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The USAID/India Urban Health Program:

An evaluation of activities to date and recommendations for the future

OCTOBER 2005

This publication was produced by a USAID team with representation from USAID/India, the Bureau for Global Health, the Bureau for Asia and the Near East, and the USAID BASICS and Environmental Health Projects.

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List of Acronyms

ANM	Auxiliary Nurse Midwife
AID/W	USAID Washington
ANC	antenatal care
ANE	Asia Near East
APAC	AIDS Prevention and Control Project
ARI	Acute Respiratory Infection
AWW	Anganwadi Worker
BASICS	Basic Support for Institutionalizing Child Survival Project (USAID)
BCC	Behavior Change Communication
BGH or GH	(USAID) Bureau for Global Health
CBO	Community Based Organization
CDM	Camp Dresser & Mckee
CII	Confederation of Indian Industry
CMO	Chief Medical Officer
CSH	Child Survival and Health
CTO	Cognizant Technical Officer
DFID	Department for International Development (UK)
DUDA	District Urban Development Authority
EAG	Empowered Action Group
EG	Economic Growth
EGAT	Economic Growth, Agriculture, and Trade
EHP	Environmental Health Project (USAID)
EPI	Expanded Program on Immunization
FCRA	Foreign Contribution (Regulation) Act
FHI	Family Health International
FICCI	Federation of Indian Chambers of Commerce and Industry
FIRE-D	Financial Institutions Reform and Expansion Project (USAID)
GOI	Government of India
HIDN	Office of Health, Infectious Diseases, and Nutrition (USAID/GH)
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Services
ID	infectious diseases
IEC	Information, Education and Communication
IFPS	Innovations in Family Planning Services
IndiaCLEN	India Clinical Epidemiology Network
IQC	Indefinite Quantity Contract
IRMS	Institute for Research in Medical Statistics
IT	information technology
JBIC	Japan Bank for International Cooperation
LHV	Lady Health Visitor
M&E	monitoring and evaluation
MCD	Municipal Corporation of Delhi
MCH	Maternal and Child Health
MCHUH	Maternal Child Health and Urban Health (Division, USAID/India)
MOHFW	Ministry of Health and Family Welfare
MOHRD	Ministry of Human Resource Development

MOUD	Ministry of Urban Development
NACO	National AIDS Control Organization
NFHS	National Family Health Survey
NGO	Non-Government Organization
NNF	National Nutrition Foundation
NRHM	National Rural Health Mission
OB/GYN	Obstetrics and Gynecology
OD	Organizational Development
OR	operations research
ORS/ORT	Oral Rehydration Solution/ Oral Rehydration Therapy
PACT-CRH	Program for Advancement of Commercial Technology - Child and Reproductive Health
PATH	Program for Appropriate Technology in Health
PHC	primary health care
PHN	Population, Health and Nutrition
PHR	Partnership for Health Reform
PMTCT	Prevention of Mother-To-Child Transmission
PPP	Public Private Partnership
PSI	Population Services International
PSP	Private Sector Program
PVO	Private Voluntary Organization
RACHNA	Reproductive and Child Health, Nutrition and AIDS Program
RCH	Reproductive and Child Health (national program)
RUDO	Regional Urban Development Office
SIFPSA	State Innovations in Family Planning Services Project Agency
SO	Strategic Objective
SOW	Scope of Work
SUDA	State Urban Development Authority
TA	technical assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
UH	Urban Health
UHP	Urban Health Program
UHRC	Urban Health Resource Centre
ULB	Urban Local Body
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization

About the Evaluation Team

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The Background section was largely drawn from the Scope of Work prepared by Dr. Massee Bateman, Chief of the Maternal and Child Health and Urban Health Division, of USAID/India, who was also very generous with his time in working with the evaluation team and in providing helpful insights into the history, current performance, and future directions of the USAID/India urban health program.

Finally, the team thanks all of those not already named in the GOI, State and municipal governments, non-governmental organizations, international partners, and USAID/India staff at all levels for their time, inputs, and feedback on this evaluation.

Executive Summary

To meet the health challenges faced by the rapidly growing urban poor population in India, and based on strategic planning decisions made in 2000-2001, USAID/India launched a new Urban Health Program (UHP) activity in March 2002. While other PHN activities contribute to UHP objectives, such as the urban components of USAID activities in HIV/AIDS, TB, polio, or social marketing, initial UHP implementation has primarily been through the USAID Environmental Health Project (EHP), scheduled for completion at the end of October 2005. In preparation, the EHP Delhi office began the transition of becoming a not-for-profit NGO, the Urban Health Resource Centre (UHRC).*

USAID's original objectives for the urban health program have evolved considerably since the 2002 launch. These changes primarily reflect the active engagement of and partnerships with the GOI Ministry of Health and Family Welfare in the program. This has led to the wholesale integration of the assistance provided by the EHP-UHRC into the Ministry's plans and activities under the second phase of the GOI Reproductive and Child Health project (RCH-2).

At this critical programmatic juncture, USAID/India decided to solicit a fresh look at its UHP activities to date, partly from an evaluation perspective but mainly to provide forward-looking thinking for possible future program directions. A five-person evaluation team, consisting of a mix of USAID/W, USAID/India, and contractor personnel, undertook this evaluation and design exercise from March 7-18, 2005, visiting field sites and policy-level organizations and individuals as well as the current implementing partner, EHP.

There are three principal lines of work in the current scope of the EHP-UHRC-implemented activity:

- building knowledge for advocacy to the GOI, States, cities, and other stakeholders (e.g. NGOs and the private sector, communities);
- providing technical assistance to the GOI, States, cities, and other stakeholders; and
- developing city models to enhance programs.

*The naming and branding of the EHP office is in flux, changing from "EHP" to "Urban Health Resource Centre (UHRC)." This change is about more than just a name, but rather reflects the evolution of this institution from a local USAID project office to an independent Indian NGO. The team has recommended a period of co-branding to take advantage of the recognition and existing brand value of "EHP", while allowing the "UHRC" to begin to be recognized. In this report, we have attempted to reinforce this by using "EHP-UHRC" throughout, which also reflects this report's dual nature in looking backwards at EHP as well as looking forwards towards UHRC. "UHRC" is also used in this report and is equivalent to "EHP-UHRC". The term "Urban Health Program" or "UHP" is used occasionally in this report to refer to the broader USAID program and objectives in urban health, which go beyond support for and working through EHP-UHRC, though this area of activity dominates.

In 2003, EHP organized the first national consultation on urban health, working with government and non-governmental stakeholders. In 2004, EHP-UHRC was designated as the nodal agency for urban health by the Ministry of Health and Family Welfare. In summary, the current position of the Urban Health Resource Centre appears to very strong in ongoing advocacy and technical assistance at all levels.

Through review of written materials, background briefings by EHP-UHRC, key informant interviews, and field visits to sites in Indore and Agra, the evaluation team broadly considered the roles within USAID's urban health program of:

- support to the GOI;
- technical assistance to states and cities;
- city demonstration and learning activities;
- generation and use of urban health knowledge for advocacy and planning; and
- building Urban Health Resource Centre capacity to support USAID and GOI objectives in urban health.

Overall, the team had a positive impression of the accomplishments of the EHP-UHRC-implemented component of the Urban Health Program to date. Considering the relatively short timeframe since activity inception, there has been significant progress in advocacy and policy development, as well as in the demonstration of practical operational models for both implementation and technical assistance at city level.

EHP-UHRC has proven itself to be very effective in supporting USAID's objectives in urban health, particularly in the programmatic mode which has dominated, namely to use very limited USAID resources to influence the much larger expenditures by the GOI under the RCH program.

The evaluation team made the following key recommendations:

Focus future USAID support on achieving two key results: better targeted policies and increased allocation of resources to improve the health of the urban poor; and improved program approaches at municipal level. *The role of city demonstration and learning activities would be to support these results, not achieving city-level health impact as an end in itself.*

Support technical assistance at city, state, and national levels; city demonstration and learning activities; and technical leadership activities (e.g. conferences and publications), since all three are important legs to support USAID/India urban health objectives. The emphasis in terms of level-of-effort and funding should be **first on TA, second on technical leadership, and third on city demonstration and learning activities,** although it is important to maintain flexibility to adjust this balance to adapt to any changing circumstances at the policy level which may arise.

Focus UHRC technical assistance at the State level, which can link resources available at the center to the needs of the municipalities. *UHRC TA needs to be coupled to sufficient capacity at the recipient end* (i.e. State level) to be effective, and USAID

should consider how best to support increasing this capacity (probably by placing long-term UHRC advisors at the State level, although the sustainability of this approach was of concern to the team).

At all levels, the **UHRC should diversify the partners with whom it works**, moving beyond RCH-2 to include ICDS, the Urban Development Authorities (SUDA and DUDA), and NGO or parastatal platforms such as CARE or SIFPSA. While UHRC has undertaken limited efforts in such outreach to date, building such partnerships will in some cases require considerable advocacy for the urban health agenda. The focus should be on developing long-term mutual commitments to this agenda, with UHRC providing technical assistance.

City demonstration and learning activities should be focused on cities with distinct socioeconomic, environment, or health characteristics or that present a special policy, leveraging, or learning opportunity. Where it becomes involved in operational aspects of urban health programs (such as in the current efforts in Indore), the **UHRC should enter into such arrangements with a clear exit strategy** laying out its level of support, the timeline within which it will be involved, and how quickly and in what manner it will reduce its inputs.

UHRC should place emphasis on mining existing program experience for best practices, tools and methods. The UHRC has the opportunity to identify and work with organizations, projects and programs that already exist on the ground but lack technical focus, effective programmatic approaches, appropriate or proper evaluation. Effective models can probably be built from these "platforms" more quickly than creating new city-level activities. As a line of work, the **UHRC should aggressively identify these platforms and work towards influencing their health content and approaches.**

The ward coordination model appears to be a viable approach for achieving greater scale, at least as implemented in Indore, including dimensions of both population addressed and the range of service which can be effectively and cost-effectively delivered. Further evaluation of the inputs required for given outputs is required, however. In contrast, the NGO/CBO model approach appears to not to be scaleable and should not be further evaluated.

Continue to focus on maternal and child health but improve links to and coordination with other USAID-supported health activities, especially in reproductive health, HIV/AIDS, TB, and malaria.

Improve internal Mission communication and coordination between PHN and EG on urban health issues, but focus these on a limited set of issues. These include: potential investments by JBIC that could relate to urban health, the development of the Agra City Development Strategy, and possible water and sanitation activities under FIRE/D in Agra and Madhya Pradesh.

Exploit opportunities to provide technical assistance to UHRC from USAID projects already on the ground in the India on other short- or long-term activities (e.g. BASICS). Specific TA requirements will need to be defined in dialogue with UHRC, which was

beyond the scope of this evaluation, and this will allow USAID to effectively leverage these opportunities.

UHRC should comprehensively and systematically catalogue other urban health activities, with a focus on identifying critical success factor and constraints, particularly for city-based efforts.

UHRC should remain the key implementing partner for USAID's Urban Health Program. Complementary support to urban health cells at the GOI central and State levels is also required, but would best accomplished through UHRC-supported long-term consultants.

Track key UHRC organizational development and technical capacity-building issues which need to be addressed before UHRC can be a successful independent NGO, including: branding issues; broadening of management capacity; improved definition of the roles of Delhi-based and city-level UHRC staff; and technical capacity.

UHRC needs to have more clearly defined and reported indicators for inputs, process, and outputs/outcomes. Current reporting does not concisely communicate clear messages about what is being accomplished. There needs to be continued emphasis on strengthening the evidence base that the guidelines and approaches advocated by UHRC "work" – i.e. have public health impact at manageable cost and are sustainable. Building this capacity within UHRC will not result from a few technical assistance visits by an external contractor. Rather, it is likely that some kind of strategic partnership over the long term with another organization with more experience in monitoring and evaluation will be required**.**

UHRC needs to develop clear "how-to" modules at central, State, and municipal level for the GOI-issued urban health Guidelines. A process to connect UHRC's growing body of experience to continual refinement and improvement of the Guidelines and modules needs to be in place.

Though the UHRC has done a commendable job of documenting its city-level work to date, the **UHRC should make sure that documents communicate effectively, are targeted well, and are as short and concise as possible.** Recognizing that documentation is expensive, in the future, more attention could be placed on the "how-to" modules, on results of monitoring and evaluation activities, and on advocacy pieces, with less emphasis on documenting inputs and processes.

USAID/India should consider channeling its support to UHRC through a cooperative agreement mechanism, rather than a contract, since the way that USAID has tended to work with this partner is more reflective of a cooperative agreement rather than a contractual relationship, especially in light of the desired advantages of ongoing flexibility. Central Leader with Associate cooperative agreements may be helpful, perhaps with initial support with field support to an AID/W Leader award "graduating" to a Mission-based Associate award.

Public-private partnerships (PPP) should receive greater emphasis in UHRC program support. PPP were expected to be significant components in urban health programming by all stakeholders, and there is a high demand for technical assistance in this area. The evaluation team recommends that UHRC build upon existing infrastructure and facilitate partnership between the municipal corporation/district health office and the private sector rather than directly engaging in service delivery PPP, e.g. contracting out models or franchises. In addition, there are numerous larger initiatives on PPPs that are currently underway within the RCH-2 implementation plan and the USAID/India PHN office. Therefore, the team recommends that the urban health program strategy and UHRC coordinate with these efforts, leveraging existing resources to the fullest extent possible.

