mahila Arogya Samiti (MAS) initiative, the city has a sharp eye on the evolution of the slum population.

Bengaluru, Pimpri-Chinchwad and Bhubaneswar are effectively using the ANMOL [Auxiliary Nurse Midwife (ANM) Online] application and the RCH (Reproductive and Child Health) portal which allows them to effectively track women and children for essential services. Tamil Nadu is using the PICME (Pregnancy and Infant Cohort Monitoring and Evaluation) app which is linked to the RCH portal. The urban health nurses create an RCH ID for all pregnant women on the PICME app, which gets linked to the RCH portal. The floating population is entered in the system as migratory, and an RCH ID is created for them. PICME also has a provision for women to be migrated to other geographies within Tamil Nadu with the same RCH ID, and can be tracked for service delivery.

Organisational structure for managing healthcare is set up in the Municipal Corporations of the four cities visited as a part of the study.

<sup>42</sup> EXAMINING THE TOWN PLANNING SCHEME OF INDIA AND LESSONS FROM LAND READJUSTMENT IN JAPAN, ADBI working paper series

### 3.2 LEARNINGS FROM THE FIELD VISITS SELECTED CITIES

The learnings from the field visits to selected cities are detailed below, both in text and in Figures 3.1 and 3.2.

### O1 Standing Committee on Health of the ULB

Greater Chennai Corporation (GCC) has Standing Committees for various matters with Health being within the mandate of one Committee.

The Committee has about 15 councillors as members, and one elected chairperson. There are additional ex-officio members such as the City Health and Medical Officers who participate. The Committee usually meets once a month and can play a crucial role in advancing the health agenda of the city, and also heeding to the needs of their constituents. In addition, the councillors from each ward play a crucial role in addressing the health needs of the ward by allocating their discretionary funds and also representing their need to the Municipal Council and Commissioner for resolution.

### 02 ULB Level Administrative Leadership

In all the four cities visited outside Bihar, the Commissioner level officer (who holds the position of Municipal Commissioner, or Deputy Commissioner, or Special Commissioner), leads the health portfolio.

Each one of these four ULBs have two verticals within the health department, one for Clinical Service Delivery and the other for Public Health. These positions are held by senior government officials (Medical Cadre) having tenures close to two decades with the government. They are designated as the City Health and City Medical Officers. These officers could be employees of the ULB as in the case of Chennai, Bengaluru and Pimpri-Chinchwad, or be deputed to the ULB from the state health department, as in the case of Bhubaneswar.

### 03 Zonal Delegation

All cities are divided into zones, and each zone has multiple wards, with each serving as a constituency for an elected councillor. The healthcare management has mostly been decentralised to the zonal offices with the Zonal/Deputy Commissioner and the Deputy Health Officers at the helm.

The infrastructure maintenance, procurement, reporting and financial powers have been delegated to the zonal level. The Deputy Controller at the Zonal level manages finances. The Zonal Civil Engineer and his/her team are responsible for the upkeep and maintenance of the government health facilities. The zonal office also serves as the nodal point for creating new health facilities by making available the unused space and infrastructure, or allocating land for construction of new health facilities.

### 04 City Health Society

In the metropolitan cities and other cities where the State Government decides to hand over the management of the urban health system to municipal corporations, a city level health society is set up.

The City Health Society is set up on the lines of a District Health Society with the Mayor/ Municipal Commissioner as the chairperson. The City Health Society receives funds from the State Health Society (SHS) and is responsible for implementation of Urban Health Initiatives in the city. The cities of Bhubaneswar and Chennai have formed City Health Societies.

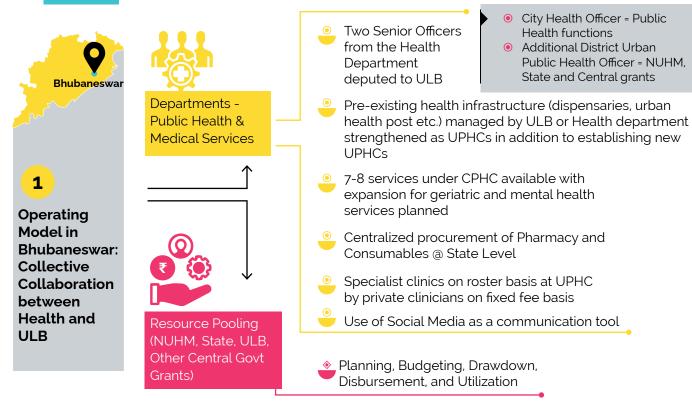
### 05 Programme Management Unit at City Level

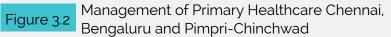
All four cities studied had a City Programme Management Unit for NUHM consisting of a City Health Manager, a City Accounts Officer, an Epidemiologist, Account Assistants, one Monitoring and Evaluation (M&E) Officer, and data entry operators. The City Health Society and/or the City PMU (Project Management Unit) hires and manages the contractual staff to be deployed using NUHM funds.

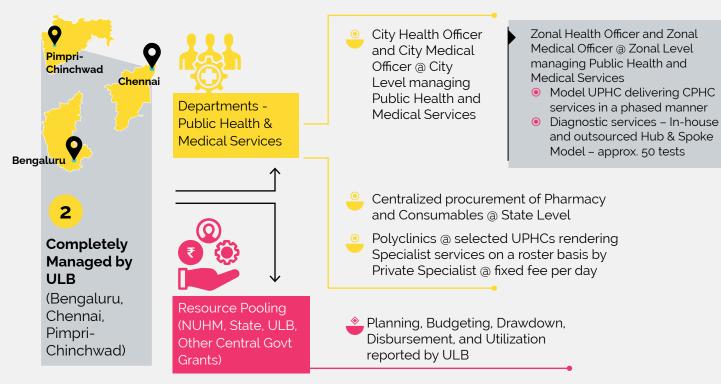
An additional staff member at the UPHCs/HWCs is a Public Health Manager who leads the managerial functions and community processes in the slums covered by the UPHC. This helps the Medical Officer in the HWC to focus on managing the service delivery at the health facility. Tamil Nadu has a medical recruitment board which recruits the requisite staff, and deputes them to the Greater Chennai Corporation. This ensures transparency in hiring.



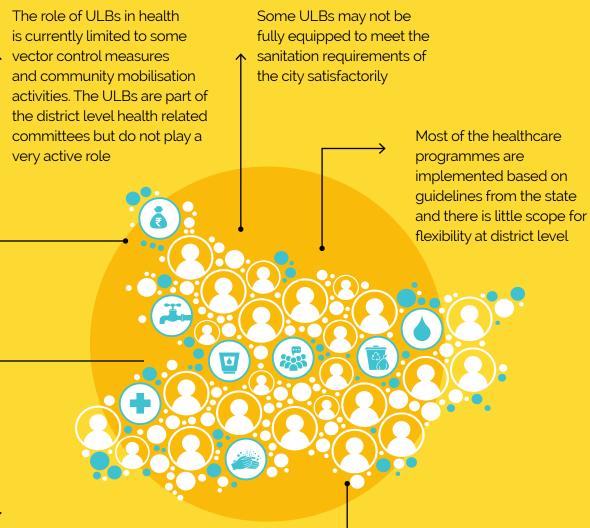
#### Figure 3.1 Management of Primary Healthcare in Bhubaneswar







#### O7 Summary of learnings from field work in Bihar



Elected representatives do not have a very clear orientation on their roles and responsibilities for healthcare services. However, some active elected representatives are playing an important role in supporting the UPHCs, particularly for conducting health camps and improving sanitation services. They also help the poor and vulnerable people in accessing basic services

The Bihar Municipal Act enables the ward committees to discharge the functions related to "health" immunisation services and slum services" subject to supervision and control of the Empowered **Standing Committee** 

With ULBs providing most civic services in the urban areas, they are closest to the community, interact with it at multiple levels, and understand their needs. Each household of the city needs to interact with the ULB for one or more services, i.e., water supply, sanitation, solid and liquid waste management, birth and death registration, cremation/burial, trade licensing, hawking licence, street lights, and many more. The elected representatives from the respective wards can represent the needs and grievances of the community, including health needs, to the ULB. The ULBs have resources such as land and buildings, for example, community centres, vacant school premises, baraat ghars, and other municipal buildings that can be more efficiently used if they lead healthcare service delivery. The critical component of success is the state and city leadership acting symbiotically for devolving the leadership for city health to the ULBs. The state of Bihar could make a significant headway in improving urban health by ULBs playing a lead role in the health of the cities. The state can develop policies and operational guidelines to empower ULBs to lead healthcare delivery in their cities.



# 3.3 RECOMMENDATIONS:

It is important that we position this change as a need of the hour rather than a stipulation of the XV-FC: The ULBs should take the lead in steering the urban healthcare. Their role should be defined comprehensively because of their significant connection with the community and the delivery of health allied services such as water supply, waste management, biomedical waste management, and birth and death registration. The change should not be made merely because the XV-FC stipulates it, but because it can significantly improve healthcare outcomes for urban populations. A clear mandate from the State Government is imperative to strengthen the municipal leadership in delivery of primary healthcare services.

The Bihar Municipal Act enables the Empowered Standing Committee to constitute ad-hoc committees on the matters it considers significant.

The XV-FC recommendations have generated an extensive discourse on the role of local government in delivering healthcare. While this was already happening in the rural areas under the NHM systematically with the constitution of the VHSCs (Village Health and Sanitation Committees) and its duty to oversee healthcare delivery, a similar transition in the urban areas was based more on local initiatives of the individuals and ULBs. The following steps can be taken to make this transition more entrenched and systemic in spirit than in letter:

- Conduct a consultation workshop at National/Regional & State Level to build a consensus that the ULBs are better positioned to lead healthcare delivery by way of having the responsibility for urban governance. Personnel from the Health Department, Urban Development from the state and national level, NITI Aayog, development organisations, academic institutions, etc., could also participate in the workshop
- Constituting a High-Level Steering Committee (HLSC) at the state-level under the chairmanship of the Chief Secretary, with Principal Secretaries from the Departments of Urban Development & Housing and Health as members. The terms of reference have to be defined for the Steering Committee
- The HLSC can draft and ratify a white paper on how the transition to ULBs leading healthcare delivery in urban areas could be a vital step towards improving health in cities and enhancing accountability of the healthcare delivery system to the urban residents. The draft White Paper must be widely shared with elected representatives, bureaucrats and technical officers in the government for their feedback and buy-in
- Strengthen the ULBs as per provisions of the Municipal Act Based on the Municipal Act, gaps need to be identified and the state is to work towards implementing all the provisions of the Municipal Act
- For effective planning and execution of the initiatives for strengthening urban health in major cities, a decentralised management structure for health will be beneficial
- Constitution of City Health Society (2 pilot ULBs) for management of Urban Health Programmes at the City level. Governing Body under the Chairpersonship of Mayor, and Executive Committee under the Chairpersonship of Municipal Commissioner, in Patna to be constituted
- ULB representatives to attend the District Level Committee (DLC) meetings for planning and monitoring of the District Health Action Plans.



#### O1 Path to Universal Healthcare

States have commitment from the highest level in the health department to provide comprehensive primary healthcare to all residents of the urban areas. Healthcare services need to cover the whole population irrespective of their legal status of residence in the city and habitation in unlisted/unrecognised slums. This commitment needs to be reiterated and passed down the chain. While some government schemes, particularly with DBTs (Direct Benefit Transfers), may have defined eligibility criteria and may require detailed documentation, access to services should be universal.

Some steps that can be implemented are suggested below.

- Health Department to issue guidelines/standard operating procedures (SOPs) to the effect that access to healthcare services including consultations, diagnostics, drugs, and therapies will be accessible to all city residents in government facilities and government supported facilities, such as the ones accredited for Janani Suraksha Yojana (JSY) and Pradhan Mantri Jan Arogya Yojana (PMJAY), irrespective of their state of domicile.
- A mechanism needs to be developed to report the service delivery to migrant populations such as those working on construction sites, or in small habitations along roads and under bridges. Since these populations are not identified, they are not served as these numbers are not included in the service delivery planning or statistics. While there is no guidance that it cannot be done, a concerted effort to make this happen will help in achieving universal coverage, and reduce the incidence of left out populations.
- For universal Comprehensive Primary Healthcare (CPHC) to be easily accessible by the urban population there should be a planned effort to map slums and slum populations. Many states and cities are now using GIS (geographic information system) mapping and other advanced IT tools for such efforts. The Health Department of Bihar has already initiated this effort and significant progress has been made in mapping administrative boundaries and health facilities.11 Satellite maps together with GIS mapping can serve as useful tools to develop slum maps that can help plan for positioning of HWCs, development of polyclinic facilities, placement of ASHAs, sites for outreach activities, etc. Line-listing of population either by ASHAs, or as an external exercise with electronic records for families, could help in the planning process for better implementation of CPHC. With ANMs using ANMOL, and ASHAs also being provided with smartphones, the initial mapping can help in monitoring universal coverage and also tracking the

population for age or disease-based services. Slum maps, which may be available with the ULBs, can be made accessible for health planning. Alternatively, an outside institution can be hired through competitive bidding to complete GIS mapping in a stipulated time. A government academic institution such as IIM Bodh Gaya or IIT Patna could be designated as a nodal institute for maintaining the currency of GIS maps of the cities. This can also dovetail into the Smart Cities Mission and National Urban Digital Mission. All slums (listed and unlisted) are to be mapped in cities and included for planning for healthcare delivery. Clear guidance is to be received from both the Departments of Urban Development and Health that access to healthcare has to be planned for unlisted slums as well.

