NATIONAL URBAN HEALTH MISSION

State Programme Implementation Plan 2013-14

Department of Medical Health and Family Welfare

Uttar Pradesh

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1. Introduction

The National Urban Health Mission (NUHM) aims to improve the health status of the urban population in general, but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based mechanism with the active involvement of the urban local bodies.

2. State Profile

i. Population and Growth Rate

According to the 2011 Census of India, 37.71 crores out of 121 crores Indians live in urban areas. This means 31.16 per cent of the country's population lives in cities. United Nations projections point out that 46 per cent of India's total population will reside in urban areas by 2030 if urbanization continues at the present rate. In Uttar Pradesh too the urban population has been increasing rapidly. While rural poverty has been on the decline in the state, the number of persons living below the poverty line in urban areas has been on the rise. As per the 2011 Census 4.44 crore persons reside in towns and cities of Uttar Pradesh.

Total Population (In lakhs)	1,995.81
Urban Population (In lakhs)	444.70
Urban Population as percentage of total population	22.3%
Urban slum population (in lakhs) (SUDA 2003-04)	119.98
Slum population as percentage of urban population	27
Number of Metro cities	0
Number of Million + cities (> 10 lakh population)	7
Number of cities with 1 to 10 lakh population	56
Number of towns with less than 1 lakh but more than 50 thousand population	59
Number of District HQs which have less that 50 thousand population but are covered under NUHM	9

Population of Uttar Pradesh as per Census 2011 is 199,812,341 and during the decade (2001-11), 33,383,556 persons have been added in the state: 23,452,683 in rural areas and the rest 9,930,873 in urban areas. Uttar Pradesh has registered a significant fall in the decadal growth rate, 60.89 percent in 1971-1981 to 20.09 percent in 2001-11. Since 1971, there has been fall in the growth rate of population in Uttar Pradesh. The state accounts for 16.5% of the country's population. Currently, India's population is 1210.2 million while that of Uttar Pradesh is estimated at 199.6 million. The State's population began to increase rapidly in the 1950's as a result of a steep decline in death rates without a corresponding decline in birth rates. From 1951 to 2001 it grew about two and three quarter times in 50 years. However, the urban population of the state has increased about over four times since 1951. The State's population has been doubling in more than 35 years since independence. The rising population in the state is also reflected in the increase in population density which has become about three and three quarter times, reaching 828 persons per sq. km. against figures of 215 in 1951. Concentration of population in urban areas of the State is very high as compared to rural areas.

Table 2.1: Population and Growth Rate

	Population 2011	Decadal Growth rate (2001-2011)
Total	**199,812,341**	**20.09**
Male	104,480,510	19.45
Female	95,331,831	20.80
Rural	**155,317,278**	**17.81**
Male	80,992,995	17.19
Female	74,324,283	18.50
Urban	**44,495,063**	**28.75**
Male	23,487,515	27.94
Female	21,007,548	29.67

Table 2.2: Decadal Population Growth of Uttar Pradesh

Decades	1901-1911	1911-1921	1921-1931	1931-1941	1941-1951	1951-1961	1961-1971	1971-1981	1981-1991	1991-2001	2001-2011
Decadal Population growth	-9.61	0.16	13.24	26.06	21.86	9.26	29.72	60.89	38.52	32.88	20.09

Table 2.3: Population and Density of Uttar Pradesh [1]

Year	1951	1961	1971	1981	1991	2001	2011
Population Density	215	251	300	377	548	689	828
Population (in million)	60.27	70.14	83.85	105.11	132.06	166.05	199.58
Urban Population (in million)	8.23	8.98	11.66	18.74	25.99	34.51	44.49

[1] Census of India, 2001 and Census of India, 2011.

ii. Demographic Projections[2]

- In the report of the working group on population stabilization for the 11th Five Year Plan (2007-2012), the projected population for Uttar Pradesh in the year 2026 will reach around 248.76 millions.
- Urban population of Uttar Pradesh will increase from 4.4 crores in 2011 to 6.7 crores in 2026 (*Census, 2011 population, Projections, 2001-26)*
- An estimated 1.17 crores (30.6%) people in urban areas are poor *(Poverty Estimates 2004-2005 and 1999-2000)*
- Uttar Pradesh has the largest number of urban poor in a single state.