The team also identified several key gaps which require further investigation and thinking but were beyond the scope, available time, or timeframe for this evaluation, including:

- A detailed evaluation from a public health perspective of the initial city proposals which were developed using the EHP-UHRC guidelines, with recommendations for revision of the guidelines, including their application, as necessary.

- Including consideration of the health systems issues for the urban poor being explored by PHR under an ANE Bureau and EGAT/Urban Programs comparative analysis in Indore and Manila.

- Exploring links to microfinance institutions, self-help groups, etc.

- Tightening linkages to address environmental sanitation, water supply, and hygiene issues as part of the urban health planning process, and developing viable solutions to these critical issues.

- Conducting a cost-effective analysis of the ward coordination model, using best estimates of public health impact.

- Identifying TA needs of UHRC and developing a plan to help meet these needs.

- Establishing criteria for city-level TA support and cataloging likely candidate cities.

Each of these is recommended for follow-up action by USAID/India.

1.0 Background

This document is the product of a USAID and USAID contractor team tasked with a "forward-looking" evaluation of the urban health program supported by USAID/India since 2002. This is not an oxymoron. Rather, the approach has been to use lessons learned from what has taken place to date, set these within the context of the current policy and program environment faced by USAID, and provide recommendations on how best to proceed in the future. The focus of the evaluation was the Urban Health Resource Centre, based in New Delhi, which has been supported through a USAID contract, the Environmental Health Project, since its inception. The program that USAID supports as well as the national programs with which USAID interacts have evolved significantly over this period, and continue to do so. These developments as well as the motivations and objectives of the program are described in this background section.*

Historically, India has largely been a nation of rural villages, but that situation is rapidly changing. Considering the burgeoning population and attendant public health burden of the urban poor, USAID/India developed and implemented a strategy to address the health needs of the urban poor in India. Public health programs in India, either supported by the central government, state governments or external assistance agencies, have primarily targeted rural populations. The authorities for assuring basic health services for urban populations are complex, a situation that has resulted in inconsistent and generally very low levels of public primary health care services in cities. Much care is provided by private providers, who are often unqualified and provide poor quality services. Preventive services are generally weak. Poor environmental conditions, especially sanitation, are a hallmark of urban slums and the living conditions of the urban poor. The result is a population with poor access to quality services and poor health indicators.

> The urban poor population of India is rapidly increasing, has health indicators that are similar to or worse than those in rural populations, and faces a per capita availability of public primary health care services that is much lower than in rural areas. India's urban population was 17% of the total in 1950, 25% in 1990 and 28% in 2001. However, this apparent slow pace of urbanization is misleading, as the urban population has grown at a high rate in India, just not at a rate dramatically higher than growth in rural areas. There are indications that this is changing with the current growth being a 2-3-4-5-6 phenomenon: all-India growth is about 2% per year, urban India 3%, megacities 4% and slum areas 5 to 6% per year. The urban poor currently constitute 25% of India's poor.

Recognizing the emerging importance of the health of the urban poor in India, USAID/India developed a new activity to develop experience in this area and to provide the basis for further development of a longer-term program. A team developed the first USAID/India Child Survival Strategy in late 2000. This strategy identified four

* The audience for this document is primarily intended to be internal to USAID. Nevertheless, it is expected that USAID's development partners in India may also find it valuable.

intermediate results, introducing urban health into the USAID/India portfolio for the first time. The four intermediate results were:

> I.R. #1: Improved nutritional status for children under three years of age
> I.R. #2: Improved health and survival of newborns
> I.R. #3: Reduced morbidity and mortality from the major childhood illnesses in older infants and children under five
> I.R. #4: Improved child health and nutrition among the urban poor

Following the identification of improved health and nutrition of children among the urban poor as a result under the 2000 Child Survival Strategy, a team developed an urban health strategy to guide the development of this new area of work. This strategy was drafted in June 2001 and stated the following goal and objectives:

> "The broad goal of USAID/India's Urban Health Program (UHP) is to improve the health of the slum dwelling urban poor in selected areas of India. To accomplish this, the mission has identified the following four objectives:

- **Effective community-based programs**: Improve health in selected urban poor communities by linking community level activities to existing municipal and private sector systems;
- **Improved municipal planning**: Address the needs of the urban poor through better use of essential information and reform of health systems;
- **Pro-poor policies**: Support the development and adoption of policies that overcome obstacles and enable improved health of the urban poor; and
- **Advocacy for urban health**: Increase the attention given to improving the health of the urban poor at the community, municipal, state, and national levels in India and within USAID."

This strategy set forth initial target cities (Ahmedabad and Indore), details of each objective including problems to be addressed, USAID's role, organizational arrangements and a draft workplan. The initiation of the activity was hampered by 9/11, delay in successfully recruiting a chief of party, and at the last minute, outbreak of communal violence in Ahmedabad. The latter led to travel and work restrictions and ultimately to Ahmedabad being dropped as the first city program.

In practical terms, this program began activities on 15 March 2002 when Dr. Siddharth Agarwal joined as country representative of the USAID Environmental Health Project (EHP), through which the main components of the Urban Health Program were implemented through October 2005, and a project office was opened soon thereafter, now the EHP-Urban Health Resource Centre (UHRC). Initial city-level activities began in the city of Indore.

The USAID urban health program, as reflected in the EHP-UHRC mission statement, aims to "*improve child health and nutrition among the urban poor in selected cities by providing technical assistance to improve newborn care practices, coverage of immunizations and control of diarrheal diseases, prevention of malnutrition, and sanitation and hygiene practices*."

The objectives of the USAID-funded EHP-UHRC program through October 2005 are:

- Increased coverage of services and adoption of key health behaviors in neonatal survival, diarrheal disease control and other reproductive and child health priorities;

- Improved capacity of CBOs, NGOs, private and public sector health providers in health behavior promotion, use of health data, and building partnerships;

- Better targeted policies and increased allocation of resources to improve the health of the urban poor;

- Development of replicable models for urban child health programs and use of these models in other GOI activities, such as the Reproductive and Child Health (RCH-2) program of the GOI;

- Institutionalization of a non-for-profit independent Indian non-governmental organization focused on providing technical support to municipalities, States, and the GOI on urban health issues, i.e the Urban Health Resource Centre.

Over the past three years, the USAID/India program environment has continued to evolve. The former USAID South Asia Regional Urban Development Office (RUDO) was dissolved, and an urban development focus within the USAID/India Office of Economic Growth was created. Within PHN, there is an increasingly strong emphasis on PPP and working with the national RCH program.

Within the GOI, there is a new urban health focus area within the national RCH program. The second phase of this program began on 1 April 2005 with an overall funding level of about $1.8 billion/year.* The current Secretary of Health and Family Welfare has a special interest in the health of the urban poor and has been a strong supporter for inclusion of activities throughout his program, particularly within RCH, to better address these needs. This has led to a very sharp increase in demand for EHP-UHRC technical assistance services, and further increases are anticipated.

2.0 Purpose, Methodology, and Questions for Evaluation

To provide direction for future USAID/India investment in urban health, USAID/India requested a five-person evaluation team to assess the effectiveness to date of the program approaches used in implementing the Urban Health Program. The team, comprising specialists from different disciplines (child health, environmental health, health systems, and public-private partnerships) included both Washington- and India-based USAID and USAID project staff.

*While this evaluation was underway, the GOI elevated the political status of RCH by folding its objectives into the new National Rural Health Mission. Despite the name, the focus of this new initiative is on all the poor without access to adequate health services, not exclusively those in rural areas.

The team used interviews with key stakeholders, examination of key documents, extensive interaction with the EHP-UHRC team, including an extensive background briefing, and site visits to Indore and Agra to inform these recommendations. Stakeholders from the Indian government side were at all levels, including national level Ministries, State bodies, and municipal health officials. Other key informants were drawn from USAID and from international partners, including local representatives of intergovernmental organizations (e.g. World Bank, UNICEF) as well as other donors (e.g. DfID). A list of contacts made is attached as Annexes 1.

Early in the process, agreement was reached with USAID/India on a set of key questions to be addressed in guiding the recommendations of the evaluation team:

1. How should the main strategic elements of the urban health program be formulated? What are the primary results and indicators that should be tracked to measure performance?
2. What should be the technical breadth and links of the program within the PHN portfolio, e.g. IFPS, PACT/CRH, CARE, etc?
3. What nature and process for collaboration with other offices within USAID/India are recommended?
4. What linkages with USAID/W programs are recommended?
5. What is the strategic niche for the USAID urban health program vis-à-vis other stakeholders, including government, development partners, NGOs, private sector?
6. What is the strategic role within the overall program and proportionate level of effort to be applied in each of the following areas:
    a. technical assistance at city, state, and national levels?
    b. city demonstration and learning activities, including recommendations on how many cities and the character (e.g. size, location, level of industrialization) of cities in which such programs be implemented?
    c. technical leadership activities, e.g. operations research, publication of technical papers, consultations and conferences, and support to resource centers?
7. What are the recommended mechanisms to support these activities? Specifically, what activities can best be supported through the Urban Health Resource Center, and what activities may be supported through other mechanisms?
8. What are the requirements for support for the organizational development of the Urban Health Resource Center – both from a strict OD point of view and from a technical capacity building point of view? What are the recommended mechanisms to support these activities?
9. What options are recommended to maintain and manage flexibility, where it is required?
10. What additional important activities can be recommended to inform the development of the urban health program – evaluations, analyses, research, tracking evolution of specific government programs and policies, and so on?

Additional questions pertaining specifically to the evaluation of past performance are included in the Scope of Work, Annex 2.

3.0 Evaluation Findings

The team's findings are organized around the major lines of work to date, as follows:

- support to the GOI;
- technical assistance to states and cities;
- city demonstration and learning activities;
- generation and use of urban health knowledge for advocacy and planning; and
- building Urban Health Resource Centre capacity to support USAID and GOI objectives in urban health.

In addition, the evaluation team looked at the current exploitation of public-private partnerships to support urban health activities.

3.1 Support to the GOI

EHP-UHRC has been identified by the GOI as the nodal technical resource agency in urban health, and as such assists the GOI directly in day-to-day consultations, support for an urban health technical cell within the Ministry of Health and Family Welfare (MOHFW), regional dissemination and training workshops in the application of the national urban health planning guidelines, and related activities. Assistance in the development of national urban health planning guidelines, now adopted and published as policy of the GOI, was an important achievement. These guidelines incorporated many of the tools and methods developed in city-based programs, highlighting a role that these demonstration and learning activities play in providing credibility for EHP-UHRC support to the GOI.

Urban health emerged as a priority in Government of India policies and plans over the last five years. Financial resources were allocated by the MOHFW towards the development of city-wide Urban Health Projects under the Tenth Five-Year plan (2002-2007). Following this, a collaborative relationship between the Government of India and EHP-UHRC evolved over the past three years on urban health programming issues, culminating in the EHP-UHRC nodal agency designation.

The first component of EHP-UHRC technical assistance to the GOI was a national consultation on "Improving the Health of the Urban Poor: Lessons Learned and the Way Forward" in June 2003. It provided a platform for governmental and non-governmental agencies to share experiences on urban health, to understand the strategies that had been effectively used in large-scale urban health programs in the country, and to identify challenges to wider adoption of these strategies.

Following this, EHP-UHRC worked with the GOI to identify several areas of activity to influence policy and program development at national and state levels. These included:

- **Situational analyses** using qualitative and quantitative research on health, socioeconomics, and stakeholders to identify gaps, critical implementers / decisionmakers, and priority interventions;

- **Slum assessment and mapping** to identify the vulnerable who did not appear on official lists of slums;
- **NFHS reanalysis** of demographic trends, health conditions, and access to services to guide better targeted urban health programming;
- **Preparation of baseline surveys at city level** to guide intervention development;
- **Follow-up surveys** to gauge program outcomes and impact; and
- **Collaboration with academic agencies (IRMS, IAP, NNF)** to seek expertise and disseminate knowledge via journal publications and other respected channels.

These activities influenced the GOI national program in several ways:

- GOI's guidelines recommended that unlisted slums be identified and mapped and urban health proposals for four cities were developed to target unlisted slums.
- The GOI established the need to focus urban health activities on EAG States, and more importantly, on poor and underserved urban populations in those States.
- The GOI directly applied the learnings from these activities to RCH II.
- The GOI constituted an Expert Group on urban health.

The recommendations from the national consultation, ongoing proposal development activities, and learnings from urban health projects in select cities culminated in GOI issuance of **Urban Health Guidelines** to assist state governments in developing urban health proposals under RCH-II. EHP-UHRC additionally supported the GOI the development of sample state urban health proposals, organizing planning workshops for state governments and city authorities, and building capacity of state and local governments through regional workshops.