- Keeping in view the significant financial allocations for Urban Health through XV-FC Health Grants, the governance and management capacity of the SHS needs to be enhanced.
  - Two public health professionals to be hired/deputed from the Health Directorate for supporting the Urban Health Cell of the SHS.
- To showcase and pilot the initiatives for strengthening the role of ULBs in primary healthcare, 2 ULBs (Patna and another one as per the decision of the state) are to be selected by a special order empowering the ULBs for implementation of the initiatives on a pilot basis (Janaagraha to support District PMU).
  - As per the mandate of XV-FC Guidelines and Learnings of the Landscape Study, ULBs are to take on an increasing role in planning, implementing, and monitoring the Urban Health and Wellness Centres (UHWCs) with technical support from the health department. Health department to depute/designate senior health official(s) with administrative reporting to the respective Municipal Commissioner for the purpose of providing technical guidance and overseeing the urban primary health initiative as envisaged by XV-FC
  - In Patna city and the other selected cities (ULB), the Programme Management Unit set up under NUHM to be placed in the Municipal Corporation under the City Health/Medical Officer for managing urban health in the city, reporting to the deputed health officials functionally and administratively to the Municipal Commissioner



- The Health Department and Urban Development & Housing Department (UD&HD) are to take a joint decision for devolution of functions related to primary healthcare to ULBs in a phased manner; community health is a core function as mentioned in the Bihar Municipal Act, 2007. This provision is to be considered as an enabler for ULBs to take on a greater role in primary health
  - Legislative rules to be promulgated to describe the role of ULBs in health as mentioned under the Bihar Municipal Act, 2007. In the meanwhile, an executive order is to be passed by the UD&HD enlisting the role of ULBs in primary healthcare (Proposed roles and responsibilities are given in Annexure No. 1 and 2 as a reference)
  - \* At the District Level Committees (DLCs), XV-FC Health Grants have low representation in the ULBs (only Municipal Commissioner/Executive Officer is a member) as against Panchayati Raj (where the District Panchayati Raj Officer, elected representatives Zila Parishad Chairperson/Member, Block Samiti, and Mukhiya are members)





To ensure that ULBs have equitable representation in DLCs, 1-2 elected representatives of ULBs should be nominated in the DLCs. State Level Committee to pass an order for inclusion of the elected representatives of ULBs as members of DLCs

- Review and monitor the activities approved by the district in the District Health Action Plan by DLC
- Conduct regular meetings of DLCs (at least once a quarter) to review the progress
- Orient and build capacities of the key stakeholders (elected representatives and executives) for effective functioning of the DLC.



Responsibility of the DLCs is not to be restricted only to the preparation of the District Health Action Plan, but is to comprise the review and monitoring of the activities approved for the district.



For the effective functioning of the DLC, orientation and capacity building of the key stakeholders (elected representatives and executives) is most important.

XV-FC PMU to continue supporting the orientation of DLCs on primary healthcare and develop capacities to take on a leadership role.

#### O2 Change self-image and perceived image of the ULBs

The ULBs need to put in a concerted effort to change their image of being responsible merely for waste collection and water-supply. This will necessitate as much an effort for the internal stakeholders within the ULBs as for the outside. The health department officials at the state and district level will be important stakeholders in motivating and encouraging the ULBs to develop leadership skills for primary healthcare delivery so as to conform to the overall objectives of the health department. This can be accomplished by convincing the ULBs of the ultimate benefits, so that diligent proactive actions implemented by them complement the comprehensive objectives of the health department. A change management process needs to be undertaken for personnel, particularly Civil Surgeons, Senior Health Department officers and the current Medical Officers (although few) in the ULBs will be crucial for the success of the transition.



 Undertaking a fundamental change management exercise will help in making great strides in effective delivery of the healthcare system. From the reports of all cities visited outside Bihar, it was revealed that there was an individual 'champion/ champions of change' who believed that ULBs could lead healthcare in the city and take the initiative to create a wave of change. This process of creating ownership within the ULBs so that they can play a larger role in health and grow into a strong health management organisation is crucial. A parallel effort will need to be undertaken with the health department at the state and district level who currently view the ULB as being unable to do anything more than mobilising communities. This will also involve a new power dynamic to be created between the Civil Surgeons and the City Health Officers in the ULBs, particularly for districts with larger ULBs.

# 04

### Governance: Learnings and Recommendations

Urban Local Bodies (ULBs) are involved predominantly in provision of basic amenities, in some state's rudimentary Health Care services such as vector control for prevention of vector-borne diseases, immunisation and epidemic control.





#### 4.1 LEARNINGS



# 4.1.1 Urban Local Body leadership in Health and allied fields

In a few selected larger cities, ULBs lead all levels of Health Care. Other ministries/departments such as Health, Social Welfare and Urban Development operate via financial allocation, and/or provision of schemes that address the proximal and distal determinants of health. The private sector remains the largest provider of curative services to urban populations, but can be financially inaccessible by the vulnerable sections. Increasingly, this sector is also being engaged by the government for delivery of services via public-private partnerships (PPPs). Another set of key stakeholders that has emerged are donor and aid organisations. 43 National Urban Health Mission (NUHM) is being implemented in cities and towns with >50,000 population with mode of delivery dependent on size and type of city. Seven cities, namely Delhi, Mumbai, Chennai, Kolkata, Bengaluru, Hyderabad and Ahmedabad are getting National Urban Health Mission Programme Implementation Plan approvals and grants directly from the Ministry of Health and Family Welfare (MoHFW), whilst in other cities it is carried out through the State Health Department.

Unlike the well-structured pyramidal system of rural health services, urban health services in India have evolved in an organic and random manner. The most peripheral and accessible health facilities in the rural areas, i.e., the subhealth centres, were not planned for the urban geographies. The result today is non-uniform and haphazard delivery of services across the country by the public sector, along with a large unregulated private sector that ranges from the solo unqualified practitioner to the large super-speciality corporate hospitals. "The major governance challenges facing urban Health Care have to do with overlapping jurisdictions between administrative entities, lack of coordination between different service providers and poor accountability to the community it serves"44.





# The role of the ULBs varies from state to state, but most often these are associated with little or no provisioning of Health Care.

Only in states such as Gujarat, Maharashtra, Andhra Pradesh and Tamil Nadu, where they have greater autonomy and authority, are they involved in provision of basic primary Health Care, while the majority of services are provided by the state departments. In the seven large metropolises and in few cities with larger corporations such as Surat, Thane, Pune, Pimpri-Chinchwad, Visakhapatnam and Madurai, they provide all levels of care – from the primary to the tertiary. <sup>45</sup> There are, however, glaring examples of mismatch in the priorities and internal policies of the local governments. Brihan Mumbai Municipal Corporation (MCGM), for instance, finds it challenging to provide Health Care to all its vulnerable sections given that more than 50% of its population lives in slums. Yet, the

Mishra A., Rao Seshadri S, Pradyumna A, Pinto P.E, Bhattacharya A, and Saligram P (2021) Health care Equity in Urban India, Report, Azim Premji University, Bengaluru.

Report and Recommendations of the Technical Resource Group For the National Urban Health Mission. MOHFW Feb 2014



Mumbai Municipal Corporation Act does not allow provision of basic public services to non-notified slum dwellers, thus creating conditions deeply detrimental to the health of populations residing in slums. This, in effect, increases the burden on the corporation's own division of health services.

Ministry of Health and Family Welfare data shows that there are serious shortfalls in the availability of Urban Primary Health Centres (UPHCs) which come under ULBs, based on the government's own norms, with the national average at almost 40% (2020).

The shortfalls ranged from 7% in Rajasthan to 100% in Lakshadweep.

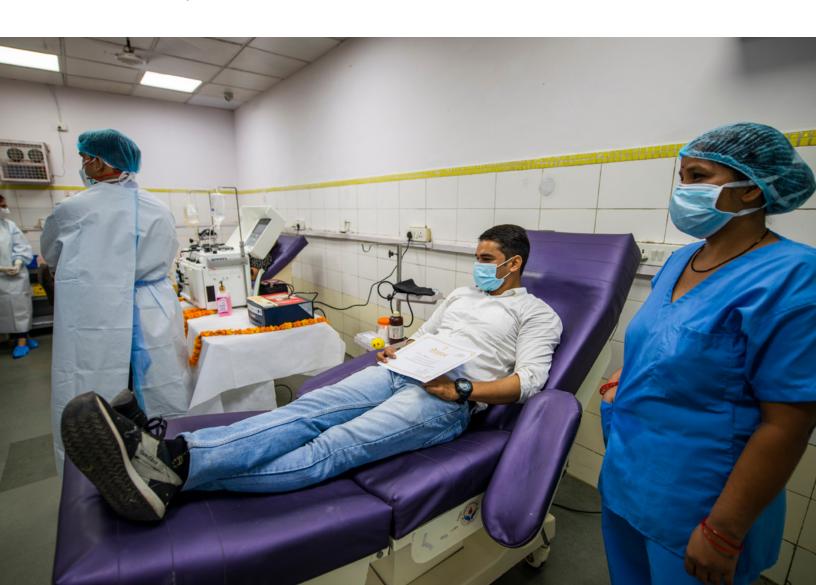




National Sample Survey (NSS) 75th Round in 2017-18 shows that almost 75% of ailments were treated at private hospitals/private doctors and clinics in urban areas as compared to around 60% in rural areas.

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It has been found that over a period of time the ULBs have seen a severe reduction in finances, "resulting in weakened governance and institutional capacity a separation between curative and public health functions, thus reducing the purview of the municipal health office, and an erosion of the power and prestige of the Municipal Health Officer and the scope of their activities". The issue of overlap between the jurisdiction of ULBs and state government institutions was not addressed in the 1992 amendment.



The four cities visited outside Bihar have practices aimed at improving quality of Health Care delivery (presented in paras below). While some Health Care practices could be replicated irrespective of whether the health department or the ULB takes the lead, implementation would be much easier if the ULB leads the health services due to the need for focused microlevel planning.

- Comprehensive Primary Health Care In all four cities Urban Primary Health Centres (UPHCs) are delivering services as per the Comprehensive Primary Health Care (CPHC) guidelines. Pimpri-Chinchwad has successfully moved from focussing on just Maternal and Child Health services and some vector control activities, to more holistic Health Care services and strengthening the UPHCs. Many of the UPHCs have been converted to Health and Wellness Centres (HWCs) with open gyms, yoga mandaps and herbal gardens.
- In Pimpri-Chinchwad, Facility-Based Screening of patients over 30 years of age for non-communicable diseases (NCDs) has been initiated, and primary care for hypertension and diabetes is available at the UPHC. Other health conditions are referred to higher institutions.
- In Chennai, the UPHCs and UCHCs (Urban Community Health Centres), have a well-functioning DOTS (Directly Observed Therapy, Short-course) centre, and labs for microscopy for tuberculosis.
- In Chennai, the UPHCs and UCHCs have NCD clinics that give patients medicines for two months in labelled envelopes contained in a plastic box. The patient is called every two months or earlier if the condition is not in control. They are referred to a UCHC or a specialist clinic if there is a need to consult a physician.
- In Chennai, the UPHCs have a tie-up with community volunteers who have been given BP apparatus and glucometers, and they are entrusted with the task of screening the community for hypertension and diabetes, particularly for areas not covered by ASHAs (Accredited Social Health Activists). The UPHC Medical Officer (MO) is allocated 10,000 for buying consumables such as glucometer strips, batteries, etc.
- of In Chennai, each Urban PHC has an Urban Health Nurse who plays a crucial role in problem solving for the community workers, and serves as a bridge to the medical officer in charge of the Urban Primary Health Centre.