Table 2.4: Projected Population (in '000) as on 1st March 2016-2026, Uttar Pradesh

Indicator	2016	2021	2026
Total population	**218089**	**234631**	**248762**
Male	114903	123532	130793
Female	103185	111099	117970
Total Population (Urban)	49169	54332	67591
% Urban Population to total Population	22.55	23.16	27.17
Male (urban)	26382	29195	36309
Female (urban)	22788	25137	31282

iii. Sex Ratio (All Ages)

The sex ratio of the state is regularly improving since 1991. In census 2011, the sex ratio of the state has reached 908 females out of 1000 males. In Urban Uttar Pradesh the sex ratio is 888. In urban Uttar Pradesh sex ratio has improved by 12 points (876 in Census 2001), where as it has improved by just 10 point in rural areas (904 in Census 2001) and by 10 points at state level (898 in Census 2001). Another fact is that the sex ratio of the state is 32 points below the national average i.e. 940 and in urban areas also it is 38 points below the national figure i.e. 926 females per thousand males. After independence, Uttar Pradesh has seen declining trend till 1991 and is getting other way round after that.

[2] Census of India 2001, Population Projections for India and states 2001-2026.

Table 2.5: Sex Ratio in All-India and Uttar Pradesh [3]

Year	1951	1961	1971	1981	1991	2001	2011
All India	946	941	930	934	927	933	940
All India Urban	860	845	858	880	894	900	926
Uttar Pradesh	908	907	876	882	876	898	912

In urban areas the sex ratio varied from 844 in Kanpur Nagar to 948 in Mau in the year 2011 and the same for 2001 varied from 817 in Allahabad to 938 in Mau. The maximum increase in urban sex ratio during 2001-2011 is recorded in Gonda district (improved by 84 points) followed in Allahabad district (46 points) and the maximum decrease was in Kanpur Nagar (10 points) and Pratapgarh district (4 points since Census 2001).

Table 2.6: Sex Ratio in All-India and Uttar Pradesh by Residence[4]

Year	2001	2011
All India Urban	900	926
All India Rural	946	947
Uttar Pradesh Urban	876	894
Uttar Pradesh Rural	904	917

Comparing the sex ratio of Census 2011, for the state (total), urban and rural areas with the figures of 2001, it is apparent that the improvement in urban areas is much higher than the improvement at state level and in rural areas. The same is true for All India.

iv. Dependency Rate and Life Expectancy

Dependency ratio (measured as ratio of population <15 and over 60 to that between 15-59 years) for Uttar Pradesh is around 82% as per AHS, it being 63% for urban. The dependency ratio for Uttar Pradesh is higher as compared to all India figure.

Table 2.7: Residence Dependency Ratio – Uttar Pradesh and All India

Dependency Ratio	Total	Rural	Urban
SRS All India	62.2	66.5	51.6
AHS Uttar Pradesh	82.1	88.2	63.4

[3] ***Census of India***
[4] ***Census of India 2001 and Census 2011***

Life expectancy at birth has improved to 66 years (66 year for males and 67 years for females) in Urban Uttar Pradesh. The age distribution indicates significant increase in 60+ populations especially in urban areas highlighting the need for geriatric care.

2.2 Urbanization

2.2.1 Urban Population as Percentage of Total Population and its Trend

Uttar Pradesh is one of the least urbanized states in India. As per the urbanization trends of 2011 census, Uttar Pradesh State is the 24th most urbanized and 11th least urbanized state in India with about 22.3 percent of urban population. Amongst the districts in the state, the lowest degree of urbanization (having much less than 5% urban population) is in the district of Shrawasti 3.45% and the highest degree of urbanization is in the district of Ghaziabad 67.5%. 2 districts have urban population below 5% and 13 districts have urban population above 30%.