In summary, the team felt that EHP-UHRC TA to the GOI and the leadership activities advanced in partnership with GOI were valued and important in influencing the directions for urban health investment by the government. While the monitoring and reporting of the impacts of city-level activities have not been strong to date (see further discussion below), clearly the experience of working at city level provided the EHP-UHRC was important to the quality, credibility, and influence of TA efforts. The theme of linkage of the city demonstration and learning activities to the TA and global leadership efforts undertaken by EHP-UHRC recurs as an important feature of the evaluation team's examination of the work undertaken to date as well as the recommendations for the future.

3.2 Technical Assistance to States and Cities

The EHP-UHRC has rapidly developed into a respected technical resource for states and cities planning programs aimed at the health of the urban poor. In this capacity, EHP-UHRC responded to requests from the government of Uttarhanchal to assist in developing urban health plans for three cities. Likewise it responded to a request from the GOI to assist four cities, one in each size class, in the development of model urban health plans for the national RCH program. To date, all Uttarhanchal plans and three of the GOI-requested plans have been completed. The program is assisting the state

government of Uttar Pradesh in developing urban health plans for five cities, and has received a request from the government of Bihar for similar assistance.

EHP-UHRC has directly provided technical assistance to the cities of Indore, Agra, Jamshedpur, Bally, and Dehra Dun to improve municipal planning for urban health, including improved capacity of CBOs, NGOs, private and public sector health providers in health promotion and service delivery, more effective use of health data, and the facilitation of partnerships amongst these various stakeholders to insure the connection of the most vulnerable populations to these efforts. The evaluation team had an opportunity to visit the city programs of Indore and Agra, which are the most advanced in terms of on-the-ground EHP-UHRC TA efforts, and the findings here are based on observations in these two cities and the examples of city-level proposals produced as part of the TA effort (and requested by the GOI as already discussed).

EHP-UHRC has been particularly effective in advocacy efforts at the local level and identifying "urban health champions" that have had the ability to influence and commit to an urban health agenda. In Indore, EHP-UHRC worked closely with the recently elected mayor who remains committed to urban health and continues to work with the project. Officials from the Municipal Corporation in Indore and the Chief Medical Officer in Agra both expressed their satisfaction and continued desire for EHP-UHRC's technical assistance and coordination.

EHP-UHRC has played an important role in facilitating broad-based, effective municipal planning to address the needs of the urban poor. One important manifestation of this assistance was the development of the RCH urban health proposals. EHP-UHRC's technical assistance has also improved coordination for more effective service delivery. EHP-UHRC's role has focused mostly on coordination, facilitation and development of the "Ward Coordination Model" in Indore (see also Section 3.3) and the "District Urban Health Center Model" in Agra. Both bring together a variety of stakeholders to address service delivery and improve service coverage (e.g. immunization) within a specific ward (the smallest unit of municipal administration). In Indore, for example, interviews with Ward Committee representatives revealed that EHP-UHRC's role was catalytic in bringing together these disparate organizations to focus on underserved slums within Ward 5.

EHP-UHRC's TA efforts were successful in engaging a wide range of stakeholders. Representatives on the Ward Coordination Committee included representatives from the Indore Municipal Corporation, Chief Medical Officer, DUDA, ICDS, Ward elected representatives, and the District Health Officer. In addition, other private sector stakeholders including Self Help Group NGOs and the local chapter of the Lion's Club are also included in the Ward Coordination Committee. This partnership has proven particularly useful in leveraging resources—for example, the Lion's Club has paid for some equipment and donated it to the district health center and mobilized volunteer private doctors to assist at immunization camps.

Technical assistance has focused mostly on city-level planning, facilitation, and applying participatory tools and processes such as the slum vulnerability assessment, stakeholder

consultation, and mapping of slum areas. These tools and processes were documented by the project and used in the preparation of city proposals. The key value of the mapping and vulnerability assessment tools seems to have been for advocacy and specific targeting of health services to underserved and previously unrecognized areas. Technical assistance was not directly provided to ANMs or district health centers on issues such as service delivery, quality of care, drug management, or logistics. Although these issues remain a concern, this type of technical assistance was viewed as being beyond the manageable interest of EHP-UHRC and sensitive since authority and supervision of service delivery resided with the Chief Medical Officer at the District. Technical assistance and training was provided to NGOs and CBOs on behavior change and health promotion messages.

In summary, the city-level technical assistance has been effective and led to improved municipal planning, including improved capacity of CBOs, NGOs, public and private health providers to better position their efforts to meet the needs of the urban poor. This is evident in the momentum behind the Ward Coordination model, multiple partnerships that have resulted in leveraged resources, and application of the mapping tools and processes documented in the project.

Two areas of concern for these technical assistance efforts were identified by the evaluation team. First, there is a need to institutionalize the local-level planning process catalyzed by EHP-UHRC, either the Ward Committee model or something equivalent in terms of approach and objectives. Improved planning and capacity at the city level has been in part due to EHP-UHRC's sustained efforts and the engagement of a core group of committed individuals at city level. Institutionalizing these committees and ensuring political commitment at the municipal level is challenging due to frequent turnover of government counterparts and staff.

Second, the EHP-UHRC has not to date clearly communicated outcomes of technical assistance in terms of benchmarks or indicators to assess or measure progress in terms of health impact or improved service delivery, and these have not been effectively monitored. The intermediate process-level monitoring that has been undertaken, such as the number of immunization camps conducted in the identified vulnerable neighborhoods, is important and valuable. Nevertheless, it will be important that the planned evaluation monitor agreed impact-level indicators, such as actual changes in immunization coverage.

3.3 City Demonstration and Learning Activities

The city-based demonstration and learning activities have been a key component of USAID's strategy for urban health since its inception, reflected in both the USAID urban health strategy as well as the work plan for the aborted efforts in Ahmedabad.

Over the three years since initiation, EHP-UHRC established two city-based programs in Indore and Kolkata (Calcutta), with only the program in Indore currently active. Other programs in earlier stages of initiation are located in Delhi, Agra (Uttar Pradesh), and Jamshedpur (Jharkhand). The work in Indore, in particular, has provided the basis for the development and validation of a number of tools for urban health planning and provided credibility and visibility to the program. In addition, and very importantly, they have allowed collective learning (by EHP-UHRC, USAID, municipalities, and the GOI) of the strengths and weaknesses of diverse approaches to improving the health of and services for the urban poor. In this sense, they have been very useful and effective. Though it is clear that these initial efforts have had significant shortcomings, they will allow future demonstration and learning activities to be constructed against refined criteria, targeted at meeting some very specific gaps in knowledge and the programmatic evidence base.

Two approaches for implementation at city level emerged from an evolving dialogue with slum dwellers, municipal and district health officials in Indore. The participatory appraisal process that influenced model design solicited ideas from municipal workers, slum dwellers and other informants on the ground as to local problems and priorities, informed by secondary data review and analysis. The "NGO/CBO community model" is aimed at creating demand and changing community and household practices, while the

General Criteria for the Evaluation of City-based Activities

1. **Addresses demand, supply, and health systems.** These three elements are both necessary and sufficient for comprehensively addressing all aspects of child health programming. Demand must exist for services to be effectively used. Supply must exist to meet demand, and system constraints to effective access, use and coverage must be identified and addressed.
2. **Design based on data.** Baseline data should inform program design. For urban health programming that addresses child mortality and morbidity, program design should be based on knowledge of morbidity and mortality patterns in the target population, knowledge of services that can address these and knowledge of system functioning (and bottlenecks) that inhibit or reduce coverage of these interventions.
3. **"80/20" rule and phasing.** Most of the benefit of a program ("80%") is the result of only a few services and behaviors ("20%"). As such, the most important causes of morbidity and the most effective interventions should be the initial focus of activities and practices with gradual expansion of interventions and practices as time, money and capacity allow.
4. **Simplicity.** The program should be conceptually and technically simple, focusing on small, doable actions. The link between inputs, process, outputs and coverage should be absolutely clear and it should be understood readily by those whose job it is to accept/adopt behaviors and implement programs.
5. **Affordability and replicability.** The program should achieve the greatest gain for the least amount of effort and be able to be implemented within existing resources. Required technical and management skills should exist, or could be readily developed, for successful startup and implementation. Detailed and clear "how to" manuals are needed to guide implementation.
6. **Evidence of effectiveness.**There should be evidence that if implemented appropriately, the model can achieve the intended results – reduced morbidity and mortality – through evidence that the model directly increases coverage of interventions and improves relevant behaviors.

"ward coordination model" is a supply-side model attempting to improve the coordination of programs and more efficient use of existing resources.

The common elements within these two models include promoting linkages between communities and service providers; use of community and other stakeholder consultation as a core element; a focus on process and inputs; service delivery by existing government programs (AWW, ANM), and; community-based services with referral and prevention.

In terms of actual service delivery, it is a bit artificial to separate the ward coordination model from the NGO/CBO implementation model since they come together at the community level, for services such as child immunization. The evaluation team observed an immunization camp set up by the Ward Coordinating Committee. It was run by the NGO, lead and slum CBO members were providing counseling, ANMs were immunizing children, and AWWs were weighing children.

The evaluation team used six criteria (see box on preceding page) to gain insights into the activities undertaken by EHP-UHRC in Indore:

Attention to demand, supply and health systems: In terms of service delivery, service utilization, and ultimately, improved health status of the urban poor, it is critical to address demand for services, supply of services, and systems issues (where health system is broadly interpreted to include all stakeholders, not just the public sector). Neither of the current EHP-UHRC approaches addresses all three aspects. The NGO/CBO model is mainly demand-focused while the ward coordination model is largely focused on service supply and coordination. Neither model addresses other key issues such as supply and logistics of commodities and supplies, supervision, and development of human resources. Both models rely primarily on services provided by the ANM, a cadre of worker which is undersupplied, overworked and frequently not available. Reliance on the ANMs was identified as the primary limiting factor to scale-up.

Design based on data: Program content emerged with consultation and experience and was based on an assessment of community felt need with some secondary analysis. A more thorough examination of the findings of the Maternal and Child Health Survey in the Slums of Indore (September 2004) may have allowed for a fine tuning of the program technical content.

Phasing and range of services offered: It is important to note that neither model as currently implemented provides services that address all the major killers of slum children: pneumonia, diarrhea, malaria, and malnutrition. The only cause of mortality directly addressed by the ward coordination model is measles, since it is currently focused on immunization. Because EPI coverage rates are already relatively high, the marginal impact of measles immunization on decreasing mortality would be expected to be relatively limited. If the underlying objective is to reduce mortality, then the technical content needs to insure that the leading causes of child mortality and associated morbidity are directly addressed.

Simplicity: The ward coordination model is simple and effective for what it is designed to accomplish. The NGO/PVO model is somewhat more complicated and time-

consuming, and it relies more heavily on EHP-UHRC staff and paid NGOs and CBOs. Community assessments must be conducted, NGOs and CBOs identified and trained, community women's groups developed, ANMs identified and so on. While these process inputs are important to the effectiveness and sustainability of community-based service provision, the time and effort required are impediments to scaling up this model.

Affordability and replicability: There has been no costing work done for either model, so it was not possible to evaluate affordability. In addition, for the NGO/CBO model there are no utilization or coverage figures and the population served is unclear, although this may become clearer through the impact evaluation of the Indore models currently in progress. The evaluation team feels that the ward coordination model, if expanded to cover additional services, could be an affordable and replicable way for improving service coverage at district, municipal and ward levels but, again, it would be best to back up this impression by quantification of actual costs.

Evidence of effectiveness: Evidence of effectiveness is anecdotal and fragmented and cause-effect relationships are unclear. However, there is evidence indicating that both models are effective at increasing either demand for or supply of covered services. The EHP-UHRC team provided some documentation of increased coverage of interventions at the slum level and the evaluation team, through interviews and observations, was provided anecdotal evidence that mortality and morbidity has declined in Indore pilot areas and that consumer demand for services has increased. Anecdotally, community members' knowledge and practices related to hygiene and care seeking have improved and knowledge and practices of community workers, including trained traditional birth attendants (TBAs), has increased. At district, municipal, and slum levels there is a growing sense of ownership in the program by community members, trained TBAs and health workers at district and municipal levels. Coordination across programs and responsible entities at district and municipal levels seems to have increased.

Other issues

Tools: EHP-UHRC has developed several tools to assist in city-level implementation activities, such as those for vulnerability assessment, but in general, the tools that exist are not always clear, easy to digest or complete. Once the models mature and are found to be effective, considerably more work needs to be done to develop clear, concise and detailed "how to" manuals for all aspects of the program.

Linkages to non-health sectors: Intersectoral linkages, particularly in the area of water and sanitation, were pursued but not particularly advanced. Although there were a few examples of the project's impact on engaging the municipal corporation to build a toilet block or mobilizing a community to obtain a bore well in a peri-urban slum, dialogue between the two sectors is not formalized or systematic. Linkages to ICDS and nutrition could also be strengthened.