## Solutions for improving Quality of Care in Maternal and Child Health

- In Chennai, the UPHC Lady Medical Officers (MOs) are trained for 15-30 days in a referral hospital to conduct ultrasound scans for pregnant women. The Lady MO does an ultrasound scan for all pregnant women coming for prenatal check-up. The Lady MOs are also posted at the UCHC for one night per week to get exposure to high-risk pregnancies and delivery complications.
- In Chennai, pregnant women are referred to the UCHC at the end of the seventh month of pregnancy for further care and delivery. The UCHC provides 24/7 delivery services including caesarean sections. Anaesthetists and gynaecologists are oncall at night in case a complicated pregnancy needs to be taken up for caesarean section.
- In Chennai, some urban primary health centres have a male medical officer. On ANM (Auxiliary Nurse Midwife) clinic days he is substituted with a female MO once in 2 weeks from a nearby UPHC.



#### **Provision of Specialist Services**

- In Chennai and Bhubaneswar, polyclinics are run in some UPHCs in the afternoon every day from 4:30 to 8:30 pm. Dental, Orthopaedic, Physiotherapy, Dermatology, Obstetrics Gynaecology, ENT, Medicine, Paediatrics, Nutrition, Psychiatric and Ophthalmology services are available. It is difficult to get specialist doctors under the new payment plan.
- In Chennai, dialysis centres are being run in PPP mode with involvement of the Rotary Club. These centres run 24X7 and provide free services to patients.



#### **Diagnostics**

- In all four cities, laboratory services are provided in a combined model.

  Haematology services are managed by the laboratory technicians employed under NUHM/ULBs, and biochemistry services are outsourced to private labs with a huband-spoke model.
- In Pimpri-Chinchwad, the Radiodiagnosis and Cardiac Services in the Pimpri-Chinchwad Municipal Corporation (PCMC) are run by a private player. The space and amenities are provided by PCMC and the equipment and staff are deployed by the private partner. The rate for each service is predefined and displayed for the users.



#### **Procurement of Drugs and supplies**

In all four cities, drug procurement and supplies are centralised at the state level and there is an on-line system of management of supply chain.



#### 4.1.2 Health Financing

#### **LEARNINGS**

State Finance Commission (SFC) reports were reviewed as part of the study to understand the recommendations of the various states and how devolution of urban Health Care to ULBs and its financing could be improved.

Reviews of the latest available reports of the SFCs (13 reports) from 9 selected states were undertaken. Status for selected states is given in Table 4.1 below<sup>46</sup>.

 Table 4.1
 Latest Published State Finance Commission Reports

	State Finance Commission					
State	State Finance Commission					
	6th	5th	4th	3rd	2nd	1st
Kerala (2020-25)	✓					
Tamil Nadu (2018-22)		<b>✓</b>				
Punjab (2017-21)		<b>✓</b>				
Bihar <sup>47</sup> (2020-25)	✓					
Haryana (2017-21)		<b>✓</b>				
Maharashtra (2013-17)		✓				
Odisha (2020-25)		✓				
Chhattisgarh (2018-22)				<b>✓</b>		
Jharkhand <sup>48</sup>					✓	
Karnataka (2019-23)			✓			
Andhra Pradesh <sup>49</sup>			<b>✓</b>			

Manish Gupta & Pinaki Chakraborty (2019) State Finance Commissions: How successful have they been in Empowering Local Governments? Working Paper No. 263, NIPFP, New Delhi

Bihar being a focused state, both 5th and 6th SFC have been analysed for the report.

<sup>48</sup> Jharkhand is not included in the analyses due to non-availability of its SFC reports.

<sup>49</sup> The inclusion of data from Andhra Pradesh is limited due to non- availability of SFC report.

The average time taken to submit the report by first SFC, second SFC and third SFC is 27, 29 and 26 months, respectively. However, the average time taken by the 4th and 5th generation SFCs of states has been higher at about 33 months<sup>50</sup>.

The commissions attempt to design an efficient and equitable intergovernmental fiscal transfer system between the State Government and the Local Governments (Local Bodies), besides suggesting measures for ensuring sound finances and governance of the Local Bodies. The study endeavoured devolution formulae and the status of Primary Health Care as a component. The findings from the reports of selected states are summarised in Table 4.2.

 Table 4.2
 Status of Primary Health Care Devolution

State	Is primary Health Care an indicator or determinant of devolution formula or not?	Remarks
Bihar (2020-25)	No	Basic service component in the formula includes convergent sectors.
Kerala (2020-25)	No	Environmental Vulnerability shares 10% weightage in the devolution formula.
Tamil Nadu (2018-22)	No	Public Health is called out as a separate head both in receipts and expenditure. For example, for Public Health Municipal Corporation- Revenue Expenditure- 0.37%, Capital Expenditure- 5.24%.
Haryana (2017-21)	No	The report mentioned "A critical learning from the field has been the need to increase capacities at the local level- Primary Health Centres, Community Health Centres, and First Referral Units - before undertaking health initiatives."
Maharashtra (2013-17)	No	The activity mapping of the 4th SFC report acknowledges the presence of Health and Sanitation, including hospitals, primary health centres and dispensaries, and describes its plan and role for its implementation.
Odisha (2020-25)	No	There is no activity mapping in respect of different functions.
Chhattisgarh (2018-22)	No	There is no activity mapping in respect of different functions.
Karnataka (2019-23)	No	Karnataka is the first state in the country to have developed a Human Development Index (HDI) for the state, district, taluk and Gram Panchayat. The commission recommends HDI as one of the critical indices while devolving funds to local bodies.

Table 4.3 shows Recommended Devolution<sup>51</sup> as Percent of States' Own Tax Revenue (SOTR)<sup>52</sup> and States' Own Revenue Receipts (SORR)<sup>53</sup> and horizontal distribution between PRIs (Panchayati Raj Institutions) and ULBs:

#### Table 4.3 Recommended Devolution in percentages

State	Percent of States' Own Tax Revenue <sup>54</sup> (specific to 2018-19)	Percent of States' Own Revenue Receipts <sup>55</sup> (specific to 2018-19)	PRI:ULB
Bihar (2022-25)56	15.90	13.91	65:35
Kerala (2020-25)	20.23	16.26	Data not available
Tamil Nadu (2018-22)	10.15	9.22	56:44
Punjab (2017-21)	3.52	2.74	Data not available
Haryana (2017-21)	5.02	4.08	55:45
Maharashtra (2013-17)	12.74	11.62 (2012-13)	55:45
Odisha (2020-25)	2.31	1.69	75:25
Chhattisgarh (2018-22)	7.88	6.06 (2016-17)	76.80:23.20
Jharkhand <sup>57</sup>	Data not available	Data not available	Data not available
Karnataka (2019-23)	46.65	42.87	75:25
Andhra Pradesh <sup>58</sup>	Data not available	Data not available	Data not available

The more urbanised states like Karnataka, Kerala, Tamil Nadu and Maharashtra recommend more than 10% of SOTR and SORR to the local bodies. However, the less urbanised states of Odisha and Chhattisgarh have started giving space to devolution to LBs, and have also increased the share of ULBs in the last two SFCs of their respective states.



- Calculated using data from SFCs reports and Finance Accounts and 2018-19 Budgets of respective states.
- The generation of SOTR varies from state to state. In general, SOTR includes revenues earned through Sales Tax, State Excise duty, SGST, Land Revenue, Stamps & Registrations etc.
- Own revenue receipts of states comprise of, (i) tax revenue which includes various taxes levied by states such as sales tax, excise duty, and stamp duty, and (ii) non-tax revenue, which includes fees charged for providing services such as electricity, water, and forestry.
- The generation of SOTR varies from state to state. In general, SOTR includes revenues earned through Sales Tax, State Excise duty, SGST, Land Revenue, Stamps & Registrations etc.
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- 5 5th SFC observed ULBs would have a resource gap of Rs 21,536 crore.
- Jharkhand is not included in the analyses due to non-availability of its SFC reports.
- 158 The inclusion of data from Andhra Pradesh is limited due to non- availability of SFC report.

The horizontal sharing of funds recommended by the SFCs between PRIs and ULBs in most states is based on rural and urban populations or a composite index comprising various indicators unique to the individual state. It is observed<sup>59</sup> that the share of PRIs is dominant in most states except Uttar Pradesh<sup>60</sup> and Uttarakhand<sup>61</sup>.

Recommended devolution to ULBs for Primary Health Care is as follows in Table 4.4:

Table 4.4 Recommended devolution to ULBs for Primary Health Care

State	Are grants devolved to ULBs for primary Health Care or not?	Remarks
Bihar (2020-25)	No	During 2015-16 to 2019-20, both *Panchayati Raj Department and **Urban Development & Housing Department provided additional funds from the State Budget to the PRIs and ULBs, over and above the SFC Transfers. A major portion of these additional allocations (8,718 crores out of a total additional allocation of 14,872 crores) was meant for two components of Saat Nishchay scheme — piped water supply and construction of Naali Gali.
Haryana (2017-21)	No	
Kerala (2020-25)	No	Although the recommendations related to primary Health Care have been highlighted by SFCs in their consequent reports, they are restricted only to schemes covered by the Central Government.
Tamil Nadu (2018-22)	No	"Public Health" is called out under a sep- arate head while addressing the expendi- ture functionality of the finances.
Maharashtra (2013-17)	No	Recommendations on public health include: "The 3rd SFC recommended 2 Lakhs per annum for Public health centres as compared to the earlier grant of 60,000 and 10,000 per annum for Medicines for sub-centres."
Odisha (2020-25)	No	Amount of 375 crores has been recommended by 4th SFC as Grants-in- Aid to the ULBs for Water Supply, and 52.46 crores for Urban Sanitation.
Chhattisgarh (2018-22)	No	
Karnataka (2019-23)	No	

<sup>🔟</sup> Also the share of PRIs is more than 65 per cent except Maharashtra and Tamil Nadu.

<sup>60 40:60 (</sup>PRI:ULB)

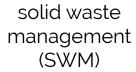
<sup>61 45:55 (</sup>PRI:ULB)

The term "Public Health" rarely figures in the SFC documents of the selected states. However, convergent sectors such as water supply, sanitation, solid waste management (SWM) and sewage disposal











sewage disposal

have ascended prominence in the reports. Though urbanised states such as Kerala, Maharashtra, Tamil Nadu and Karnataka have expressed gradual awareness towards including the term in the recommendations, the developing states like Odisha, Chhattisgarh and Harvana mention the investment and recommendation in sectors such as water supply and sanitation, SWM, etc. The mention of centrally sponsored schemes and major state initiatives in the report related to allied sectors of Health. The progress of major schemes such as Atal Mission for Rejuvenation and Urban Transformation (AMRUT), Swachh Bharat Mission (SBM) and SMART Cities has been extensively discussed in most of the states' SFC reports. Also, the mention of state initiatives in the convergent sectors of public health is taken as the point of dialogue for showing the development progress over the period along with the limitations restricting them to achieve benchmark levels given by the Ministry of Urban Development (MoUD).

Table 4.5 below lists a few initiatives mentioned in the SFC reports of the states, which relate to public health and convergent sectors, apart from AMRUT, SBM and SMART Cities.

Table 4.5 Initiatives mentioned in SFC reports

State	Schemes Mentioned in SFC Reports
Bihar <sup>62</sup> (6th SFC- 2020-25)	-Mukhyamantri Shahri Peyjal Nishchay Yojana -Namami Gange Programme
Kerala (6th SFC- 2020-25)	-Jalanidhi -Kudumbashree
Tamil Nadu (5th SFC- 2018-22)	Public Health is mentioned as a separate head in Receipt and Expenditure table
Punjab (5th SFC- 2017-21)	24*7 WSS (water supply and sanitation)
Haryana (5th SFC- 2017-21)	-Indira Bal Swasthya Yojana -Solid Waste Management Master Plan -OYE! Ambala ('Open Your Eyes Ambala')
Maharashtra <sup>63</sup> (4th SFC- 2013-17)	Maharashtra Jeevan Pradhikaran
Odisha (4th SFC- 2020-25)	Initiatives of Odisha Water Supply & Sewerage Board
Chhattisgarh (3rd SFC- 2018-22)64	Bhagirathi Nal Jal Yojana
Karnataka (4th SFC- 2019-23)	Malkapur case study on Solid Waste Management

The SFC documents have constantly evolved in addressing the health and convergent sectors through the process of activity mapping and increasing the financial recommendation and relevant share.

On account of low capacity of ULBs, Bihar has not been able to take advantage of the central funds.

The State of Maharashtra has witnessed fast urbanisation accentuated by migration and the rapid development of slums in the urban areas of the cities. The datasets concerning public health centres have observed a significant shift from Rs 2 Lakhs per annum for Public health centres as compared to the earlier grant of Rs 60,000 and Rs 10,000 per annum for Medicines for sub-centers in their 3rd SFC report. Likewise, developed states like Kerala and Tamil Nadu have focused clearly on Health, drinking water, sanitation and waste processing in their reports to prove their vital importance in current times.