Though the urbanization in the state (22.28%) is low in comparison to the national average of 31.16 percent as per the 2011 census and the urban decadal growth of the state during the last decade (2001-2011) has also shown low growth rate of 29.3 percent compared to the national growth rate of 31.8 percent. It is noteworthy that the State's population during the last decade has grown by about 21.4 percent while that of the urban population has grown at about 29.3 percent.

Urbanization is a natural consequence of socio-economic change taking place due to gradual and steady transformation of traditional rural economies in to modern industrial economy. Mostly the phenomenon of urbanization is seen as an outcome of demographic outburst resulted from poverty driven migration from rural areas into urban settings. Different factors, classified as "urban pull factors" and "rural push factors", which are also the outcomes of globalization, liberalization and privatization are making urbanization a faster than before. The table below gives the percentage of Urban Uttar Pradesh population to its total population.

Table 2.8: Urbanization in Uttar Pradesh

Year	1951	1961	1971	1981	1991	2001	2011
Population (in million)	60.27	70.14	83.85	105.11	132.06	166.05	199.81
Urban Population (in million)	8.23	8.98	11.66	18.74	25.99	34.51	44.49
Percentage Urban Population	13.65	12.81	13.9	17.83	19.68	20.78	22.28

Due to creation of new states after 1991, the data for the years prior to 2001 for the states of Bihar, Uttar Pradesh and Uttar Pradesh include the data of newly created states namely Jharkhand, Chhattisgarh and Uttrakhand, respectively.

The total urban population of the state has increased to about 44.5 million (Census 2011) from 34.5 million (Census 2001), showing an increase of ten million. Thus the population residing in urban areas has increased from about 20.8% percent (Census 2001) to 22.3 percent (Census 2011), and likely to reach 27. percent in 2026.

2.2.2. Level of urbanization

As per Census - 2011, there are 63 urban agglomerations/cities with more than one lakh population. The seven urban agglomerations having more than one million populations in the state are Kanpur, Lucknow, Ghaziabad, Agra, Varanasi, Meerut and Allahabad.

2.2.3. Urban Local Bodies in Uttar Pradesh

In 2001, there were only 704 towns in Uttar Pradesh, which has grown up to 915 in 2011. In other words, the urban population of the state has increased from 20.8% in 2001 to just 22.3 % in 2011. Among these urban towns, Government of Uttar Pradesh has 13 Municipal Corporations, 194 Municipal Councils and 423 town areas .

According to the data from the Census of 2011, cities and towns can be broadly classified as:

Class I: 100,000 and above
Class II: 50,000 to 1,00,000 people
Class III: 20,000 to 49,999
Class IV: 10,000 to 19,999
Class V: 5,000 to 9,999
Class VI: Less than 5,000 persons
And
Megacity: >5,000,000 population
Metropolis : 1,000,000-4,999,999 -
Sub-Metropolis : 500,000-999,999

In Uttar Pradesh, there are 648 Statutory Towns. All other places which are having minimum population of 5,000; at least 75 per cent of the male main working population engaged in non-agricultural pursuits; and the density of population is at least 400 persons per sq. km. are known as Census Town. In Uttar Pradesh, such towns have increased from 66 (2001 census) to 267 (2011 census). In the process numbers of villages have decreased from 107,452 to 106,704 in 2011.

2.2.4. State Income and per capita Income

Income levels are an important determinant of the economic well being and social development. In terms of per capita income, U.P. is among the 'low income category' States along with Bihar, Madhya Pradesh and Orissa. Moreover, due to sluggish economic growth in U.P., the gap in per capita income of the State and that of the country has been increasing. Per capita income in U.P., which was almost equal to the national average in the beginning of the planning period, is now half of the national average.

Uttar Pradesh is the second largest state-economy in India contributing 8.34% to India's total GDP. Uttar Pradesh had been one of the leading Indian BIMARU states for long time, the term that was used for state developing at very slow growth rate. But recently in 11th five year plan (2007-12), Uttar Pradesh has registered 7.28% GDP growth rate against the target of 6.10% and is the part of 5 states the exceeded the targets of growth rates.