3.4 Increased urban health knowledge for advocacy and planning

EHP-UHRC has established itself as the key resource for information on health matters among the urban poor in India. It has collaborated with the Indian Academy of Pediatrics to produce a series of articles on urban health in India, which are being published in the journal *Indian Pediatrics*. EHP-UHRC is regularly requested to make presentations, or assist eminent public health figures in making presentations, at national pediatric, child health, and public health events. EHP-UHRC has reanalyzed NFHS II data to generate important and unique information on the health conditions of the urban poor in India. This information is the raw material for many presentations, articles and reports. For example, in response to a request from the GOI, the UHP is developing urban health situation analyses for eight northern states. All of these point to significant achievements by EHP-UHRC is providing leadership in urban health knowledge generation and dissemination, a role that has concurrently increased and reinforced the ability of EHP-UHRC to undertake the effective advocacy and planning activities already discussed.

EHP-UHRC has taken dual tracks in knowledge generation and dissemination. One has been the compilation and sharing of existing urban health information, including program information, at national level – through both documentation and national conferences. Key events included organization of the 2003 national consultation on urban health ("Improving the Health of the Urban Poor: Lessons Learned and the Way Forward"), a symposium at the 2005 Annual Conference of Indian Public Health Association, and collaboration with the Indian Academy of Pediatricians.

A second track developed situational analyses at both state and municipal levels, with advocacy activities such as the state-level urban health workshop in Uttar Pradesh. The situational analyses have served as key planning documents which have directly fed into both city activities (already described) and the development of five-year urban health proposals under RCH-II for Agra, Bally, Dehradun, Haldwani, and Haridwar. Overall, the quality of the documents produced has been very good, and they have been well-received by counterparts.

There extent to which the successful advocacy has led to state and municipal ownership of the work and urban health issues generally varies. In Delhi, the MCD was the clear driver of the planning process, and EHP-UHRC played a key facilitative and consultant role, which is appropriate. In other locations, while the leadership of the local process was clearly in the public sector, full engagement was sometimes limited by the availability of personnel with sufficient time allocated to the planning process.

3.5 Urban Health Resource Centre capacity to support USAID and GOI objectives

Because the institutional and management capacity of UHRC was the subject of ongoing technical assistance efforts by EHP-UHRC, through both international consultancies and local subcontractors, the evaluation team focused on this in less detail than for other areas, and a comprehensive institutional evaluation of UHRC was beyond the scope of the evaluation.* Nevertheless, the team reached several general conclusions.

- EHP-UHRC has proven itself to be very effective in supporting USAID's objectives in urban health, particularly in the programmatic mode which has dominated, namely to use very limited USAID resources to influence the much larger expenditures by the GOI under the RCH program. In addition, the TA function has been well implemented by EHP-UHRC, which has also served USAID and GOI objectives.

- The short, variable lengths of the project cycle has been a constraining factor in the most effective evolution/ implementation of the program, including professional staff retention. The initial EHP-UHRC project cycle was through June 2004. This was initially extended until September 2004, and then extended again through the current Task Order which runs through October 2005. The anticipated transition of UHRC to a more independent status, less dependent on contract end dates, should help alleviate this.

- The allocation of staff and division of roles and responsibilities between Delhi-based and city program staff requires clarification, as well as rationalization of the deployment of city-based staff. For example, the Indore program appears to require a dedicated documentation officer, while Jamshedpur has excess support staff in view of its current suspended status.

- The role of the UHRC vis-à-vis skill building of the National Health Systems Resource Center of the GOI remains to be fully agreed, but this is a critical function which the UHRC is now well-positioned to fulfill.

- Appropriate professional growth potential of UHRC staff needs to be ensured, through both a business plan that allows for promotion as well as the identification of short-term training opportunities.

- A key factor in the successful efforts of EHP-UHRC to date has been the flexibility of USAID/India management of the activity to allow for changes in staffing and deliverables. This adaptability has been critical in allowing EHP-UHRC to take advantage of opportunities as they arise and to realign its strategy against a changing policy backdrop, such as the evolution of RCH and National Rural Health Mission (NRHM).

The evaluation team also examined the process of transitioning the EHP-UHRC USAID project into the independent Urban Health Resources Center (UHRC) from an

* The staffing pattern of the UHRC as of March 2005 is detailed in Annex 3, but it should be emphasized that this was and is in flux.

organizational development perspective. The findings and recommendations are based on a review of the institutionalization plan, existing staffing patterns, and an interview with EHP-UHRC Director Dr. Siddharth Agarwal. Based on this review, UHRC is well en route to becoming an established NGO with a vision and mandate in its own right. There is a well documented work plan outlining key steps and milestones. Steps towards legalization and obtaining the FCRA certification (enabling the acceptance of foreign donor funds) are underway and should have been in place by May 2005. Major organizational development issues such as governance, human resources systems, and financial management systems are being addressed through the use of specialized consultants. Key findings that may pose challenges or impact these developments include:

- **Communication and Branding Strategy**: The project activities to date have been marketed and communicated under the EHP name and logo. UHRC may face challenges in re-branding its prior work and future mandate with a new name. In addition, USAID's branding strategy requiring contractors to display the USAID logo may be challenging for UHRC as it builds a new identity and seeks to establish partnerships with the Government of India.

- **Management:** The leadership, management, and development of the EHP-UHRC project has been dependent on the Director, Dr. Siddharth Agarwal, to date. As the project scales up with increasing demands for technical assistance at the National, State, and City level, program management will become increasingly complex. During the team's interview with the Ministry of Health and Family Welfare, Secretary Hota said that he expected UHRC to double its efforts in supporting the Ministry on urban health issues. Staff seconded to urban health cells at the national, state or city level will require supervision, mentoring and support from UHRC's head office in order to be successful. UHRC is planning on hiring two senior staff to alleviate the management burden on the Director. However, this may take some time and impact program implementation in the short run.

- **Organizational Structure:** UHRC has developed an organogram that will be revised once the business planning process take place and the evaluation report is finalized. The functional staff positions are well articulated but technical roles still need to be reviewed. This may depend on whether UHRC ventures into new technical areas such as family planning and reproductive health. The staffing, roles, and responsibilities of UHRC staff in both the Delhi and field offices needs to be reviewed and rationalized. For example, Indore seems relatively understaffed compared to Jamshedpur, a relatively smaller city program.

- **Systems Transitions:** The EHP-UHRC project was reliant on CDM for support on financial and human resources systems. UHRC is transitioning to its own financial and human resources systems and has hired the consultancy services of Bansal and Company (financial) and Ernst and Young (human resources.) There may be some issues when the financial management and human resources systems transition to UHRC.

3.6 Public-private Partnerships

The evaluation team was asked to assess opportunities to incorporate public-private partnerships in the next phase of USAID's urban health program. The private sector is defined as both for-profit actors (private providers, corporations) and not-for profit actors (NGOs, CBOs, associations, and PVOs). Interviews with nearly all GOI stakeholders revealed a high degree of interest and consensus on the importance of public-private partnerships in RCH 2 and in the implementation of urban health programs. It is clear that there will be a high demand to incorporate PPP models and approaches in technical assistance and planning on urban health issues.

The majority of people in India, in all income groups, access health care in private sector—80% of health expenditures are out of pocket and only 20% is spent on primary health care. Moreover, government resources are overstretched. During the field visits in Indore, the evaluation team consistently heard that it was not uncommon for a single ANM to have responsibility for catchment populations up to 60,000. Slum residents also consistently reported their preference to visit a private doctor particularly when a family member fell ill. In most cases, slum residents chose doctors close to the *basti* and were not aware whether the doctors were qualified or registered providers.

EHP-UHRC's experience with public private partnerships has been ad hoc. In Indore, the project has successfully engaged a few private obstetrician/gynecologists to conduct ANC camps and worked with the Lions Club in the Ward Coordination model. They are also in the process of developing a contracting-out model in Agra where EHP-UHRC would initially fund an NGO to operate an urban health center on behalf of the district in an underserved area. In addition, EHP-UHRC has also begun to develop a relationship with the Confederation of Indian Industries (CII). While these efforts have been highly positive, the urban health program has the opportunity to meet the demand for expertise on public private partnerships and link with other PPP efforts both in USAID and other partners.

Much of the work to document and analyze examples of public-private partnerships in India has already been done. There are several World Bank case studies on public-private partnerships in Andhra Pradesh, Karnataka, and Calcutta. In addition, USAID/India recently conducted a comprehensive assessment of various public private partnership models in terms of their applicability within the RCH-2 context.

4.0 Recommendations for the Future

The team considered several areas for recommendations within the overall framework of the questions listed in Section 2.0, including:

- a revised Urban Health Results Framework;
- the relative roles of technical assistance, technical leadership activities, and city demonstration and learning activities;
- recommendations for city-based demonstration and learning activities;
- the niche for urban health within PHN and USAID

- the role of public-private partnerships
- organizational development of the Urban Health Resource Centre;
- complementary mechanisms to support USAID urban health programs, including linkages with USAID/Washington programs;
- USAID management, including considerations of flexibility;
- monitoring and evaluation; and
- additional activities to support urban health program development.

4.1 A Revised Urban Health Results Framework

The evaluation team felt that a revision of the results framework is required to guide future strategic development of USAID/India's urban health program. The draft results framework presented here is based on the team's evaluation findings, recommendations, and guidance from the USAID/India PHN office. Specifically, guiding principles for developing the results framework and recommendations for the urban health strategy included:

- USAID's resources for India vis-à-vis the government and the magnitude of the target population are relatively small. Therefore, direct service delivery is not a strategic use of scarce resources or a means to achieve health impact for the urban poor on national or state level. Therefore, any direct service delivery components must have a defined strategic purpose such as demonstration models or pilot projects from which lessons learned can be drawn or policy and resource allocation decisions influenced.

- Technical assistance and support in the health sector must be designed to influence policy at scale and leverage other resources, e.g. RCH 2.

- Proposed interventions, demonstration projects, research, capacity building activities must be designed with an intent and ability to be scaled up.

- The urban health program strategy should be designed to work through and strengthen local Indian institutions in both the public sector and private sector.

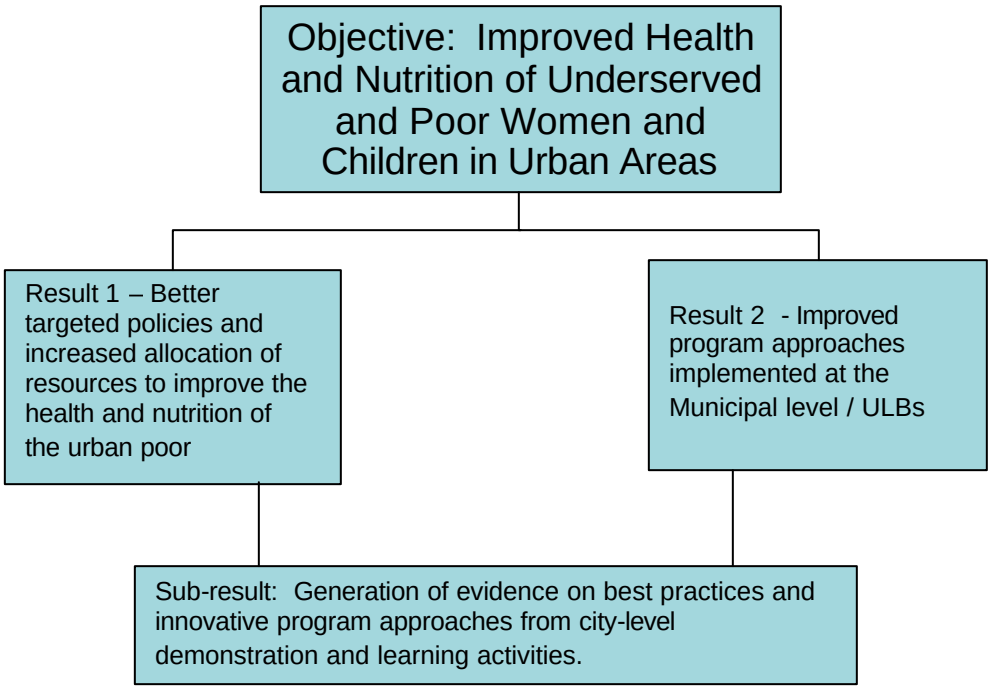
- Sustainability and a clear exit strategy is a primary consideration in the development of the urban health program strategy.

The team proposes the following urban health program objective:

Improved Health and Nutrition of Underserved and Poor Women and Children in Urban Areas

with two supporting results and a common sub-result, depicted in the results framework below:

Urban Health Strategy Results Framework



To date, the urban health program has focused exclusively on a select basket of child survival interventions. These interventions included improved immunization coverage, ANC, improved community practices on home deliveries and neonatal care, nutrition education, and household hygiene practices for diarrhea prevention. The team recommends that the urban health strategy expand its mandate in the near term to include reproductive health, a full package for maternal and child health, and nutrition. This recommendation is based on several factors:

- **Needs in urban slums:** The health needs of women and children in poor urban areas are comprehensive and include, at a minimum, reproductive health and family planning, diarrhea prevention and treatment, ARI treatment, and combating malnutrition. Nutrition is explicitly stated to highlight that it is managed by a separate GOI agency—ICDS, not the Ministry of Health and Family Welfare. Although the EHP-UHRC implementation to date has been successful in linking target beneficiaries to some of these services, the project did not explicitly measure impact or coverage in these areas. Expanding the technical intervention focus to include RCH 2 interventions as well as nutrition would be expected to have a greater impact on reducing morbidity and mortality among women and children.