<sup>■</sup> The 3rd SFC report quotes the Solid waste management model in Ambikapur as an example under SBM and the clean mission initiative



#### **State Finance Commission for Bihar**

#### The 6th SFC has recommended raising the share

of ULBs to 35% during the period 2021-22 to 2024-25. The UD&HD<sup>65</sup> (6th SFC) has reported the status of devolution of functions to ULBs in Bihar, in which public health, sanitation conservancy and SWM are among 13 functions devolved to the ULBs. The 6th SFC has recommended that at least 40% of the Development Fund should be untied.

The ULBs will be able to use these untied funds to take up schemes for local level development under the subjects enshrined in the Twelfth Schedule of the Constitution, subject to the overall guidelines of the State Government. The 5th SFC report cites the situation for Patna Municipal Corporation, Nagar Parishads and Nagar Panchayats as an unsustainable situation<sup>66</sup> and predicts it to continue and "frustrate all efforts of the ULBs to provide even essential services to the people".67 The 5th SFC report emphasises formulating a comprehensive urban policy for the state to limit its citizens' declining quality of life and the reluctance among investors to commit the resources to the urban centres. In the 5th SFC report, Bihar recognises the importance of a healthy environment 68. The report has prominently measured the state as lagging behind the national average in terms of SWM, tap water supply, sewerage and drainage connection under the civic amenities status. The data from Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and other sources have been discussed intensively to highlight the issue of convergent public health sectors. As reported by the UD&HD, activity mapping has not been done yet. Keeping in view the best interests of an allround sustainable urban development, the 6th SFC recommends that activity mapping should be done on priority basis.

<sup>55 6</sup>th SFC Bihar, Page No. 75

Mo activity mapping has been done by UDD

Final report for 2015-20 THE FIFTH STATE FINANCE COMMISSION, Bihar Volume- 1, Preface Point 4.

Safe & Clean water supply, SWM



#### Public Health - National

A one-size-fits-all decentralisation approach is not desirable. As far as the operational aspects are concerned, it is observed that despite having statutory provisions for a timely constitution, the constitution of SFCs is delayed in many states. **The term 'public health' is only occasionally used in the reports, while its allied sectors have found relevant expanse in the SFCs.** The focus on healthy living is limited to water supply, sanitation, SWM and access to sewerage facilities.

The other important aspect of the

findings of this review is the differences in the treatment of divisible pools by individual SFCs.

The least urbanised states like Bihar, Chhattisgarh and Odisha have entered the phase of evolving their separate plans for urban areas.



At the same time, the most urbanised states are positioned to expand their sectoral expenses and include health facilities in their primary ambit. Few of the SFCs have also tried to establish a dialogue between the Central Government and NITI Aayog's plan to fulfil the aspects of quality living.

Most ULBs are underfunded and resource deficit<sup>69</sup> and continue to look to the state Health Departments to shoulder the bulk of the responsibility<sup>70</sup>. Paucity of funding for urban health and nutrition programmes is a major concern. The current funding is estimated only at one-third of the total requirement for catering to coverage and quality of basic primary services.



Larger, older and budget surplus ULBs, like the Municipal Corporations in Chennai, Bengaluru and Pimpri-Chinchwad, have been receiving funding for Health Care in the cities from their corpus much before NUHM was launched.

The State Governments were usually providing vaccines and drugs. After 2005, the Urban RCH (Reproductive and Child Health) component was merged with National Rural Health Mission (NRHM), and after 2013 the NUHM funds started flowing to the ULBs in all four cities. All four cities develop their annual Programme Implementation Plans (PIPs) which are included in the State PIP. In accordance with the NUHM financial guidelines, the fund flow to the Urban Health Institutions is transferred for local implementation.

Mishra A., Rao Seshadri S, Pradyumna A, Pinto P.E., Bhattacharya A, and Saligram P (2021) Health care Equity in Urban India, Report, Azim Premji University, Bengaluru.

Municipal Bodies Failing to Cater to Health Care Needs of Urban Poor, NewsClick 20th November 2021





#### **Benchmark Cities**

The corporations in all four cities make provision for health budgets as part of the Municipal Corporation Annual Budgets. While the amount of the budget provisioned and amount actually spent varies by city, the process reflects the leadership and commitment of the elected ULB representatives and the administrators to take responsibility for the health of the city residents.



Bruhat Bengaluru Mahanagara Palike (BBMP), apart from paying the salary of the managerial and service provision staff in the city, also makes a provision in the budget for purchase of drugs in case of emergencies.

Pimpri-Chinchwad Municipal Corporation (PCMC) has budgeted an impressive amount of approximately 470 crores on Health Care delivery, i.e., about 9.4% of its annual revenue of 5,000 crores for FY 22-23. Of this, approximately 280 crores will be spent on Primary Health Care; 120 cores on Yashwantrao Chavan Memorial Hospital (a Medical Postgraduate Institution); and about 70 crores on purchase of drugs and equipment by the central store. NUHM provides approximately 14 crores each year to PCMC, which is fully utilised. PCMC also collects some user fees from the health services that go into the PCMC corpus.

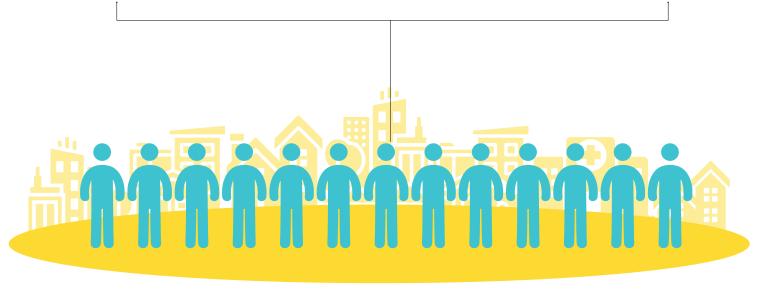
**Greater Chennai Corporation (GCC)** has three sources of funding for Health Care: NUHM, state health schemes, and GCC corpus. GCC is being allocated 83 crores under the 15th Finance Commission recommendations to set up 140 HWCs and a City Public Health Laboratory. GCC is also setting up 40 polyclinics. After de-limitation is planned in the near future, GCC will have 200 wards, and hence 60 more HWCs have been approved, one for each ward. Government's requirement of all drugs and supplies in Tamil Nādu is managed by the Tamil Nādu Medical Supplies Corporation. The Government of India transfers funds for supply of drugs to the State Health Society, Tamil Nadu, which then transfers the money to GCC; who subsequently transfers the amount

to the Tamil Nadu Medical Services Corporation (TNMSC). GCC has an emergency fund for procurement of drugs, but it is rarely used. GCC also tops up the remuneration for the Medical Officer, which is over and above the amount provided by NUHM. NUHM has a provision for 40,000 for the Medical Officers, and an additional 20,000 is paid by GCC.

NUHM funds are the primary source of funds for Bhubaneswar Municipal Corporation (BMC) for implementing urban health interventions, including infrastructure upgradation, human resources, drugs and supplies. BMC pitches in additional resources, as needed. NUHM funds have been devolved to the UPHCs for Untied Grants, Operational Expenditures, etc., and grants to Mahila Arogya Samitis (MASs).

urban geographies making technical and operational guidelines, additional funding and opportunities for innovation and cross-learning available.

The Fifteenth Finance Commission (XV-FC) has highlighted the need to focus on urban populations, as well as the fact that ULBs are better positioned to lead urban health. Both NUHM and XV-FC have made significant financial allocations to urban health and make CPHC for urban populations a reality.



# 4.2 RECOMMENDATIONS: Health Financing

### O1 ULBs to Plan for and Execute with NUHM and XV-FC resources based on city needs:

Decentralised planning by the ULBs at the level of UPHCs/HWCs will enhance efficient use of resources. Review the staff versus usage statistics to refine activities to increase usage and/or adjust staff/frequency of the visiting specialists to ensure productivity. Similarly, planning for health camps is to be based on need, e.g., areas with poorer utilisation of UPHC services are to have more camps. These mandates are to be planned by the ULB with the health team based on need and not based on allocation of physical and financial targets by the state. Vulnerability assessment and location-based planning for setting up sanctioned Ayushman Bharat - Health and Wellness Centres (AB-HWCs), need to be undertaken. PHMs at the level of UPHCs/HWCs can certainly improve community mobilisation and outreach by working with the ASHAs (Accredited Social Health Activists) and Mass.



- Undertake activity mapping for subjects under the Twelfth Schedule of the Constitution to allocate resources for ULBs.<sup>71</sup>
- 03 Increase financial allocation for ULBs as part of municipal finance reforms.<sup>72</sup>
  - As per the recommendations of the 6th SFC of Bihar, at least 40% of the Development Fund is to be untied. 5th & 6th SFCs of the state have also recommended that activity mapping is to be implemented on priority basis. Activity mapping to help identify the priority for sectoral allocation of funds to ULBs.
  - UD&HD to undertake activity mapping to disseminate the functions for available subjects under the Twelfth Schedule. ULBs are to adapt to the mapped activities, and the pool of funds devolved may be used for their local conditions. (Activity mapping undertaken by Maharashtra and other states for PRIs can be taken as a reference.)
- O4 Institutionalise the financial devolution process to ULBs ensure that the fund flow from the State Government is timely and utilised for the purpose.
- 05 ULBs to be empowered to enhance their revenue generating capacity and utilise these resources for providing social services including health.
  - For primary health to be institutionalised as a function of the ULB, the ULBs should be empowered by the State Government to increase the pool of funds available for financing primary health by introducing instruments like bonds, grants, taxes, user charges etc.. The example of Pimpri-Chinchwad Municipal Corporation can be followed in this regard as it has embarked on raising Capital via a Municipal Bond to fund Health Care infrastructure and services.

<sup>1 6</sup>th SFC Bihar

The 6th State Finance Commission has recommended to raise the share of ULBs to 35 percent during the period from 2021-22 to 2024-25



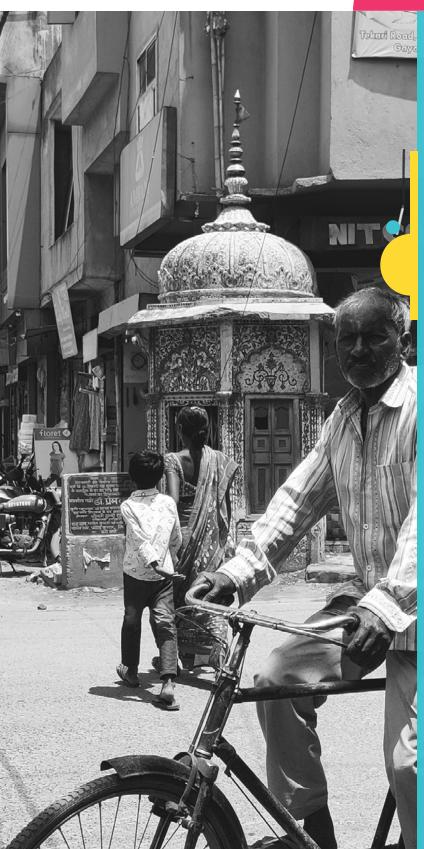
# 05

## Operational: Learnings and Recommendations





# 5.1 HEALTHCARE DELIVERY IN BIHAR



Bihar has undertaken various initiatives to improve the healthcare delivery system as described in Section 1.2.2 - 'Efforts to improve Urban Health in Bihar'. These efforts were visible during the field visits in the state.

The Health Department is managing the healthcare services in the state. State and District Programme Management Units have urban health cells supporting the NUHM. With the support of NUHM, the Health Department has established and operationalised 105 UPHCs in the 25 cities. ULBs support the health initiatives for outreach activities, disease outbreak management, mobilising the community for health camps, etc. ULBs have played an important role in supporting the Health Department for containment and vaccination efforts for COVID-19 management.

During the visit, it was observed that the key officials of ULBs are willing to take a proactive role in health if they have technical staff to support the programmes, and capacity building of existing human resources on health services is undertaken.

- Overall, Service Providers were of the opinion that NUHM funding has improved the infrastructure, maintenance and availability of drugs and diagnostics. Service delivery in urban areas has improved; however, there is a need to improve quality and expand coverage. UPHC at Bhagalpur had more than 75 OPD consultations per day. A special initiative was taken by Purnia District to address the health problems related to high iron content in the water.
- Many UPHCs are located in rented buildings. While the range of services have expanded, the larger focus continues to be on Family Planning and MCH services.
- Special Immunisation Corners set up in UPHCs are well maintained and highlight the importance of immunisation to all people visiting the UPHC. Some UPHCs have good arrangements for providing privacy for pregnant and lactating women. Many UPHCs conduct yoga sessions on alternate days.
- Most of the UPHCs visited had two laboratory technicians, one recruited under NUHM, and the other placed by the PPP contracted for providing laboratory services.
- Drugs and supplies are sourced from the district stores, but the drug store in the UPHCs did not seem to be very well organised.
- Districts have good rapport with the urban elected representatives and they are actively involved in community mobilisation for special health campaigns.
- Despite the costs, FGD respondents perceive private hospitals to provide better healthcare in terms of quality of doctors, time given by the doctor per patient, time taken to get medical attention, treatment by the right speciality doctor, continuity of treatment from the same doctor, access and quality of treatment of serious ailments, and access to quality laboratory and testing facilities.