- **Scope of RCH-2:** The EHP-UHRC has been highly successful at positioning its role in supporting the national government to implement RCH-2 in poor urban areas. EHP-UHRC will provide staff for an urban health cell that will provide support to the

Ministry of Health and State governments through the National Health Systems Resource Centre (a parastatal organization that will assist with the implementation of RCH 2). Expansion of the urban health mandate to RCH 2 interventions will enable the program to remain aligned with the goals of the GOI and have a greater impact on influencing policy.

- **Options for further expansion:** In the medium term, the team recommends that the urban health program mandate remain open to identifying convergence points with other technical health areas including HIV/AIDS, tuberculosis and malaria.* However, the team recommends that the program focus in the near term on RCH-2 interventions plus nutrition given the capacity of the UHRC, GOI expectations, and upcoming launch of the RCH 2 program.

- **Flexibility of funding:** Expanding the program focus beyond child health to include family planning and reproductive health will require USAID/India to invest CSH population funds in the urban health program. In addition, to the extent that the IFPS II project will also be mandated to support the implementation of RCH 2 in Uttar Pradesh, USAID/India may consider funding both projects with population, child survival and micronutrient funds. Adding HIV/AIDS, TB, and malaria foci to the program also could potentially introduce other sources of funding for urban health.

Result 1: Better Targeted Policies and Increased Allocation of Resources to Improve the Health and Nutrition of Urban Poor

This result builds upon the achievements of EHP-UHRC in improving municipal planning, providing technical assistance to the national and state government levels, and advocacy on urban poor issues. Illustrative activities supporting Result 1 include:

- support to the GOI at the national level and state level through the provision of technical advisors and urban health cells;
- technical assistance to cities on planning, program development, implementation and monitoring;
- dissemination of research, best practices and evidence on successful program approaches throughout India to policy makers; and
- national, state, and city level advocacy efforts on urban health.

Indicators for measuring progress for Result 1 need to be developed further. Illustrative indicators include:

- Number of municipal plans targeting health service delivery to the urban poor developed

* There are promising avenues to pursue when it makes sense to further expand. For example, in a meeting with Dr. Quraishi, Director General of NACO, he discussed NACO's initiative to set up PMTCT centers in various district health centers. In addition, the USAID/India PHN office is conducting a study to assess malaria prevalence in urban areas. The findings may help make the case to include select malaria prevention/treatment interventions in the urban health program.

- Non-USAID funds ($ or rupees) mobilized/leveraged (GOI, private sector, donors) to improve health for the urban poor

Result 2: Implementation of Improved Program Approaches at Municipal/ULB Level Result 2 focuses primarily on the provision of technical assistance and capacity building at the municipal level including non-governmental stakeholders such as NGOs, private sector, medical colleges, and voluntary organizations. Illustrative activities to support this result may include:

- technical assistance, coordination, and facilitation of stakeholders at the municipal level to address urban health;
- technical assistance to municipal corporations and district health officers (Chief Medical Officers) on developing proposals and plans for implement urban health programs;
- capacity building and training for NGO partners on health promotion, behavior change, etc.;
- facilitation and development of public-private partnerships;
- coordination of study tours and visits to learning sites in model city programs;
- conduct research and collect evidence on programming approaches and best practices; and
- documentation and development of templates, guidelines, and models that can be replicated and used in other cities.

Indicators for developing indicators to measure progress on Result 2 need to be further developed. Illustrative process indicators include:

- Number of city programs targeting the urban poor implemented
- Number of public private partnerships facilitated

Ultimately, these results should result in real, measurable improvements in health and behavioral outcomes amongst target populations. These would be captured at the objective level.

Sub-result: Generation of evidence on best practices and innovative program approaches from city-level demonstration and learning activities.

EHP-UHRC has implemented a demonstration city program in Indore and is in the process of developing another demonstration project in Agra. Per the guiding principles listed above, city-level demonstration and learning activities are intended to support Result 1 and Result 2 as a means to those ends, not ends in and of themselves. This is a key difference from the approach taken to date. It is not intended to undervalue the role of city-based activities, which have been critical to USAID and UHRC learning as well as to the consequent delivery of effective technical assistance which has already been discussed. Rather, it puts city-level activities in a context appropriate to the magnitude of the resources to be applied by USAID to the urban health program, that is, support of the development of improved approaches and for advocacy, particularly in the way that effective demonstrations can effect increased resource allocation for urban health.

The evaluation team feels that the city-level models should be developed and used only to the extent they influence policies and programs at a state and national level. They can be used as demonstration sites, sites for development of "how to" manuals, or learning sites for training purposes.

This sub-result is also designed to capture technical assistance provision, capturing of lessons learned, and documentation of best practices that UHRC could provide for activities focused on the health of the urban poor implemented by others – municipalities, NGOs, other USAID activities, or other development partners.

4.2 Relative Roles of Technical Assistance, Technical Leadership Activities, and City-based Demonstration and Learning Activities

It is recommended that USAID/India continue to support all three legs of current activity – including **technical assistance at city, state, and national levels; technical leadership activities (e.g. conferences and publications); and city demonstration and learning activities.** However, the emphasis in terms of level-of-effort and funding should strategically be first on TA, second on technical leadership, and third on city-level demonstration and learning, although it is important to maintain flexibility to adjust this balance to adapt to any changing circumstances at the policy level which may arise.

UHRC technical assistance should be focused at the State level, which is well-positioned to link resources available from the GOI to the needs of the municipalities. However, UHRC TA needs to be coupled to sufficient capacity at the recipient end (i.e. State level) to be effective, and USAID should consider how best to support increasing this capacity (probably by placing long-term UHRC advisors at the State level, although the sustainability of this approach was of concern to the team).

At all levels, the **UHRC should diversify the partners to whom TA will be provided**, moving beyond RCH-2 to include ICDS, the Urban Development Authorities (SUDA and DUDA), and NGO or parastatal platforms such as CARE or SIFPSA. While UHRC has undertaken limited efforts in such outreach to date, building such partnerships will in some cases require considerable advocacy for the urban health agenda. The focus should be on developing long-term mutual commitments to this agenda, with UHRC providing technical assistance.

City demonstration and learning activities should be focused on cities with distinct socioeconomic, environment, or health characteristics or that present a special policy, leveraging, or learning opportunity. All demonstration activities should be entered into with a clear exit strategy. Because USAID resources for such activities are very limited, opportunities to learn from others' investments, with minimal additional USAID investment under UHP, should be actively sought out. The team's initial recommendation to focus mainly on medium-sized cities with high growth rates was made less restrictive following discussions with the Mission staff, acknowledging that capacity was weak in such settings and that some attention should be focused on working with large cities.

The ultimate effectiveness of UHRC technical assistance efforts will depend critically on enhancing linkages and coordination at all levels. At the GOI level**,** there are opportunities to improve coordination and synergy between the different ministries (MOHFW, MOUD and MOHRD) as well as between their individual departments, such as those that touch on health, water and sanitation, and nutrition departments. In addition, UHRC is uniquely positioned to foster linkages between programs within Ministries such as between RCH and NACO. An additional area of UHRC support to USAID should be focused on developing improved linkages with urban health activities funded by other international agencies (e.g. World Bank, UNICEF, DfID, WHO, etc.).

There are also a number of issues that demand technical leadership and that UHRC could address in partnership with the GOI, subject to its own capacity and staffing limitations. Examples include:

- Assisting the GOI to improve referral linkages mechanisms, which are currently ad hoc and relatively weak;
- Developing guidelines/ methodologies to assist in burden of disease mapping for underserved poor urban;
- Supporting training from the GOI to state governments on formulating proposals for urban health guidelines;
- Develop recommendations to improve infrastructure provision and service delivery structures and quality, as a complement to health interventions;
- Increasing the focus on documenting implementation effectiveness, the flip side of the documentation of problem assessment and program planning.
- Improving and enhancing accountability mechanisms to the GOI for programs implemented at the state level and below, with agreed frameworks for monitoring and evaluation.

4.3 Recommendations for city-based demonstration and learning activities

The supportive role envisioned for the city-based activities suggests several promising avenues for the future and recommendations for UHRC.

- The team felt that the ward coordination model is a viable approach for achieving greater scale, including dimensions of both population addressed and the range of service which can be effectively and cost-effectively delivered. The evaluation team feels that more M&E work is needed before the effectiveness and, more importantly, the cost-effectiveness of this approach can be fully determined. Nevertheless, it is important to remember that different "models" will likely be required in other settings, so the effort to be devoted to impact-level M&E and cost-benefit analysis of any one approach needs to be reasonable in the context of a city program.

- UHRC should place emphasis on mining existing program experience for best practices, tools and methods. Developing new models and approaches is important but if models already exist there is no need to create them again The UHRC has the opportunity to identify and work with organizations, projects and programs that already exist on the ground but lack technical focus, effective programmatic

approaches, appropriate or proper evaluation. Effective models can probably be built from these "platforms" more quickly than creating new city-level activities. As a line of work, the UHRC should aggressively identify these platforms and work towards influencing their health content and approaches.

- Knowledge of all urban health-related activities in India is limited – there is no one single repository of experience and knowledge. The UHRC could play this role and should collect, assess, and strategically transfer experience across urban health programs and to those in the program development stage.

- The UHRC should have technical capacity, if not fully-dedicated staff, to address demand, supply, and systems issues. Demand creation and improved household and caretaker behavior alone is inadequate to improve service coverage. From a systems perspective, the UHRC needs to be able to identify and analyze bottlenecks to the delivery of health services and understand options and methods of overcoming these constraints.

- The UHRC should look beyond its own learning and experience with city-level implementation and determine whether there are other programmatic approaches that would have more visible, more rapid impacts on service coverage and use. Beyond the opportunities presented under RCH and the NRHM, UHRC should look for other partners with large-scale platforms in urban areas to which assistance could be provided to increase impact on the health of the urban poor. Fully exploiting existing platforms, such as with technical assistance focused on strengthening a limited set of interventions targeted at the urban poor, could allow more rapid start-up and impact.

- UHRC should focus its initial efforts in any city activity on a limited package of services, i.e. more than the focus on a single intervention such as measles immunization but less than a full suite of MCH and nutrition activities. For example, such a limited package could focus on routine distribution of vitamin A, promotion of exclusive breast feeding, use of ORS/ORT during episodes of diarrhea, provision of zinc for each bout of diarrhea, and promoting the "four cleans" for hygiene (clean water, clean hands, clean food, and a feces-free environment) and could probably be implemented quickly if built upon existing platforms.

- Though the UHRC has done a commendable job of documenting its city-level work to date, the UHRC should make sure that documents communicate effectively, are targeted well, and are as short and concise as possible. Recognizing that documentation is expensive, in the future, more attention could be placed on "how to" manuals, on results of monitoring and evaluation activities, and on advocacy pieces, with less emphasis on documenting inputs and processes.

- More "how to" manuals and guidelines for city activities are critically needed. They should be clear, concise and self-explanatory. The UHRC should examine existing manuals to determine if they are adequately complete and self-explanatory and what other manuals, addressing other aspects of the program, are needed. Those manuals should be developed as a matter of priority. Manuals should address all aspects of

urban health programming including demand creation, community case management of common illnesses, BCC/IEC, supervision, and M&E.

- Where it becomes involved in operational aspects of urban health programs (such as in the current model in Indore), the UHRC should enter into such arrangements with a clear exit strategy laying out its level of support, the timeline within which it will be involved, and how quickly and in what manner it will reduce its inputs.

4.4 Niche for urban health within PHN and USAID

There are a number of opportunities for linkages and leveraging within USAID that can be more fully exploited. Within PHN:

- Improve linkages to reproductive and maternal health by identifying linkages with IFPS and ITAP. Linkage could also be considered with the PACT-CRH program of PATH and Abt Associates.

- Urban health related questions or an enhanced urban health sampling frame should be included in NFHS 3 questionnaire.

- Mission-supported urban health activities could be linked up with the urban AIDS activities.

- IndiaCLEN could be used for Urban Health related OR issues.

One opportunity for coordination within USAID outside of PHN is with the EG office. Three specific opportunities were presented: potential investments by JBIC that could relate to urban health, the development of the Agra City Development Strategy, and possible water and sanitation activities under FIRE/D in Agra and Madhya Pradesh. It is recommended that PHN and EG develop a mechanism for regular communication on the progress of their respective activities, particularly if the Agra City Development Strategy bears fruit (though this was not certain at the time of this evaluation).

4.5 Role of Public-Private Partnerships

Key recommendations on public-private partnerships include:

<u>Coordination with Larger Public-Private Partnership Initiatives</u>

It is clear that public private partnerships are expected to be a significant component in urban health programs and there is a high demand for technical assistance in this area. There are numerous larger initiatives on PPPs that are currently underway within the RCH 2 implementation plan and the USAID/India PHN office. Therefore, the team recommends that the urban health program strategy and UHRC activities be coordinated with these efforts to the extent possible.

There is also a joint donor working group on PPPs and plans to staff a PPP cell within the National Health Systems Resource Center (a parastatal organization that will assist the GOI to implement RCH 2). This working group has already developed a concept paper on PPP guidelines, identified PPPs that are currently underway, and analyzed PPPs that are being proposed under State PIPs (program implementation plans.) It is critical that the urban health cell and PPP cell coordinate technical assistance efforts.