### **RECOMMENDATIONS- SERVICE DELIVERY**

## 01

#### Facility assessment-basis 'Design Thinking'

While selecting the site for UPHCs, easy accessibility (by pucca roads) by the general population, including poor and marginal sections of the society, is to be taken into consideration. Facility assessment- basis 'Design Thinking' by considering socio-demographic profiling and vulnerability assessment of the area, is to be done.

- Health institutions are to be accessible to the community at large establishing UPHCs in the middle of a slum will restrict the usage by the periphery area because of the overcrowded slum and adjoining population, which will lack sanitation facilities and have an unhygienic environment.
- Establishing UPHCs/UHWCs within an already existing outpost of a medical college or hospital will not be any value addition for the community.
- Assess the existing health infrastructure and bridge infrastructure gaps according to the facility assessment survey for existing UPHCs. ULBs need to plan for HWCs based on population norms. The existing facilities can be refurbished to HWCs as appropriate. The location of the HWCs should be accessible to the poor populations and be as close to the slums as possible. The ULBs can review the list of buildings/plots of land which may be unused, and could perhaps be used for running HWCs.
- The number of ASHAs needed to be determined based on the slum mapping and the population residing in slum-like settlements. Similar planning for ANMs for outreach services is required. The requisite number of health outreach workers to be hired, trained and inducted as needed.





## Expand Coverage of Comprehensive Primary Healthcare in a phased manner

Seven services are being provided in the UPHCs. The ambit of services is to be expanded for screening and management of communicable diseases, ENT and elderly care in a phased manner.

While expanding the services in Bihar, it is imperative that MCH services and communicable diseases continue to be a priority as the state is yet to achieve the desired results in Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR) and control of communicable diseases.

Specialist services to be provided, at least on a weekly basis, including Medicine, Obstetrics & Gynaecology, Paediatrics and Dermatology (on honorarium basis) at selected UPHCs which are to function as polyclinics.



## Decentralise planning of primary healthcare by ULBs at the UPHC/HWCs to use resource more efficiently

- Planning based on population projections and geographical expansion should be undertaken for establishing the new health institutions.
- Map the area, assess the existing health infrastructure and identify the sites and buildings for the health centre. ULBs to steer the identification of sites/ areas for establishing UPHCs/UHWCs.



## 5.2 HUMAN RESOURCES FOR HEALTH INSTITUTIONS

01

A major Human Resource (HR) challenge in Bihar is the recruitment of doctors and General Nursing and Midwifery (GNM) nurses. The recruitment takes time, many candidates do not join, and the attrition rate is high. Currently, there are 25 Urban Primary Health Centres (UPHCs) functioning in Patna with doctors available only in 8 of them. The doctors recruited during the COVID-19 pandemic period have been contracted only for one year. The recruitment of Auxiliary Nurse Midwives (ANMs) from distant places also impacts service delivery and there are issues of absenteeism and lack of accountability.

Table 5.1 below indicates the human resources available at UPHCs in Bihar.

Table 5.1 Human Resources at Urban PHCs

Total UPHCs - Functional	105
Medical Officers (full time MOs)	124 (98 Deputation and 26 *NUHM)
UPHCs without MOs (full time)	21
UPHCs with MOs from both NUHM and Deputation	11
UPHCs with more than 1 MO	32
Total No. of Laboratory Technicians	98
UPHCs having more than 1 Laboratory Technician	69
UPHCs with 1 Laboratory Technician	29
UPHCs without Laboratory Technicians	7
Pharmacists	54
ANMs	514

Note: \*NUHM - National Urban Health Mission

## RECOMMENDATIONS FOR HUMAN RESOURCES

Innovations for addressing the paucity of Human Resources for Health: Lack of resources to hire qualified and trained healthcare personnel and high rate of attrition are constant problems faced in Bihar. Staff retention can be improved by linking performance with some financial and nonfinancial incentives (Nominate, Recognise and Reward best performing institutions/service providers). Flexible mechanisms can be worked out for delivering specialist care. The Urban Local Body (ULB) leadership and elected representatives may be better positioned (by way of time available and enforcement powers) to negotiate with the local private providers and medical colleges. Hiring locally resident health personnel will resolve the unwillingness of staff to join or leave due to transfers to locations away from the hometown. Recruitment at the district level can be considered to address the lack of human resources.







- Rational Deployment of Human Resources HR assessment already undertaken by the state are to be the basis for the rationalisation, ie. addressing the availability of MOs and other staff
- Conduct walk-in interviews for recruitment of Medical Officers for UPHCs and UHWCs (Urban Health and Wellness Centres).
- Devolve recruitment of paramedical staff at the district level, which will ensure the availability of local HR and better retention. This will ensure district level cadre and restrict the inter-district transfers, with some exceptions.

  (If required, a state level written test may be conducted and thereafter candidates to apply at district level, and further selection process to be undertaken at district level)

Along with the fixed pay and perks, some financial and non-financial incentives (performance-based incentives, area allowances, leave, higher education opportunities) to be introduced based on the service delivery in the underserved and low performing districts where retention of Human Resource is a challenge, e.g., additional incentives may be given in the city like Purnia, which is underserved and low performing as compared to Patna.

#### Some steps that can be taken to implement the recommendations are suggested below.

- A comprehensive assessment of HR requirements for urban health, based on population projections for at least 2030, needs to be undertaken to have a highlevel understanding of the shortfall, and the need to create posts within the health department or the urban development department. State Health Society, Bihar (SHSB) already has an online Human Resources Information System (HRIS) that can be customised to provide city/town-specific information.
- ❖ A High-Level Working Group to be set up to recommend a Human Resource for Health (HRH), with focus on reforming hiring, retention and growth management of HRH.



While the larger policy level ground work is underway, immediate bottlenecks can be addressed by hastening the recruitment of contractual staff already approved under NUHM.

This can be accomplished by having a transparent list of all open positions on the district website and conducting walk-in interviews for immediate recruitment, particularly for doctors and nurses. A systematic process for maintaining data for candidates who appeared but could not be recruited will also help the District Health Society (DHS)/Urban Local Body (ULB) to reach out to candidates who may be available in the same town/city and are still willing to join.

- A mechanism to be developed for providing incentives, both financial and non-financial (in the form of additional allowances, leave, residential quarters, and higher education opportunities), for towns/cities where HR needs to be brought in from outside the city/town.
- Service delivery statistics from outreach and facility-based services need to be reviewed against the expected numbers, based on demographic profile for preventive services. Productivity for outreach camps, fixed facilities and HR, need to be regularly reviewed to understand the demand and supply side factors. Local planning should also allow for deploying manpower based on need, e.g., increasing the number of specialist sessions if there is a higher footfall and vice versa.





\* Appoint Public Health Managers (PHMs) on a cluster basis, i.e., UPHCs, as per NUHM guidelines, in these ULBs. PHMs at City/ Circle Level to lead the managerial functions and community processes in the urban areas with funding support from NUHM. The PHMs can play an important role in supporting the doctor in managing the services, outreach and client satisfaction to improve the utilisation of the services available in the Health and Wellness Centres (HWCs).



As is evident from the data and reports compiled on the availability of Human Resources, there is a lack of human resources in public health facilities. Hence, in the short term, the state needs to focus on:

- A comprehensive assessment of Human Resources (based on population projections) to be undertaken to assess the shortfall and create new posts within the health department or the urban development department.
- Depute/designate senior health official(s) from the health department to provide technical guidance to the selected ULBs.
- Prioritise recruitment and posting of the cadre of Assistant Health Officer at Circle/Zonal level in ULBs, which has already been approved by the state.
- The existing HRIS are to be customised to provide city/town-specific information. Retirement planning is already a part of the HRIS.



Multi-skilling of existing Human Resources to meet the specific service delivery requirements to help reduce the gap between the needs and availability of services.

- Undertake capacity building of Medical Officers for management of diseases for special groups, i.e., adolescents, geriatric care, mental health, etc. For example, in Chennai, all the Female Medical Officers have been trained for conducting ultrasound scans for antenatal cases, thereby addressing the shortage of Radiologists
- Undertake capacity building of GNM/ANM cadre for counselling services on different health issues and mental health



#### Operationalise Health Cadre 73

Recruit and post Assistant Health Officer @ Circle/Zonal level within the pilot ULBs. 5th & 6th SFCs in Bihar have strongly recommended a proposal for creating a Municipal Cadre in Bihar to overcome the challenges restricting the development of the urban areas in the state.

- The cadre of Assistant Health Officer @ Circle/Zonal level has already been approved by the state; recruitment and posting needs to be undertaken on priority.
- The role of the Health Officer appointed under the act to be expanded to include primary healthcare in its ambit by a legislative amendment in the act.
- However, since a legislative amendment is a lengthy process, it can be instantly operationalised by passing an executive order, as can be seen in the example of Bruhat Bengaluru Mahanagara Palike, in short term for pilot ULBs.



#### Recognise and reward

Mechanism should be developed for monitoring the performance of the health institutions and service providers based on Key Performance Parameters (KPPs).

Based on the KPPs, the best performing health institutions and service providers to be identified and rewarded.



73 Final report for 2015-20 the fifth state finance commission, Bihar Volume- 1.

## 5.3 COMMUNITY PARTICIPATION

#### LEARNINGS BASED ON DESK/FIELD RESEARCH

The 74th Constitutional Amendment mandated the constitution of ward committees. As per Article 243S, ward committees, consisting of one or more wards, have to be constituted within the territorial area of a Municipality having a population of three lakhs or more. The state legislature is supposed to make specific provisions for the composition and conduct of the ward committee. The ward committee is a platform where the administrative officials and elected officials (and in most states, the citizens) come together to discuss the issues of the ward.

Zonal Committees are comprised of a number of wards as specified by the Municipal Corporation. The elected representatives are members of the committee. Its powers and functions are specified in the state legislation/act. This is not mandated by the 74th Amendment but is present in many states like Jharkhand and Bengaluru.

The concept of Area Sabha was introduced by JNNURM; it provided for the enactment of the Community Participation Law to institutionalise citizens' participation in urban areas. It comprises all persons registered as voters of the area. Its functions and duties are specified by the state legislation/act.

These platforms are important for democratic decision-making at the local level. Provisions related to zonal committees, ward committees, area sabhas and the role of councillors that highlight the specific role of elected representatives were reviewed. A specific role in public health, water, and sanitation for elected representatives has been chalked out in only seven states. The seven states are listed in Table 5.2 below



Analysis of Municipal Legislations/Acts on Participative Platforms for Democratic Decision-Making

Title of Legislation/Act		Zonal Commit- tee	Ward Commit- tees	Area Sabha	Specific role of councillors
Bihar Municipal Act, 2007	Н				
	W				
	S & SWM				
Bruhat Bengaluru Mahanaga-	Н				
ra Palike Act, 2020	W				
	S & SWM				
Jharkhand Municipal Act, 2011	Н				
	W				
	S & SWM				
Karnataka Municipal Corpora-	Н				
tions Act, 1976	W				
	S & SWM				
Maharashtra Municipal Coun-	Н				
cils, Nagar Panchayats and Industrial Townships Act, 1965	W				
industriat Townships Act, 1905	S & SWM				
Maharashtra Municipal Corpo-	Н				
rations Act, 1949	W				
	S & SWM				
Orissa Municipal Act, 1950	Н				
	W				
	S & SWM				
Orissa Municipal Corporation	Н				
Act, 2003	W				
	S & SWM				

Legislation Act has a specific role for Zonal Committee, Ward Committee, Area Sabha, and Councillors

H – Health

W - Water Supply S & SWM - Sanitation and Solid Waste Management





01

In Bengaluru, Ward Level Committees, with the Corporator as the President, function effectively and health is a key agenda item for them. The Ward Level Committees and the Resident Welfare Associations play a key role in easy flow of information to the residents and this was an asset during the COVID-19 pandemic, as the frequent changes in guidelines could be easily passed on to the community. Elected representatives serve as a link to the community, which in turn creates a system of public accountability of health services.

02

In Bhubaneswar, the MASs are very active and have taken a leadership role in ensuring health of the slum populations. The MASs have well-maintained records for the meetings and activities conducted, and the funds expended. The ASHAs are well trained and their area of service is clearly demarcated.

03

GCC does not have any ASHAs. The Self-Help Groups at the community level have been recognised as the MASs.

04

Bhubaneswar and Bengaluru had well-functioning and effective Jan Arogya Samitis (the erstwhile Rogi Kalyan Samitis - RKSs) that met monthly. UPHCs have a list of the Governing Body and Executive Body members clearly displayed in the facility. Citizens' Charter is consistently displayed in all facilities including services provided, grievance redressal mechanism, and patient responsibility. The staff list, and names of drugs and diagnostic tests available at the facility are prominently displayed. A time table indicating the days and timings when specialist services are available is also displayed.

#### **Community Participation in Bihar**

- JASs are constituted in UPHCs with the MO In-charge as Chairperson, and UPHC MO as Member Secretary. Local Councillors are members but their participation is limited. Meetings of JASs are not held at regular intervals.
- Councillors are involved in mobilising the community for availing the healthcare services and enabling access to the underserved and vulnerable communities. If ward councillors are also involved prior to any health activity, then the number of people participating will increase and make the activity successful.





## RECOMMENDATIONS – COMMUNITY PARTICIPATION



Empower Elected Representatives to understand and address local health needs

It is crucial for the ULBs to have political support and the resource allocations to lead health programmes. Sensitisation of councillors on how healthier populations can be economically more productive and lead to development of their constituents can go a long way in garnering their support. Supporting the councillors in playing a catalytic role in improving health will, over a period of time, create community expectations to deliver better healthcare in their areas. The COVID-19 pandemic has highlighted the cross-cutting role that health plays in economic development and growth. Riding the wave, the local elected representatives can be oriented to realise the importance of health in their portfolio, which is a fundamental community need for existence.

❖ A process is to be instituted for all elected representatives to be oriented to their roles, responsibilities, healthcare needs of urban populations, healthcare delivery system, and the resources available with the ULBs to improve health of the cities and towns. An important aspect would be to make the councillors understand the complex interplay between health and other factors such as pollution, road congestion, accidents, and lifestyle, so that they can truly evolve into leaders who can view and lead health in the city more holistically. A development partner could support this process with a technical agency that can apply creative adult learning methodologies to make this paradigm shift over a period of time, rather than treating it as a one-time training exercise.



#### 02

#### **Activate Standing Committee on Health in Municipal Corporations**

All ULBs have a provision for standing committees to address specific aspects of functioning of the ULB. Many have a separate committee on health, while others club it with social services or services for women and children. These committees which oversee healthcare for urban populations need to be activated and empowered.

The committee members need to be taken through sessions that cover health needs of urban populations, current government programmes on healthcare, and the role that the committee can play in achieving universal health coverage in the city. A development partner can support the training needs assessment, development of training material, and training of members of the standing committees working on health.

## 03

#### Strengthen communitisation of urban health

Ensuring coverage by ASHAs, ANMs and MASs will help communities be active participants rather than passive beneficiaries in improving the health of the city.



Resolving city-specific challenges in recruiting, training and supporting ASHAs need to be prioritised. The state has been recruiting contractual ANMs who have been deputed to urban areas. Any additional shortfall should be addressed by securing additional funding from NUHM and/or XV-FC pools. Cities like Bhubaneswar, Chennai and Bengaluru have very vibrant MASs. Cross-learning to understand the processes and lessons can help adapt to urban geographies in Bihar. Jeevika has been a game changer in rural Bihar for women's empowerment and health and nutrition issues. The SULM (State Urban Livelihoods Mission) platform can be used in urban Bihar to include the functions for the MASs.

Constitution and training of MASs and opening their bank accounts is a priority. The MASs can play an important role in need-based planning and also ensuring that no households are left out. They can also be vital players in mobilising strategies for Social and Behaviour Change. This can be done at household level by emphasising the factors which promote or hamper healthy lifestyles:



Raising awareness on aspects which adversely impact health behaviour (e.g., smoking, excessive alcohol, poor diet, etc.)



Promoting timely healthcare utilisation, to improve health for positive life changes.

- SULM groups can be recognised as MASs where possible
- Training and Capacity Building of ULB officials for PHC with special focus on Women Councillors by the cadre of master trainers trained by Janaagraha
  - Ensure regular meetings of JASs, discuss and address gaps in service delivery and resources
    - Induct local elected representatives as members of JASs
    - Orient JAS members about their roles and the processes stipulated for the functioning of the JAS
- Utilise platforms of National Urban Livelihoods Mission (NULM) and Swachh Bharat Mission (SBM) for community engagement and convergence
- Regularly updating the City Health Action Plans will help in consistent planning based on the gap assessment and priorities of the state. The state is to undertake an assessment of urban demography, slums and health facilities, human resources, etc. (an assessment was undertaken in 15 cities in 2013-14)
- Annual updating of the dynamic data, i.e. human resources and Infrastructure; and updating the demographic and slum data every three years should be mandatory.

## 04

#### **Making JASs effective**

Making the JASs function effectively will go a long way in ensuring quality and accountability of healthcare facilities and the providers. The members need to be empowered to make JASs effective and represent patient needs.

It is crucial to make JASs effective for all health facilities. The elected representatives of ULBs can take the lead in ensuring that the meetings are held on a regular basis, and gaps in service delivery and resources are discussed and addressed. JAS members can be oriented to their roles, processes stipulated for the JAS functioning, and ultimately empowered to represent patient needs at the facilities.



## Constituting and Operationalising the Ward Committees and Sthaniya Swasthya Sabhas

- A resolution by the HLSC defining the functions of the ward committees regarding primary health should be passed
- Strengthen ward committees with regular meetings, with emphasis on mechanism of convergence.
- Strengthening Ward Committees, with regular meetings, and by entrusting ULBs with requisite power and authority. This can be done by defining it in the rules to be passed under the municipal act. For example, the Gujarat legislature passed the Gujarat Municipal Corporation's Wards Committees Functions, Duties, Territorial Areas and Procedure for Transaction of Business Rules, 2007 under the Gujarat Provincial Municipal Corporations Act, 1949.
- For local level solutions and creating awareness about public health activities and supporting the health systems, Ward Level Committees and Sthaniya Swasthya Sabhas should be constituted and regular meetings convened. This will support last mile reach.



## GRIEVANCE REDRESSAL AND INCENTIVISATION

- Set up a grievance redressal mechanism and ensure the smooth operation of health centres. TeleHelpline Service – Dial '104' is a medical advice helpline number, which is to be expanded for registering community grievances
  - Develop a mechanism for follow-up of the grievances and action taken (timelines and responsibilities for resolving the grievance based on the type of grievance). Feedback to be provided to the complainant regarding the action taken and the solution to the problem
- The Bihar Municipal Act enables the ward committees to discharge the functions related to "health immunisation services and slum services" subject to supervision and control of the Empowered Standing Committee
  - A resolution by the HLSC defining the functions of the ward committee regarding primary health to be passed
- "Nominate, Recognise and Reward" best-performing institutions/service providers
  - Mechanisms to be developed for monitoring the performance of the health institutions and service providers based on Key Performance Parameters (KPPs)
  - Based on the KPPs, the best-performing health institutions and service providers to be identified and rewarded.

# 06

## Innovation: Learnings and Recommendations

This section is focused on health information systems and public private partnerships (PPP).





## 6.1 LEARNINGS



BBMP has effectively used publicprivate partnership (PPP) models for healthcare delivery. It has partnered the renovation and infrastructure for some of the UPHCs. Further, management of some UPHCs has been outsourced to NGOs which have been able to deliver

While F-Aushadhi app (web-based drug supply chain in providing primary healthcare to citizens) is being used in all four of the benchmark cities, PCMC has gone further in digitising patient records and linking diagnostics and drug dispensing on a pilot basis in one HWC (Health and Wellness Centre).

Patients can be registered at the HWC and referred for consultation or diagnostics to a referral facility without having to register again at the referral facility. This system also makes provision for downward referral and hence ensures continuum of care. There are plans to digitise all health care records over the next year.



BMC has been very effective in ensuring universal COVID-19 immunisation by using simple pragmatic process innovations for systematic and client-friendly services.

BMC hired 10 private taxis that could be booked by the elderly and differently abled people by calling the Central Coordination Centre, which would transport them to the vaccination sites and back. BMC did target segmentation for improving vaccination coverage by reaching out to Food Delivery apps to cover delivery boys, newspapers to cover newspaper vendors, cab driver associations, NASSCOM (National Association of Software and Service Companies), old age homes, beggars, and the homeless.



BMC has also used social media to improve accountability of service providers.

The names and time schedules of the specialists who will be available at a particular polyclinic are tweeted under the BMC Twitter Handle the previous evening. This enables patients to plan better and makes the providers more accountable.



## 6.2 RECOMMENDATIONS

The greatest challenge in improving urban health is understanding the city-specific challenges and potential for solutions. The local government, NGOs and academic institutions should come together at the city level to define solutions that can be tested locally. A culture of innovation needs to be built and action needs to be reinforced by providing technical and financial support from the health department and donor-supported projects in the state.



- Organise workshops where citylevel health leadership can come together and arrive at innovative solutions to combat local challenges
- Encourage city leadership and resources to experiment with out-of-the-box solutions to build a culture of innovation and a spirit of ownership
- Annual state level performance review meetings to bring together urban health stakeholders to prioritise urban health challenges and develop solutions that can be supported with donor funds and subsequently scaled up with XV-FC or NUHM funds, can be considered
- Strengthen systems for data collection for urban areas to improve the availability of data for evidence-based planning and implementation of Urban Health Services



- Recording of disease profile of patients visiting UPHCs/UHWCs, collection, and analysis of OPD, using digital platforms
- Analysis based on the National Family Health Survey (NFHS) and other survey data to be utilised for the implementation of programmatic health facilities
- As per the mandate of Integrated Disease Surveillance Programme, capacity building and equipping grassroots workers for disease surveillance should be undertaken
- Involvement of the Community/Councillors for reporting outbreaks will be given emphasis in the capacity building module for ULBs. Awareness among the community to identify and report the inordinate/unusual health incidents in their locality, e.g., fever, diarrhoea or other such conditions in 2-3 families in a locality
- Rapid response to the outbreak/suspected illness by the local health and ULB officials
- Use social media for surveillance; reporting the outbreak for quick response and containing the outbreak, as well as providing information on the health-related issues
- Implement the Ayushman Bharat Digital Mission

## 6.3 PUBLIC-PRIVATE PARTNERSHIPS IN HEALTHCARE DELIVERY

PPP can be considered for operating UPHCs and other services. Laboratory diagnostics are already being run in PPP mode. Other services such as radiology, etc., could also be considered for running on a PPP contract model in the higher level facilities. The not-for-profit sector can be invited to run UPHCs and HWCs in PPP mode. Private diagnostic centres can be roped in for providing laboratory and radio diagnosis services in a hub-and-spoke model. This effort will also entail creating a strong mechanism and capabilities for managing PPPs at the ULB/DHS (District Health Society). This will include having a standardised scope of work, contracts, performance measurement benchmarks, payment schedules, patient satisfaction benchmarks, and mechanisms for conflict resolution.



- Doctor on hire- Doctor to be hired by the department for a limited period/ hourly basis/per case basis. Full time Paramedical staff to be hired by the department. Service delivery will be as per the in-house model presently functional
- Private/academic bodies can be engaged for concurrent monitoring of quality of services, and assessing community level outcomes using rapid methodologies such as Lot Quality Assurance Sampling
- Operationalise Telemedicine Services in PPP mode at UHWCs and selected UPHCs (polyclinics) for specialist services. Provide specialist services at least on a weekly basis including Medicine, Obstetrics & Gynaecology, Paediatrics and Dermatology (on honorarium basis) at selected UPHCs

# 07

## Agenda For Discussion

A Landscape Study on the 'Role of Urban Local Bodies in Primary Healthcare' was conducted by the Janaagraha Centre for Citizenship & Democracy as a part of the Project 'Transforming Governance of Primary Healthcare. The focus of the study was to support the State of Bihar to draft a roadmap to strengthen Primary Healthcare outcomes through ULBs. Recommendations given in the study, although focused on Bihar, can be adapted by other States as almost all the Urban Local Bodies do not manage primary healthcare functions. Therefore, this study may be helpful to all State Governments/ Urban Local Bodies and at National Level for drawing a plan of action for strengthening the Primary Healthcare Systems with the proactive support of Urban Local Bodies and Urban Local Bodies managing Primary Healthcare in the long run.

Based on the Learnings, specific recommendations are part of each chapter. For the high-level initiatives at the national & state levels, an attempt to put forward some points/agenda for discussion ensues in the sections below.



## 7.1 MODEL MUNICIPAL LAW (MML), 2003



The Model Municipal Law (MML) circulated by the Ministry of Urban **Development guides states toward** implementing the provisions under the 74th CAA. The MML acts as a resource for states to tailor their municipal acts. The Law aims to enhance the capacities of ULBs to leverage the course of development for urban areas and provide a backdrop so that urban local bodies can play their role more effectively and ensure better service delivery. The MML has mentioned various aspects of Public Health and its allied sectors in its different parts and chapters. The purpose is to enhance the understanding of ULBs towards Public Health, and states can refer to the MML as a guiding document for addressing the different aspects of building Healthy Cities.