The USAID/India-funded IFPS 2 (Innovations in Family Planning and Services) project which provides funding and technical assistance to SIFSPA is primarily focusing on the development, testing, and replication of PPP models to support family planning and other RCH 2 services in Uttar Pradesh. The IFPS 2 will have a bilateral component that supports SIFSPA (a parastal organization) and the ITAP technical assistance component that will support SIFSPA to implement PPP models. To the extent possible, the urban health program should leverage this technical assistance component in addition to keeping up to date on the activities of the PPP cell and donor working group. While ITAP will focus primarily on supporting IFPS 2 and SIFSPA, it can also be a resource for the urban health program for specific, discrete activities such as developing planning guidelines for implementing PPPs within the context of municipal urban health planning exercises. The team also recommends that UHRC collaborate with ITAP before UHRC implements PPPs within city level demonstration and learning sites to ensure that state of the art knowledge is being applied and the activity is not duplicative.

UHRC has just begun discussions to explore partnership opportunities with Confederation of Indian Industry (CII). There are several potential areas where a partnership would make sense. For example, CII described a project involving mobile health clinic vans to slum areas in Delhi where construction workers tended to reside. In addition to strengthening the UHRC-CII relationship, the evaluation team recommends that USAID/India PHN office also formalize a relationship with CII to address other technical areas. While CII has an interested in supporting maternal and child health, their priority areas of interest and support is in HIV/AIDs, tuberculosis, and hepatitis.

Using Public Private Partnership Models to Improve Service Delivery

There are a variety of public private partnership models that can be applied within the urban health context. To the extent possible, the evaluation team recommends that UHRC builds upon existing infrastructure and facilitates partnership between the municipal corporation/district health office and the private sector rather than directly engaging in service delivery PPP on its own e.g. contracting out models or franchises.

There are several models that can be successfully incorporated into urban health programs at the municipal level. PPPs at the city level have the opportunity to address two key issues — (1) the shortage of ANMs, and (2) improved quality of private health care that is already being sought out by target slum residents. These models need to be assessed within each context for the following: cost; availability of qualified providers; price to beneficiaries; sustainability; administrative complexity; and health impact. The appropriateness of various models will differ according to each city. Therefore, the team recommends that UHRC work with ITAP to develop PPP assessment guidelines that can

be incorporated as municipal planning tool. Potential PPP models (not an exhaustive list) for use in urban health settings are described below:

- **Contracting Out:** Contracting out refers to an agreement or contract for a private provider to manage a government health unit or provide health care services on behalf of the government. This model is best used in situations where the government health services are unavailable or nearly defunct. The feasibility of contracting out models should generally be assessed on quality and cost dimensions. In essence, does contracting out result in higher quality, greater coverage, and lower/equivalent cost than the government providing the services itself? Other issues for consideration in contracting out involve the government's (municipal corp or district health office) to effectively manage, monitor, and ensure payment of the contract. UHRC is planning on implementing a contracting out model in Agra—soliciting NGOs to provide RCH 2 services in underserved peri-urban slum. The team recommends that UHRC obtains assurances from the District Health Office on its plans to take over the contract within a reasonable time frame and provide TA to enhance its capacity to manage the contract.

- **Franchise:** A franchise is a model where a private provider is given the "right" or franchise to provide certain services in a prescribed manner under a branded network. The franchiser typically owns the "brand" and will often monitor quality, price, and set some guidelines for how the franchisee conducts business and uses its brand. The franchisee usually will benefit from marketing, brand recognition, access to training, etc. The franchiser is usually an NGO or private organization. Franchise models are being seriously considered within the RCH 2 implementation plans. Franchise models are highly applicable within the urban health context. However, setting up franchise models requires considerable effort and expense. Therefore, we recommend that UHRC not try to set up its own franchise network. Rather UHRC should try to partner with existing or new franchises that are being created under the RCH 2 PPP efforts.

- **Social Marketing:** Social marketing is the use of commercial marketing strategies, distribution networks, and branding to achieve a social objective. There are several social marketing programs that are working in India including the PSI maternal child health program, Hindustan Latex program, and the USAID-funded PSP One project. The team recommends that UHRC partner with existing social marketing programs in cities that are the focus for technical assistance and demonstration and learning sites. For example, in Indore, a partnership with PSI could result in Basti CBO workers selling socially marketed products for a small profit.

Corporate Social Responsibility

Corporate Social Responsibility is gaining considerable ground in India with the well publicized efforts of Tata and formation of groups such as Confederation of Indian Industry (CII) and Federation of Indian Chamber of Commerce and Industries (FICCI). In addition, social clubs such as Rotary International and Lions Club have played significant roles supporting various health issues. In Indore, the Lions Club is playing an active role in the Ward Coordination model.

- **Capacity Building/Local Partnerships with Private Providers**: The shortage of ANMs and difficulty in providing sufficient coverage is well documented. The team discussed this issue with a variety of stakeholders in the field and discovered that at least one LHW (Lady Health Worker who is responsible for supervising ANMs) and the Chief Medical Officer in Agra have already begun to form an informal partnership with private providers to address this issue.

  The LHW in Indore has formed partnerships with three private providers in her catchment Ward to provide immunization services to slum residents since her ANMs were finding it difficult to cover the entire catchment area. She provided these providers with the vaccines and supplies and negotiated the price they would charge (Rs. 20) for the immunizations. Slum residents in the catchment ward were given the choice of either going to the immunization camp, waiting for the ANM worker to come on her monthly rounds, or going to a nearby private provider for Rs. 20. Since the Rs. 20 was often less than losing a day of work waiting at the immunization camp or waiting around for the ANM to arrive, many people availed of the private provider. The CMO in Agra also indicated that his office was in talks with private providers to form this type of partnership with an expanded basket of services—providing vaccines, family planning supplies, ORS, and cotrimoxizol to certified providers in exchange for lower fees.

  The team believes that this may be a cost effective model that addresses the ANM shortage issue while providing slum residents with the choice to avail themselves of services that make the most economic sense for their particular circumstance. We recommend that UHRC further explore formalizing this model perhaps with added incentives such as training, recognition program, etc. Partnerships with association such as the local or state chapters of the Indian Association of Pediatrics, Indian Medical Association may be helpful in facilitating this type of arrangement.

4.6 UHRC Organizational Development

To date, the USAID urban health program has been implemented through the EHP IQC mechanism. As EHP comes to a close, USAID has made the decision to support the long-term institutionalization of UHRC. The Urban Health Resources Center is envisioned to become an institutionalized Indian NGO with unique capabilities to serve as the nodal technical leader in urban health issues, as already discussed.

Key recommendations on UHRC's organizational development are listed below:

1. **Communications and Branding Strategy**: The evaluation team recommends that UHRC develop a comprehensive communications, marketing and branding strategy to launch its new identity. In addition, the team noted that the project would benefit from greater clarity and clearer messages about its activities and purposes. The team recommends a period of co-branding to take advantage of the recognition and existing brand value of "EHP", while allowing the "UHRC" to begin to be recognized. The team also noted that the USAID branding strategy may create obstacles for UHRC. The team recommends that in this scenario, USAID/India may

wish to investigate whether a grant/cooperative agreement mechanism would provide greater flexibility.

2. **Management:** The increasing managerial burden on the Director as the program scales up and UHRC becomes institutionalized is apparent to the team. We recommend that the recruitment of senior staff to UHRC be a top priority. In addition, UHRC senior staff should review which managerial duties can be delegated to other staff. Assuring quality of technical support to GOI stakeholders will be critical. UHRC can develop an orientation plan for new staff as well as ensuring that there are open lines of communication to the Delhi office.

3. **Organizational Structure**: UHRC will face challenges in rationalizing the organogram and staffing for the new organization. The evaluation team recommends that UHRC undertake a comprehensive technical skills and staffing review once the business planning is complete and programmatic goals are set. This review should include a review of existing technical skills and capacity to identify additional skills or training needs. In addition, the roles and responsibilities of the Delhi office vis a vis city and GOI technical support should be clearly articulated and defined to ensure quality of technical assistance and adequate support. For example, technical staff in Delhi can be measured during performance evaluation on support to city programs.

4.7 Complementary mechanisms to support USAID urban health programs

The USAID/India urban health program, and the EHP-UHRC implementation of the major part of the program, is cutting edge in terms of its focus and progress. It can fairly be said that no other Mission in the ANE region has so comprehensively considered its role in the problems of urban health at the country level and taken concrete programmatic steps to address it. While implementation began under the USAID/W-based EHP, it would be fair to say that, at this point, in terms of the lessons learned specifically relevant to urban health programming, USAID/Washington has less to offer USAID/India than vice versa.

That said, there is much specialized expertise in both AID/W staff and in the projects supported by AID/W, expertise in topics such a immunization, health systems, hygiene improvement, that could fruitfully be tapped for technical assistance to the UHRC. Because resources for the urban health program are very limited and focused on country activities rather than purchasing expatriate TA, it is proposed that "leveraged TA" opportunities be sought from AID/W central projects such as BASICS and the Hygiene Improvement Project, i.e. that TA be sharply defined and piggybacked on related TA either in India or by stopping in India en route to other TA assignments in the region. Properly managed, such TA should be available at low cost and could, over time, have a large technical payoff for both UHRC and the cooperating agency.

USAID/W also needs to evolve to respond to the demands from Missions for technical and program partnerships in urban health. One key issue which will be addressed soon is staffing. Beginning in late 2005,and partly in response to effective USAID/India advocacy on urban health with USAID/W, GH/HIDN and the EGAT Bureau's Urban Programs Team will jointly support a full-time position focused on urban health. The

objective in establishing the position is to have one person dedicated to advocacy efforts for urban health, to identify and work with Missions that wish to address this issue, to share lessons learned from field activities (including both those supported by USAID and those supported by others), and to establish innovative mechanisms and partnerships to facilitate Mission investment in urban health.

4.8 USAID management

The team recommends that the flexibility of USAID management of the urban health program and, specifically, of the EHP-UHRC be continued. Clearly, an evolution of the policy environment away from enthusiastic support by the GOI for urban health activities would require a shift of priorities and resources. But even absent a dramatic shift, having flexibility allows the exploitation of new opportunities, a strategy that has proven very effective to date in building support for work in urban health.

The nature of such interactions strongly suggests that a cooperative agreement would be more appropriate than a contract for ongoing support to the UHRC. The team recommends looking at a GH leader-with-associates award implemented by World Learning as a possible mechanism; this was designed for support of in-country NGOs and would seem to be appropriate for the gradual weaning and increasing independence of UHRC.

4.9 Monitoring and evaluation

Monitoring and evaluation (M&E) has played an important role in EHP-UHRC implementation to date but needs to be significantly strengthened to meet future needs. Monitoring of program inputs and processes will be important to determine the cost of doing business and the efficiency with which the program is operating. Outputs should be monitored to determine productivity while periodic monitoring of outcomes (e.g. coverage of interventions) is needed to measure program impact. The M&E framework for the UHRC should be well defined with clear input, process, output and outcome performance indicators followed by periodic reporting in a simple, easy to read format.

The revised results framework proposed by this evaluation team focuses on three results: 1) improved programming, 2) improved policy environment and resource allocations, and 3) support of and assistance to city-based demonstration and learning activities to help achieve the other two results. Demonstration and learning activities will show how to improve coverage of key interventions including a range of services that exceed those provided under the existing city programs. In supporting these activities, the UHRC will need to expand the breath and depth of its support to carefully demonstrate and document the expanded impact that that these approaches may have.

Specific recommendations for future monitoring and evaluation efforts:

- While monitoring of inputs and processes (e.g. training, facilitating, meetings, puppet shows) and outputs and outcomes (e.g. number of vaccinations given and vaccination coverage rates) are all necessary, future monitoring should focus more heavily on outputs and outcomes. Urban health activities, however diverse,

need to clearly demonstrate their effectiveness. Such "proof of concept" is a key learning objective that the UHRC could be well positioned to exploit with strengthened M&E capacity. Proof needs to come in the form of evidence that processes lead to products which lead to improved coverage of key interventions in the most cost/effective manner possible.

- The UHRC's M&E program should be based on a clear, simple M&E framework. This framework should have clear and concise input, process, output and outcome indicators, a well defined and explained method for collecting needed data, clear guidelines for recording and reporting out of results in a timely manner. Significantly more work is needed in this regard.
- Current UHRC reporting does not concisely communicate clear messages about what is being accomplished. Building this capacity within UHRC will not result from a few technical assistance visits by an external contractor. Rather, it is likely that some kind of strategic partnership over the long term with another organization with more experience in monitoring and evaluation will be required**.**

4.10 Additional activities to support urban health program development

The team also identified several key gaps which require further investigation and thinking but were beyond the scope, available time, or timeframe for this evaluation, including:

- A detailed evaluation from a public health perspective of the initial city proposals which were developed using the EHP-UHRC guidelines, with recommendations for revision of the guidelines, including their application, as necessary.

- Including consideration of the health systems issues for the urban poor being explored by PHR under an ANE Bureau and EGAT/Urban Programs comparative analysis in Indore and Manila.