The MML classifies municipal functions into three categories, namely "Core municipal functions", "Additional functions 74", & "Other functions 75".

- Each State Government may consider and decide whether the costs for performing such functions which strictly do not belong to the functional domain of the Municipalities shall be underwritten by the sponsoring Government Central or State.
- Each State Government may consider the various lists in this clause and add or delete any function.

Drainage & Sewerage, Solid Waste Management, Community Health, and protection of the environment are among the functions related to Public Health and its allied sectors falling into the category of Core municipal functions. Curative Health is placed among the additional functions assigned by the state government. Each State Government may decide whether the costs for performing such functions, which strictly do not belong to the functional domain of the Municipalities, shall be underwritten by the sponsoring Government - Central or State.

At the same time, Public Health and Sanitation is classified into other functions, which the respective State Government may consider in this clause and add or delete any function. The Law empowers the Chief Municipal Officer<sup>76</sup> to issue any such order for the improvement of any unsanitary premises which are likely to cause disease risk to the inhabitants of the neighbourhood or area and likely to endanger community health or safety. Also, the provision and maintenance of public conveniences, regulation of public bathing and washing & ensure proper environmental sanitation are among the duties of the Municipality under Chapter XXX. The act significantly focuses on Public Health with the provisions of Community Health, preventive, promotive and curative health. Except for a few major ULBs, most of the ULBs may not be able to manage the Curative Care Systems, i.e. secondary & tertiary care services. But, basic curative services as part of Comprehensive Primary Healthcare can be provided at UPHC, which includes management & treatment of basic ailments, communicable diseases (TB, Malaria, and Dengue), non-communicable diseases (hypertension, diabetes, ophthalmic & ENT care and screening of common cancers) can be managed. All the ULBs may have different resources or capacities to manage the primary health systems but can strive to play a proactive role with the support of the health department and, in the long run, steer and manage the primary healthcare systems. In the sphere of "Public Health & Sanitation", functions like mass inoculation campaigns for the eradication of infectious diseases, advancement of civic consciousness of Public Health, maintenance of all public tanks and others are included. The recognition of Health-related aspects in the sphere of public welfare talks about, Construction or maintenance of, or provision of, aids, hospitals, dispensaries, asylums, rescue homes, maternity houses, and child welfare centres in public welfare. In Chapter XXXI, "Restraint of Infection", "Preventive care" is cited, and the Municipality has to prevent and check on the spread of dangerous diseases. The Municipality is duty-bound

<sup>&</sup>quot;Community health" is listed under the core functions of a ULB and is exclusively defined under PART VI URBAN ENVIRONMENTAL MANAGEMENT, COMMUNITY HEALTH AND PUBLIC SAFETY. Chapter XXX is dedicated to Environmental Sanitation and Community Health.

to take such measures necessary for preventing or limiting the reach of any dangerous disease in the municipal area or of any epidemic disease among any animals therein. Contrary to that, The Epidemic Diseases Act of 1897<sup>77</sup> does not recognize the three-tiered governance structure. Also, The Epidemic Diseases (Amendment) Act 2020 remains silent on empowering responsibilities to the urban local bodies to prevent the spreading of any epidemic disease.

Model Municipal Law 2003 can be used as a guiding document for strengthening the Urban Local Bodies. The state can adapt the act's provisions as the state/ULBs need. States/ULBs can work towards additions/modifications or amendments in the Municipal Acts to empower the ULBs to strengthen the public health systems.



## 7.2 TYPOLOGY OF ULBs

The engagement of Urban Local Bodies in primary healthcare varies from state to state. While the ULBs are responsible for managing civic services in the city, the flagship health programme for cities, National Urban Health Mission (NUHM) is implemented by state health departments except in the mega cities and in a few cities selected by the state governments. This often leads to a diminished role for ULBs in urban healthcare.

ULBs have historically played an important role in healthcare and social determinants of health. However, their role was not institutionalised before the promulgation of the 74th Constitutional Amendment Act, 1992.

This necessitated amendments in the state municipality legislations as "local government" is a state subject. In 2003, Model Municipal Law was circulated as a directive for making the necessary amendments. It included three aspects of health to be added in Core, Additional and Other Functions – community health, curative health, and health and sanitation. Many states amended their acts according to the directive but this did not translate into policy and practice on ground.

After reviewing municipal legislations and other relevant literature and conducting field visits, it was found that there is no single narrative in which all the ULBs can fit. In the first case, the participation of ULBs in healthcare is negligible due to lack of the requisite infrastructure and absence of the institutional memory. This indicates low capacity in the ULB to engage with healthcare as well as lack of human resources. In the second case, the engagement of ULBs is limited to registration of vital statistics and prevention of vector-borne diseases and coordination with the Health Department. In the third situation, the ULBs are involved in healthcare but do not take a lead in planning and financial management. In the fourth case, the ULBs are empowered to manage health in convergence with other programmes at the city-level. Thus, to optimally engage with healthcare, different categories of ULBs need to take different steps including building capacities, creating shared platforms for health and ULBs, recruiting human resources and creating an enabling policy architecture.

In light of the preliminary findings from the study and thrust on engagement of ULBs in primary healthcare, there is a need to closely study a larger number of ULBs. There is an opportunity to engage at the national level to draw upon a policy framework

on the progressive involvement of ULBs in primary healthcare and look at the set of recommendations that can be generalised and replicated across ULBs. This would create a robust typology and a specific roadmap for each set of ULBs. The typology would be based on predefined metrics of involvement, capacity, and performance classifying them into four groups- Small ULBs, Medium sized ULBs-II, Medium sized ULBs-I, and Large ULBs. It is simultaneously necessary to equip them with resources and capacities to take on greater roles given their location. This will facilitate advocacy with states for adoption focused on i) mainstreaming urban health in urban policy ii) financing of urban primary healthcare and iii) building capacities in ULBs. It will help in conceiving a detailed roadmap for each model/typology to take on roles defined against time goals (short, medium, and long term) and creating a toolbox of SOPs and Checklist to Conceive pathway for scale and adoption country-wide.

In the figure below is an emerging hypothesis on the role of municipalities in primary healthcare

Figure 7.1 Emerging Typology of ULBs

Small ULBs	Need handling for most of the roles; evolve shared services of model	5-7 years	Cluster-based services model with role in community engagement,
<b>Medium ULBs II</b> Patna, Nagpur, Kanpur, Varanasi, Ghaziabad	Active role in planning, Gap analysis, Financing, Vulnerability assessment, Monitoring	3-5	monitoring  Well defined role in planning, financing, community
<b>Medium ULBs I</b> Kochi, Tiruananthpuram, Mysuru, Bhopal	Own basic primary healthcare delivery	years	engagement, monitoring
<b>Large ULBs</b> Mumbai, Bengaluru, New Delhi, Chennai	Comprehensively own primary healthcare delivery	years	Comprehensive urban health programming through conversions of all urban development programs

## 7.3 PROPOSAL FOR HEALTHY CITIES, INDIA INDEX REPORT

Healthy City India Index can be prepared in line with the Healthy States, Progressive India Health Index report released by the NITI Aayog. The Healthy Cities, Progressive India Index report can be prepared specifically for Million Plus Cities. The indexing exercise can be commenced with only major cities of the states and then further extended to other cities in coming years. These cities can be divided into different categories as per the typology. Indicators similar to the Healthy States, Progressive India report (Health Outcome, Governance and Information, Key Inputs and Processes) can be used..



In addition to these Indicators, Indicators on provisions of primary healthcare in municipal acts and financial allocations by the cities for health and financial management can be added. Presently, city-wise outcome indicators, i.e. Maternal Mortality Ratio, under five/Infant/Neonatal Mortality Rate and others, may not be available. However, intermediate health outcomes and outputs, governance, data integrity, data on health systems & service delivery can be used for the index. The mechanism under NUHM for data collection and analysis can be strengthened for city-segregated data. Similar reports have been prepared globally by WHO, named "National Healthy Cities network<sup>78</sup>" in WHO European region, and also by Building Research Establishments "International Healthy Cities Index<sup>79</sup>" for the assessment of global cities against the indicators that impact the Urban environment and wellbeing. The BRE index contains a set of 58 evidence-based indicators in 10 categories and covers 20 global cities. WHO, in collaboration with Georgia State University School of Public Health, has created a handbook for calculating and using the Urban Health Index. The UHI80 provides a flexible approach to selecting, amalgamating, and presenting health data. Its purpose is to furnish visual, graphical, and statistical insight into various health indicators and health determinants within particular geographic boundaries and health disparities, focusing on capturing intra-urban health disparities. The UHI can be used by evaluators, statisticians, program managers, academic researchers, and decision-makers to examine the current status of urban areas, assess change and the effect of program interventions, and plan for urban improvements.

National healthy cities networks in the WHO European Region Edited by Leah Janss Lafond, consultant, United Kingdom Promoting health and well-being throughout Europe

https://www.bregroup.com/bretrust/wp-content/uploads/sites/12/2017/09/4.pdf

The Urban Health Index: A Handbook for its Calculation and Use I. World Health Organization. ISBN 978 92 4 150780 6 Subject headings are available from WHO institutional repository © World Health Organization 2014

# 08 ANNEXURES

## 8.1 PROPOSED HEALTH COMMITTEE OF THE MUNICIPAL CORPORATIONS

Chair	Experienced ward councillor
Members	Councillor (7-8)
	Assistant Municipal Commissioner/Executive Officer (Enforcement & Sanitation)
Convener	Chief Medical Officer/Medical Officer ULB- till the time Medical Officer is posted, City Manager may be designated



## 8.2

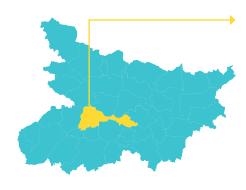


## **CONSTITUTION OF CITY HEALTH SOCIETY -GOVERNING BODY UNDER** THE CHAIRPERSONSHIP **OF MAYOR AND EXECUTIVE COMMITTEE UNDER** THE CHAIRPERSONSHIP **OF MUNICIPAL COMMISSIONER IN PATNA**

As per the NUHM mandate, States may decide to either constitute a separate City Urban Health Missions / City Urban Health Societies or use the existing structure of the District Health Society / Mission under NRHM with additional stakeholder members.

## City Level

District/ City	District/ City	Urban Health
NUHM Health	NUHM Health	management
Mission	Society	Unit
City mission to be headed by Mayor/ chairperson	City society to be headed by Municipal Commissioner/ DM	To be strengthened by placement of Consultant



Patna being a major city having population more than 2.3 million, primary health needs more focus and coordinated effort at city level specifically with SBM, AMRUT, NCAR and other determinants of health.

So for the better management of primary health care, City Urban Health Society under the chairpersonship of City Mayor/Municipal Commissioner Patna can be constituted. Many states i.e. Punjab, Bhubaneshwar among others have City Health Society to manage the NUHM and other urban health care programs in the cities.

## 8.3 PROPOSED STRUCTURE OF CITY URBAN HEALTH SOCIETY

	Governing Body-City Urban Health Society	Executive Committee- City Urban Health Society
Chairperson	Mayor	Commissioner
Co-Chairperson	Commissioner	
Chief Executive Officer	Civil Surgeon	Civil Surgeon
Members	AMC (Enforcement & Sanitation)	AMC (Enforcement & Sanitation)
	Director (Urban Planning)	Deputy Director-Urban Planning
	Chief – Municipal Engineer	Ex. Engineer (Head Office)
	Chief Medical Officer	Chief Medical Officer
	District Education Officer	District Education Officer or representative

District Programme Officer-ICDS	District Programme Officer-ICDS or representative
Program Officer-SBM, AMRUT and PMAY	Program Officer-SBM, AMRUT and PMAY
Additional CMO	Additional CMO
District Programme Manager-NHM	District Programme Manager-NHM

	Governing Body-City Urban Health Society	Executive Committee- City Urban Health Society
Chairperson	Mayor of the city	Commissioner of the City
Co-Chairperson	Commissioner of the City	
Member	Additional Deputy Commissioner	Representative of Deputy Commissioner
Chief Executive Officer	Civil Surgeon of the District	Civil Surgeon of the District
	Administrator-Local Development Authorities (GLADA)	Representative Local Development Authorities
	Additional Commissioner	Zonal Commissioners
	Additional Commissioner Technical/ SE Water and Sanitation	XEN Water and Sanitation
	Municipal Town Planner	
	District Education Officer	District Education Officer
Programme Officer-ICDS		Programme Officer-ICDS
		District Family Planning Officer
Members		District Immunization Officer
	District Health Officer	Programme Officers Disease Control Programme
	City Health Officer	City Health Officer
	District Programme Manager	District Programme Manager.
	Programme Office JNUHM, RAY and others	Team Leader/Manager of PMU- JNURM, RAY and others
	Representative of NGOs/Mahila Arogya Samiti	
	City Programme Coordinator	City Programme Coordinator
Convener	Deputy Medical Commissioner	Deputy Medical Commissioner

The City Urban Health Society will meet at least once in six month and Executive Committee -CUHS will meet at least once in a quarter. The details by-law and MoA may be as per the District Health Society.

ULBs in health-based planning & monitoring - Steering planning & implementation of healthcare delivery e.g. City Health Action Plan

## 8.4 WALK-IN INTERVIEWS FOR RECRUITMENT OF MEDICAL OFFICERS



#### CITY HEALTH SOCIETY, BHUBANESWAR National Health Mission, Odisha Dept. of Health & Family Welfare, Govt. Of Odisha



Date: 15/07/2019

#### Walk-In-Interview

Adv No. 19 /NUHM /2019,CPMU/BBSR

Walk in interview will be conducted as scheduled below for filling up the posts of Medical officers/Specialists under National Health Mission, City Health Society, Bhubaneswar on contractual & part-time basis with monthly remuneration as noted against each and subject to renewal as per OSH & FW Society terms and conditions

S. No	Name of the post	No. of posts	Remuneration	Venue	Walk -In- Interview
01	Medical Officer (Full Time )	2	Base - Rs.52,920 /- + P.I max @ 25% on base		
02	Medicine Specialist (Full- time)	1	Base - Rs. 66,150/- + P.I @ 25% on base		24.07.2019 (10:00AM
03	Medicine Specialist (Part time) (once a week)	3	Rs. 1500/- per session (Two session a day Morning & Evening session)	Conference Hall, Bhubaneswar	onwards)
04	Skin & VD (Part  -time specialist) (once a week)	2	Rs. 1500/- per session (Two session a day	Municipal Corporation	
05	Eye Specialist/ Opthalmologist (once a week)	1	Morning & Evening session)		
06	Psychiatric specialist (Part- time) (once a week)	11	Psychiatric specialist Rs.1250/- per session Clinical Psychologist Rs. 500/- per session (Two session a day Morning & Evening session)		25.07.2019 (10:00AM onwards)

The above posts are purely temporary and co-terminus with the scheme. Interested candidates can log on to www.bmc.gov.in for details of vacancy, eligibility criteria, age, application form etc. Candidates fulfilling the eligibility criteria may appear for registration and walk –in interview on the date as mentioned above. Registration timing will be from 10.30 A.M to 11:30A.M only on Walk-in-Interview date. No application will be received after scheduled timing of registration. The authority reserves the right to cancel any or all application without assigning any reason thereof.

Sd/-

## 8.5 TOOL FOR VULNERABILITY ASSESSMENT IN THE CITIES

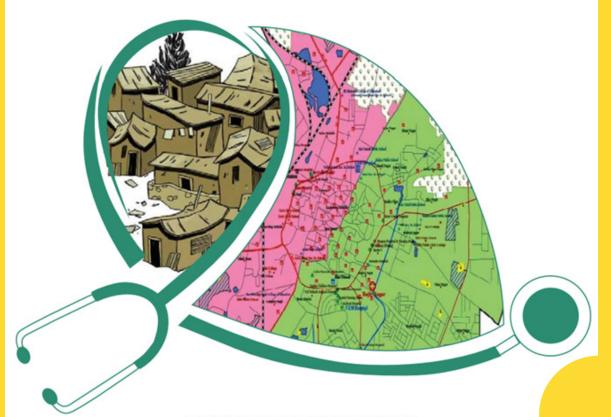




## **GUIDELINES AND TOOLS**

for Vulnerability Mapping & Assessment for URBAN HEALTH

2017

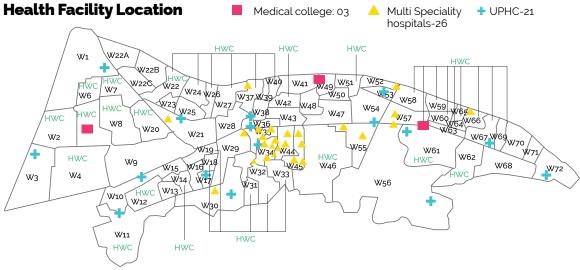


NATIONAL URBAN HEALTH MISSION

Ministry of Health and Family Welfare Government of India

## 8.6 EXAMPLE OF CITY PATNA MAPPING

Assess the existing health infrastructure and identify the sites and buildings for health centres, these inputs critical to preparation of DHAP



- ❖ Identified area need few more U-PHC to ensure accessibility of health services
- U-PHC can be assigned catchment area for addressing delivery of National health programs, disease, surveillance and addressing disease outbreak

## 8.77 FOCUS ON CPHCs IN A PHASED MANNER- 7 SERVICES ARE BEING PROVIDED, EXPANDING THE SERVICES

1.	Care in pregnancy and childbirth.			
2.	Neonatal and infant health care services.			
3.	Childhood and adolescent health care services.			
4.	Family planning, Contraceptive services and other Reproductive Health Care services  Already being implemented in most			
5.	Management of Communicable diseases including National Health Programmes.			
6.	Management of Common Communicable Diseases and Outpatient care for acute simple illnesses and minor ailments.			
7.	Screening, Prevention, Control and Management of Non-Communicable diseases.	Some UPHCs are implementing/initiating		
8.	Care for Common Ophthalmic and ENT problems.			
9.	Basic Oral health care.			
10.	Elderly and Palliative health care services.	V-44- I ::-::::-4I		
11.	Emergency Medical Services.	Yet to be initiated.		
12.	Screening and Basic management of Mental health ailments.			

## 88 INTERNATIONAL EXPERIENCES-CITY HEALTH PLAN

In this spirit, many countries and cities have started developing comprehensive health and wellness plans.

# Australia

#### The city of Melville

in Australia proposed a "Healthy Melville Plan" for 2019-23, focusing on creating healthy environments in the areas where people **live**, **learn**, **work and recreate**.

Increasing physical activity, healthy eating, creating a mentally healthy community, reducing alcohol and drug abuse and creating a safe and healthy urban environment.



Chicago

The plan Healthy Chicago 2025 is themed on "Closing our life expectancy gap" throughout 2020-25. Every five years, the Chicago Department of Public Health (CDPH) and a coalition of local organisations called the Partnership for Healthy Chicago (Partnership) review data and work with community members to understand the needs and strengths of their neighbourhoods. Then, they work collectively on a plan to improve community health and well-being. The project focuses on cross-sector<sup>81</sup> collaboration, working to promote health and racial equity through coordinated action and planning.

The City of Chicago has taken aggressive policy action to prevent tobacco use and invested more than \$26 million in 2021 under the framework for Mental Health Equity in critical areas.

Under the Australian Government's Public Health and Well-being Act 2008, all Victorian local councils must address their municipality's health and well-being needs through a Health and Well-being Plan. For the fourth time, the City of Melbourne has integrated the city's Health and Well-being Plan into the Council Plan 2021-25. The health and well-being outcomes in the municipality across six focus areas as outlined in the Council Plan 2021-25. The six focus areas are:

Including community groups, government agencies, businesses, faith-based organisations, researchers, community development professionals, health and social service providers and others.



#### Public health and safety



Healthy and sustainable lifestyles



Food security



#### Mental well-being and inclusion



#### **Housing and homelessness**



#### Health impacts of climate change

Under the Public Health and Well-being Act 2008, Council reviews health and well-being activity annually and reports progress on this plan through the Council's Annual Report. A set of 22 indicators have been elevated from the complete set of Council Plan 2021-2025 indicators to help track the health and well-being of the community and gauge progress made toward the health and well-being focus areas.

The City of Armadale in Australia proposes Community Health and Well-being Plan 2021–2024 (CHWP). The plan is a three-year strategic document and is the leading mechanism that provides a framework to achieve the vision for residents to enjoy the highest attainable standards of good health, well-being and participation at every age. The City's Community Health and Well-being Plan focuses on three areas within the WA Plan that are aligned with local priorities. These include: Chronic disease prevention, Environmental health protection, and Improving Aboriginal health and well-being.

In the WHO's European Healthy Cities Network Phase 2 (1993–1997), cities advanced the healthy cities approach by developing healthy public policies and drawing up comprehensive city health plans focusing on equity and sustainable development. The Network operated according to a four-year strategy (2013–2016), which focused on four action areas implemented through annual action plans. Seven municipalities established the Finnish Healthy Cities Network in 1996. These municipalities came together as part of a project (Terveyttä kaikille vuoteen 2000) that supported the local implementation of Finland's policy for Health for All by the year 2000 from 1986–1998.



City	Respondents from DoHFW	Respondents from Municipal Corporation/ Council
Patna	<ul> <li>Dr Vibha Kumari Singh, Civil Surgeon</li> <li>Dr. Vivek Kumar Singh-DPM</li> <li>Ms Neha, Regional Urban ASHA Consultant</li> <li>Dr Davel Roy- UPHC Shashtri Nagar UPHC Kamla Nagar</li> </ul>	Mr Animesh Parashar, Municipal Commissioner
Purnia	<ul> <li>Ms Brajesh Kumar Singh- DPM Purnia</li> <li>Mr Qaisar Equabal- Urban Health Consultant</li> <li>Mr Avinash K.Singh Block Health Manager-Banmankhi</li> <li>Dr Naveen Kumar- UPHC Purnia Court</li> <li>Dr Arvind Kumar- UPHC Mata Chowk</li> <li>Dr M.D. Nissar- UPHC Madhepura</li> </ul>	Mr Arif Ahsn - MC Commissioner Mr Chander Raj Prakash B.A.S- MC- Executive Officer- Banmankhi
Bhagalpur	<ul> <li>Dr Ramesh Sharma-Civil Surgeon</li> <li>Md. Faizan Allam DPM</li> <li>Mr Dayanand Mishra- DPC</li> <li>Dr Ashwani Rai- UPHC Hussainabad</li> <li>Dr Kalpana Kumari- UPHC Mohaddi Nagar</li> </ul>	Smt Sandhya Gupta-Councillor
Siwan	<ul> <li>Dr Yaduvansh Kumar Sharma- Civil Surgeon</li> <li>Mr Thakur Vishewendra Mohan-DPM</li> <li>Mr Imamul Hooda- District Planning Coordinator</li> <li>Dr Nisar- MO/IC, MD</li> <li>Dr Priyanka- AYUSH</li> <li>Mr Alok Kumar- Block Health Manager</li> </ul>	Mr Rahul Dhar Dubey- Executive Officer, Nagar Parishad Siwan
Gaya	<ul><li>Dr Arvind Kumar- Civil Surgeon</li><li>Nilesh Kumar- DPM- NUHM</li><li>Vinay Kumar- Consultant- NUHM</li></ul>	

City	Respondents from DoHFW	Respondents from Municipal Corporation/ Council
Chennai		Dr. Manish S Narnaware, Deputy Commissioner (Health) Dr S. Tulsi-Zonal Medical Officer Dr. M. Jagadeesan – City Health Officer Ms. Priya Rajan, Mayor Dr. Shantha Kumari – Chairperson Standing Committee (Health & Family Welfare) Dr. Bhanumathi, ACMO Dr. Hemalatha –Medical Officer Mr. Soundar Rajan - Sanitation Inspector Dr. Sheela - Zonal Health Officer
Bhubaneswar	<ul> <li>Dr Basanta Mishra-City Health Officer</li> <li>Dr Antaryami Mishra-Additional District Urban Public Health Officer</li> <li>Ms Neha-City Programme Manager</li> </ul>	Sh Sanjay Kumar Singh, Municipal Commissioner Sri Suvendu Kumar Sahoo, OAS- Deputy Commissioner Health/ Sanitation Smt. Sulochana Das, Mayor Mr. Ashwini, Councilor Councilor
City	Respondents from DoHFW	Respondents from Municipal Corporation/ Council
Pimpri-Chinchwad		Mr.Vikas Dhakane- Additional Commissioner-1 Dr Shrikant Supekar-Medical Officer Dr Chaya Shinde – Medical Officer In Charge UPHC Dr. Laxman Gophane – Asstt. Medical Officer of Health Mr. Jeetendra Kolambe – Chief Accounts and Finance Officer Dr. Pawan Salve – Addl. Medical Officer of Health
Bengaluru	Mr. Randeep D, Commissioner  • Health, Govt of Karnataka	Mr. Tushar Giri Nath – Chief Commissioner Dr. K.V. Trilok Chandra– Special Commissioner Health & Information Technology Dr. Balasundar A S – Chief Health Officer (Public Health) Dr. Maheshwari Madhava – Medical Officer Dr. Sandesh Biradar – COVID-19 Medical Officer Mr. Abdul Majid – Ex Councillor Ward 33 BBMP



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