- Exploring links to microfinance institutions, self-help groups, etc.

- Tightening linkages to address environmental sanitation, water supply, and hygiene issues as part of the urban health planning process, and developing viable solutions to these critical issues.

- Conducting a cost-effective analysis of the ward coordination model, using best estimates of public health impact.

- Identifying TA needs of UHRC and developing a plan to help meet these needs.

- Establishing criteria for city-level TA support and cataloging likely candidate cities.

Each of these is recommended for follow-up action by USAID/India.

5.0 General Lessons Learned in Urban Health Programming

The evaluation felt there were some general lessons to capture, drawing upon the experience of this evaluation but also similar evaluation work undertaken by others, such as the World Bank's Urban Slum Project.

- There are no simple solutions or universal model for addressing the health of the urban poor or the poor living in urban slums. There is a need for flexibility to apply the most effective available approaches depending on the local situation. Focus on a few critical services and monitor their delivery.

- There is tremendous opportunity in urban health to partner with community-based organizations as well as private sector

- Long term financial sustainability, institutional viability, and adequate human resources are, as always, critical to the long-term sustainability of urban health efforts.

- From the beginning ensure management focus on outputs and outcomes rather than inputs. All other evidence is of little consequence. This will require a baseline, clear indicators of inputs, process and outputs, a method for collecting needed data, and the clear and concise recording and reporting out of results in a timely manner. Without this evidence the appropriateness and effectiveness of the approach will always be in question.

- Be careful about creating and disseminating guidelines, methods and materials that are not thoroughly tested and grounded in evidence that they produce the intended results.

- Documentation should be minimized while still being complete. Strive for clarity, simplicity, and smaller size. Documents that are repetitive, wordy and unclear document events, and maybe progress, but do not communicate impacts well.

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Mr. Jeevan Kumar, Program Coordinator, Puspkunj Family Helper Project
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Annex 2: Evaluation Team Scope of Work

1. Summary of main features and background

In three years the EHP-UHRC has become a nationally recognized technical assistance and information resource in urban health. Demand for technical assistance from the EHP-UHRC is high and increasing. City programs have been developed and have been successful in developing methods and producing tools. Some city programs have not developed as quickly as initially anticipated. Private sector activities are included in the city programs, but are not as prominent as the level of interest indicated elsewhere in the PHN office of USAID/India or that of the GOI. There is strong and apparently burgeoning interest and support at the highest bureaucratic and political levels for better addressing the health of the urban poor in India. The RCH program has evolved to be a very important vehicle for supporting urban health programs at scale and the EHP-UHRC has developed a strong position in support of that program. Newer initiatives focused on the health of the urban poor are being developed at the mission level (run out of the Prime Minister's office – similar to a Presidential Initiative in the US). While the EHP-UHRC initially focused on child health, its work has broadened into planning and systems issues in reproductive and child health or primary health care more generally. The program today is quite different from that planned for in 2002, when that national RCH program was not considered to be an opportunity, GOI interest appeared to be limited, as did political interest. The program has made a number of adjustments to respond to these opportunities as they arose. Responsiveness and flexibility have been hallmarks of the EHP-UHRC and these appear to be key features contributing to the strong relationships that have been built with the government. From the initial conception and throughout this program the definition of urban health and its determinants has been broad. On the ground activities have been largely confined to some aspects of child health (in city programs) and to RCH (technical assistance to the government in planning). Inclusion of non-child health elements, either USAID/India supported or otherwise, has been very limited. Likewise, inclusion of health-related factors outside of the health sector – especially water and sanitation for the urban poor – has not been successfully addressed to date.

2. Purpose and Overview

This scope of work is for an evaluation of the overall USAID program of support in urban health. The objectives of this activity are to evaluate (1) the development of the urban health program – particularly in terms of positioning itself to substantially and measurably contribute to improved health among the urban poor in India; (2) assess the quality of program activities; (3) assess the institutional development of the urban health project; and (4) provide recommendations for the future direction, development and scope of USAID/India's urban health program. The scope of work is comprised of main tasks, a series of questions to be addressed and related sections covering logistics and management, personnel and roles and responsibilities and deliverables.

3. Main Tasks

In order to accomplish the objectives of this evaluation, the team will be required to complete the following tasks.

1. Review background documents including the USAID India "Child Health Strategy" March 2001, the Urban Health Strategy June 2001, GOI plans and documents (Five year plans, RCH II), documents produced or supported by the EHP-UHRC in India and other relevant documents.

2. Participate in a team planning meeting at USAID/New Delhi to review and refine understanding of the SOW, agree on the table of contents of final product, establish roles and responsibilities and develop a detailed workplan for the evaluation.

3. Describe and assess the progress of the urban health program June 2001 – February 2005 in major areas of work through
    a. Interviews with major stakeholders
    b. Presentations by EHP-UHRC staff
    c. Field visits
    d. Document review

4. Develop recommendations for program development and program priorities.

5. Develop and deliver a presentation of the evaluation process, findings and recommendations to USAID/India

6. Prepare a final report incorporating feedback from the oral presentation.

3. Evaluation Questions

These evaluation questions are meant to guide the team in information collection and analysis. The priority is to develop an analysis, supported by assembled information, that supports the recommendations. Analysis of the Recommendation Question Set will therefore provide the priority guidance for developing a detailed workplan and table of contents for the report.

Strategic Management Question Set

USAID/India Country strategic plan and strategic objective

1. How does the urban health program relate to priorities articulated in the USAID/India Country Strategic Plan?
2. Does this activity contribute to one or more of the cross-cutting themes covered by the country strategic plan (governance, gender, urban issues, partnerships, cutting-edge technologies)? If yes, how?
3. How successful has the activity been in addressing the problems and challenges identified in the country strategic plan?

USAID/India Strategic Objective 14

1. How appropriate is the urban health activity to the strategic framework and indicators of SO14?

2. Have opportunities to contribute to SO14 results been missed, and, if so, what opportunities and constraints can be identified?

Inter SO and interoffice collaboration

1. To what extent and in what manner has the PHN urban health activity benefited from work with other offices and SO's?
2. To what extent and in what manner have PHN urban health activities contributed to urban activities in other offices or SO's?
3. What are the practical possibilities for PHN to work more effectively with other USAID/India offices to improve the overall impact on maternal, child, and reproductive health of the urban poor?

USAID/W collaboration

1. Describe the nature and effectiveness of collaboration with ANE Bureau, BGH, and other bureaus in USAID/W. Describe opportunities and constraints for more effective collaboration.
2. What offices and activities provide the best opportunities for collaboration and support of USAID/India's urban health program. Are there any technical projects in the BGH that are designed to provide assistance in urban health?

USAID Management and Implementation Question Set

1. How has USAID management contributed to problems encountered or activity accomplishments?
2. What aspects of USAID management have most contributed to program impact?
3. What aspects of USAID management have constrained program impact?

Partnership and Stakeholders Question Set

1. Describe the Indian government interest in the USAID/supported urban health program (includes all levels of government—central, state, city-level).
2. How does the USAID urban health program contribute to the national RCH program? Are there other central government missions, schemes or programs with which the USAID urban health program should be working?
3. How does the USAID urban health program complement other donors' activities? Are there duplications? Is USAID support sufficient to meet the needs in the area identified for USAID support?
4. To what extent have stakeholders beyond the government been identified and working relationships established at the national, state, and city level. Describe opportunities and constraints to working more effectively with nongovernmental stakeholders.

Implementation Question Set

Activity design

1. To what extent has the USAID approach of providing flexible support for an evolving design been appropriate and successful? Would the program have benefited or been constrained were a more rigid design used at the outset?

2. To what extent has the program operated within the strategy established in the 2001 Child Survival Strategy and the Urban Health Strategy? What have been the major areas of deviation from the original strategy, and what accounts for this?
3. Has the need for flexibility in the strategy and workplan changed over time? To what degree does the program benefit from flexibility currently?

City program implementation effectiveness and efficiency

1. Describe the city programs and characterize the accomplishments in Indore, Calcutta, Agra, Jamshedpur and Delhi. What have been the facilitating and constraining factors in these accomplishments? What are the main contributions of the city programs to the larger urban health activities of USAID, the government and other partners? What are the main contributions of the city programs to the long term improvement of health among the urban poor in these cities? What others lessons learnt can be identified?
2. Characterize the technical areas of intervention in city programs. To what extent has the program been assisted or hindered by a narrow focus on child health? Has the selection of technical components been appropriate to achieve impact in child health and nutrition? Characterize the quality of these interventions.
3. Characterize the methods and accomplishments of working with partners, governmental, not-for-profit and private sector for-profit, in city programs. To what extent has this methodology been successful in building a coalition of the most important stakeholders?
4. Specifically, characterize the efforts and achievements in working with the private sector – associations, networks of health care providers, independent health care providers, private hospitals and institutions, and the private corporate sector. To what extent has working with this sector been a success and what are the opportunities and constraints to work more effectively through the private sector to increase the scope, scale and impact of these activities?
5. Describe the approach to working with non-governmental, community-based organizations. To what extent has this approach been effective in identifying and recruiting effective partners, and developing and managing effective programs?
6. Describe the achievements in terms of improvement in health indicators among targeted populations; development, validation, and documentation of methodologies; and development of new knowledge through operations research. Assess the value of these achievements in terms of improving the health of the urban poor in India, at scale.

Technical Assistance to City, State, and GOI urban planning and implementation

1. Describe the nature and evolution of the technical assistance component of the urban health program. To what extent has the program been able to respond effectively (quality, extent of services offered) to demand from city, state, and national governments.
2. Describe the model of technical assistance management used – local vs. expatriate; full time staff vs. consultants; episodic support vs. long term placement and so on. To what extent has the model chosen facilitated or constrained the responsiveness and quality of technical assistance?

3. What is the significance of this technical assistance activity to the extent, quality, and ultimate effectiveness of programs aimed at improving the health of the urban poor in India?

Advocacy, Information Management and Research

1. Describe the products of the urban health program in terms of advocacy events, workshops, reports, and articles.
2. Describe the quality and effectiveness of these products.
3. Describe any tangible or probable benefits to the health of the urban poor in India of these products.

Development of Institutional Capacity in Urban Health in India

4. Describe capacity building activities of the urban health program that target government and non-governmental institutions. What have been the constraints to the effectiveness of these efforts? What are the opportunities identified and successes of these efforts?
5. Describe and assess the organizational development activities under the EHP task order. Are the goals of institutionalization for long term leadership in urban health likely to be realized? Identify constraints, opportunities and critical areas for immediate action.

Problems and options

1. Are there any major problems or conflicts that require immediate attention?
2. What specific options are available for resolving any problems or conflicts or other implementation constraints? How would these options be implemented?

Recommendation Question Set

11. How should the main strategic elements of the urban health program be formulated? What are the primary results and indicators that should be tracked to measure performance?
12. What should be the technical breadth of the program within the PHN portfolio? What nature and process for collaboration with other offices within USAID/India are recommended? What linkages with USAID/W programs are recommended?
13. What are the recommended mechanisms to support these activities? Specifically, what activities can best be supported through the Urban Health Resource Center, and what activities may be supported through other mechanisms?
14. What level of effort and organizational arrangements should be employed to provide technical assistance at city, state, and national levels?
15. What is the strategic role of support to city activities within the overall program? What proportion of level of effort and in how many cities of what character should such programs be implemented?
16. What are the main aims of a program of operations research, publication of technical papers, consultations and conferences, and support to resource centers? What proportionate level of effort should be applied in each area?
17. What are the requirements for support for the organizational development of the Urban Health Resource Center – both from a strict OD point of view and from a technical capacity building point of view.

18. What balance of flexibility and rigid specificity should be sought in each aspect of the program in the future? What options are recommended to manage flexibility, if and where it is required?
19. What additional important activities can be recommended to inform the development of the urban health program – evaluations, analyses, research, tracking evolution of specific government programs and policies, and so on.

4. Evaluation Management

Roles and Responsibilities

Massee Bateman, CTO for Urban Health Project and MCHUH Division Chief, will provide overall guidance for the activity. Logistics support will be provided through the USAID/India PHN office and the EHP-UHRC office in New Delhi.

The Evaluation Team:
John Borrazzo, CTO for the Hygiene Improvement Project, will be the team leader and is ultimately responsible for the evaluation team and its products.
Dan Kraushaar, Director of BASICS III
Sonali Korde, Senior Technical Advisor for private sector/sustainable health in the ANE bureau of USAID/W
Rajiv Tandon, Senior Advisor Child Survival in USAID/India/PHN/MCHUH
Lehar Zaida, consultant, EHP-UHRC

Performance Period

March – April 2005: The team will work in India 7 – 18 March, which does not include travel, document review, and post-travel document revision time.

5. Deliverables

- Team Planning Meeting products: individual SOW"s for team members, table of contents for the final report, and workplan
- Oral briefing: The evaluation team will provide an oral briefing of its findings and recommendations to USAID/India staff. The team will also brief GOI counterparts and project managers of the Urban Health Resource Center on the main findings and recommendations.
- A draft report will be prepared prior to departure from country.

Annex 3: EHP-UHRC staffing pattern as of March 2005

The staffing pattern of the EHP-UHRC as of March 2005 consists of:

1. Country Representative
2. Documentation Officer
3. Urban Health Planning Specialist (2)
4. M&E Specialist
5. Capacity Building Officer
6. Program Officer
7. Administration Officer
8. Contract Officer
9. Accountant
10. IT & Admin Support Assistant
11. Intern – currently providing assistance in documentation activities.
12. Research Specialist
13. Librarian
14. Jamshedpur Program Coordinator
15. Indore Program Coordinator
16. Indore Program Support Officer
17. Agra Program Development Specialist

In addition, EHP provides various consultants on an as-needed basis.

The Country Representative supervises all Delhi staff and the city support staff is supervised by city Program Coordinators who in turn are supervised by the Country Representative.

Note that there are no expatriate full-time staff, though international consultants and EHP home office staff have been used to support EHP-UHRC efforts.

Annex 4: Presentation of initial findings to Mission staff, 18 March 2005

Evaluation and Recommendations for the USAID/India/PHN Urban Health Program

March 18, 2005

John Borrazzo, USAID/GH
Sonali Korde, USAID/ANE
Dan Kraushaar, BASICS
Rajiv Tandon, USAID/India/PHN
Leher Zaidi, consultant, EHP

- Background
- Evaluation process
- Summary of Recommendations
- Key Messages

USAID/India's response to UH challenges

USAID's Child Health Strategy, 2000:IR 4: "Improved child health and nutrition among the urban poor in selected cities"

USAID's Urban Health Strategy, 2001:

- Effective community-based programs
- Improved municipal planning
- Pro-poor policies
- Advocacy for urban health

USAID Support in Urban Health

- Urban components of many programs – HIV, TB, Polio, social marketing, etc.
- Systems approach in city programs – Ahmedabad (CI), Indore and others (EHP)
- Technical assistance to the GOI's RCH program at national, state, and city levels (EHP)
- Information dissemination and advocacy activities (EHP)

Evolution of EHP Program

- GOI increased focus on Urban Health for the Tenth Five Year Plan (2002-07)
- 2003- EHP organized first national consultation with government and non government stakeholders in urban health
- 2004: Designation as nodal agency for Urban Health by GOI MoHFW

Current Scope of Work of EHP

- Advocacy: to the GOI, states, cities and other stakeholders(NGOS, private sector etc.), communities
- TA: to the GOI, states, cities, and other stakeholders(NGOS, private sector etc.), communities
- Development of City Models: for enhancing programmes and activities

The EHP City-Based Demonstration Activity Model

Situation Analysis to provide evidence for planning

Vulnerability Assessment and mapping of slums, beyond official list

Stakeholders' Consultations (Individual and group)

Proposal Development Process & NGO Contracts

Underlying principles:
- Flexible, responsive, evidence-based consultative planning
- Build on and build capacity of existing platforms (NGOs, CBOs, government)

Beyond City Demonstrations…

- ***GOI Urban Health Guidelines*** – provided framework for proposal development under RCH-2 to strengthen urban health infrastructure and services
- ***Nodal Technical Agency*** - USAID designated by GOI as nodal technical agency for Urban Health for RCH II
- ***Sample proposals*** for four categories of cities (GOI request)
- ***Technical Assistance*** to State Governments based on formal requests to USAID
- ***Urban Health Cells*** - Strengthening institutional capacity within govt. – GOI/MOHFW and GOUP

What we looked at

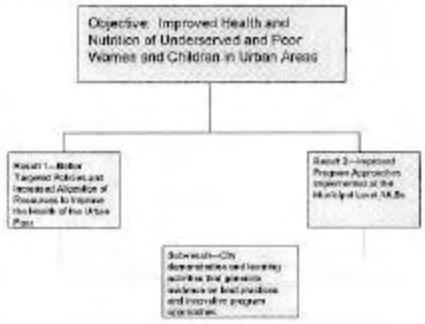
- City demonstration and learning activities
- Generation and use of UH knowledge for advocacy and planning
- Support to the GOI
- TA to states and cities
- Organization and structure of the EHP Urban Health Program

Process used

- Reviewed and discussed evaluation and recommendation questions with USAID
- Read background materials
- Background briefing by EHP in Delhi
- Key informant interviews
- Field visits (Indore, Lucknow, Agra)
- Analysis and discussion

How should the main strategic elements of the urban health program be formulated? What are the primary results and indicators that should be tracked to measure performance?

Urban Health Strategy Results Framework



Illustrative Indicators

Process

- Number of funded RCH-2 municipal-level proposals focused on improving the health of the urban poor

Outcome

- Coverage of key PHC services for the urban poor (city-level indicator)

What should be the technical breadth and links of the program within the PHN portfolio, e.g. IFPS, PACT/CRH, CARE, etc?

- Focus on MCH; expand links to RH esp. IFPS TA contractor, PACT-CRH; support planned urban health collaboration on NFHS-3; expand PPP linkages
- Also, increase networking and coordination to include urban AIDS, TB, and malaria activities, e.g. PMTCT; urban AIDS activities in Mumbai
- Other possibilities to look at: strengthen links to state-level biannual activities and IndiaCLEN

What nature and process for collaboration with other offices within USAID/India are recommended?

- EG: Improve collaboration and communication between PHN and EG on (1) development of the City Development Strategy for Agra; (2) JBIC investment plans; (3) water and sanitation activities under FIRE/D in Agra and maybe in M.P.
- EEE: increasingly focused on power sector reform – limited interface with community level urban health; monitor EEE foundry activities in Agra for any possible future connection to urban health program
- OSD: HIV/AIDS, trafficking (SARI/Q); education (REACH) – in Delhi, Mumbai, Kolkata

What linkages with USAID/W programs are recommended?

- USAID/India should continue to aggressively advocate for increased ANE Bureau and GH resources (time and money) for urban health
- Exploit "leveraged TA" opportunities – i.e. obtain TA from USAID/W contractors already on the ground or here for other short-term TA assignment (e.g. BASICS)

What is the strategic niche for the USAID urban health program vis-à-vis other stakeholders, including government, development partners, NGOs, private sector?

What is the strategic role within the overall program and proportionate level of effort to be applied in each of …

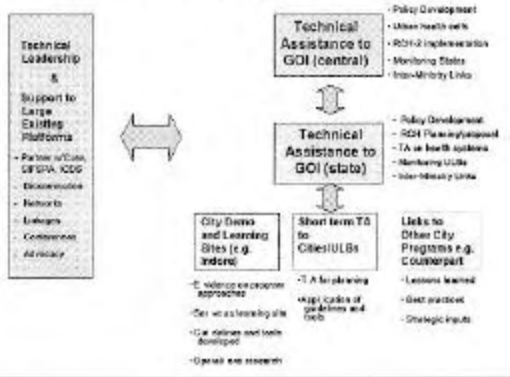
- technical assistance at city, state, and national levels?

- city demonstration and learning activities, including recommendations on number and character of cities?

- technical leadership activities, e.g. operations research, publication of technical papers, consultations and conferences?

- Team feels that all three lines of activity (TA, city demonstration, and technical leadership) are important legs to support USAID urban health objectives.
- Emphasis in terms of LOE should be first on TA, second on city demonstration, and third on technical leadership, although flexibility to adjust these allows exploitation of opportunities and/or adaptation to changes that may arise.

Urban Health Program Components



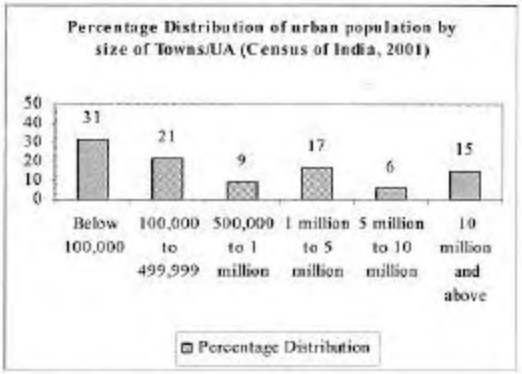
TA role

- Important at all levels
- A key role is at state level, linking resources at the center to needs and proposals at municipal level
- Expand UHRC capacity to work simultaneously with multiple cities – focus on planning. Management of implementation should be a TA activity, not an end in itself.
- Needs to be coupled to sufficient capacity at the recipient end.
- At all levels, diversify partners to whom TA is provided - beyond RCH-2 to include ICDS, UDA, NGO or parastatal platforms like CARE or SIFPSA.

4

City Demonstration and Learning Activities

- Limit to those with distinct socioeconomic, environment, or health characteristics, special policy, leveraging, or learning opportunity
- Always need a clear exit strategy based on a transition to sustainability.
- Consider a spectrum of activities ranging from major activities (probably no more than two simultaneously within current resource levels, e.g. Indore) to leveraged opportunities (taking advantage of USAID or other investment, e.g. Ahmedabad)
- Apart from TA, activities should be focused on medium-sized cities w/ high growth rates (e.g. population 500,000 to 5 million)



City Demonstration and Learning Activities

- Limit to those satisfying criteria of new socioeconomic or health characteristics, special policy opportunity, or unique environment
- Always need a clear exit strategy based on a transition to sustainability.
- Consider a spectrum of activities from major activities (probably no more than two simultaneously, e.g. Indore) to leveraged opportunities (taking advantage of USAID or other investment, e.g. Ahmedabad)
- Major activities should be focused on medium-sized cities w/ high growth rates
- Consider Jamshedpur redeployment if activity on the ground does not begin soon.

What are the recommended mechanisms to support these activities? Specifically, what activities can best be supported through the Urban Health Resource Center, and what activities may be supported through other mechanisms?

- UHRC will be the key USAID-supported mechanism to achieve these results
- Complementary support to urban health cells at GOI central and state levels is required – probably best satisfied through UHRC-supplied long-term consultants

What are the requirements for support for the organizational development of the Urban Health Resource Center – both from a strict OD point of view and from a technical capacity building point of view?

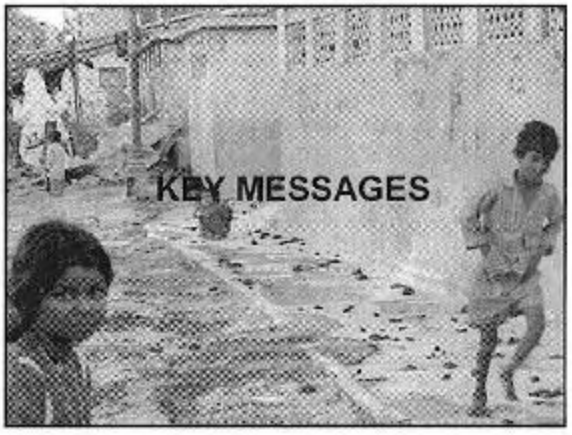
- Address branding issues
- Rationalize management structure
  - Broaden management capacity
  - Better define role and appropriate support of Delhi-based and city-level UHRC staff
- Enhance technical capacity
- Support current planned USAID capacity-building efforts to have a functional independent organization in place by August 31st, including appropriate staffing

What options are recommended to maintain and manage flexibility, where it is required?

- Consider a cooperative agreement mechanism to support UHRC

What additional important activities can be recommended to inform the development of the urban health program – evaluations, analyses, research, tracking evolution of specific government programs and policies, and so on?

- Look for PHR comparative health systems analysis for urban poor in Indore and Manila
- Explore links to microfinance institutions, self-help groups, etc.
- Figure out how to address environmental sanitation and water supply issues as part of the planning process
- Fill gaps in programming and "how-to" tools
- Undertake cost-effectiveness analysis of current models
- Comprehensively and systematically catalogue other urban health activities and identify critical success factors and constraints
- Establish criteria for city-level TA support and catalog likely candidate cities



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Overall Positive Evaluation

Given the relatively short timeframe since UH activity inception, there has been significant progress in advocacy and policy development, as well as the demonstration of practical operational models.

Define a clear role for USAID-supported Demonstration & Learning Activities

Role of city-level D&L activities is

- as sites for learning; places to be visited and studied
- to develop evidence for advocacy and program effectiveness

→ need for how-to tools that can be easily applied elsewhere

- Constraint: Demand for assistance outstrips what USAID can provide → key role of city-level TA

Tighten M&E

Results framework needs to be updated for consistency with proposed future directions.

UHRC needs technical assistance to have more clearly defined and reported indicators for inputs, process, and outputs/outcomes.

Continue to Strengthen Evidence-based Programming

- Continued/renewed emphasis on building the evidence to that these guidelines/approaches "work" – i.e. have public health impact at manageable cost and are sustainable
- Need "how-to" modules for GOI Guidelines at each level, and continually refine/improve the Guidelines and modules.

Promote Linkages

- Across national programs (RCH-2, ICDS, UDA etc.)
- Across other organizations working at state and city level (CARE, SIFPSA, IFPS) and with other organizations (IMA, Rotary)
- Key need is to look at linkages that address physical conditions, e.g. environmental health esp.
- PPP

Some Issues for Discussion

- Making sense of the Agra program
- Bigger cities vs. smaller cities – and other characteristics (e.g. industrial?)
- Broadening the networking function – role of UHRC
- Any other opportunities missed?