The major economic activity in the state is agriculture; in 1991, 73% of the population in the state was engaged in agriculture and 46% of the state income was accounted for by agriculture. UP has retained its preeminent position in the country as a food-surplus state.

The Per Capita Income (PCI) at Constant and Current prices have been presented in the table ahead. The per capita income for Uttar Pradesh is Rs. 29417 for 2011-12 which is much lower than the national average. It can be seen from the table that the Per Capita Income at Current Prices has gone up by approximately 127% during 2004-05 to 2011-12. At constant prices, that is, setting aside price fluctuation, the Per Capita Income have gone up during 2004-05 to 2011-12 by 40%.

TABLE 2.9: PER CAPITA NET STATE DOMESTIC PRODUCT (PER CAPITA INCOME) AT CURRENT/ CONSTANT PRICES: Uttar Pradesh[5]

YEAR	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Per Capita Income at Current Prices	12950	14221	16013	17785	20422	23392	26355	29417
Per Capita Income at 2004-05 Prices	12950	13445	14241	14875	15713	16374	17349	18103

[5] Directorate of Economics & Statistics of Uttar Pradesh State

2.2.5. Employment Status

The following table gives the employment status of various castes in urban Uttar Pradesh for the year 2004-05. Relatively higher percentage is for 'self- employment' and next is for Regular Wage/Salaried for All castes. The casual labours are mainly from SC and OBCs.

Table 2.10: Employment Status of Households by Caste - Uttar Pradesh for the year 2004-05[6]

Household Group Type	SC	OBC	Others	All
Urban				
Self-Employed	44.9	57.7	45.0	50.7
Regular Wage/Salaried	29.3	23.3	39.3	30.4
Casual Labour	19.4	10.5	4.7	9.8
Other Households	5.9	8.3	10.3	8.7
All Households	100.0	100.0	100.0	100.0

Table below present monthly per capita consumption for persons in different employment by caste. On an average MPCE is Rs. 857, at being higher for other casts the MPCE is higher for these on regular waged/salary and lower for casual labour.

Table 2.11: Average MPCE by Caste and Employment Status Uttar Pradesh

Employment	SC	OBC	Others	All
Urban				
Self-Employed	527.5	651.4	1100.9	811.7
Regular Wage/Salaried	817.2	855.6	1201.3	1019.0
Casual Labour	429.1	555.9	494.7	509.5
Other Households	967.8	874.9	1012.8	943.7
All Households	637.5	702.3	1103.1	857.1

2.2.6 Work Participation

The Work Participation Rate (WPR), which is defined as the percentage of total workers to the total population, is 32.5 per cent as per the 2001 Census. While the WPR for males 46.8 percent in the year 2001, for females it was 16.5 in the corresponding year.

The results from 2001 Census clearly suggest a shift in the composition of labour force from a predominantly agriculture to moderately non-agriculture sector. It would be interesting to note that in rural areas while the proportion of workers engaged as cultivators among males (42.7) exceed those among females (36.1), in the category of agricultural labourers the proportion of workers

[6] NSSO Report No. 541 on Household Consumer Expenditure Among Socio-Economic Groups: 2004 – 2005.

among females (39.6) far exceed the males (20.1). There is larger proportion of female workers engaged in Household Industries than males both in rural as well as urban areas.

2.2.7 Literacy

Table 2.12: Literacy and Gender[7]

Literacy	Total	Male	Female	Gender gap	Urban	Male	Female	Gender gap
2001	**56.27**	67.30	43.00	26.60	**69.75**	76.76	61.73	15.00
2011	**69.72**	79.24	59.26	19.98	**77.01**	81.75	71.68	10.07

The effective literacy rate for U.P. in Census 2011, works out to 69.7 percent. The corresponding figures for males and females are 79.24 and 59.26 per cent respectively. The state has continued its march in improving literacy rate by recording a jump of 13.5 percentage points during 2001-2011. !e increase in literacy rates in males and females are in the order of 12 and 16 percentage points respectively.

An extremely positive development in the present decade is that the gap of over 26 percentage points recorded between male and female literacy rates in 2001 Census has reduced to 20 percentage points in 2011. Though the target set for the year 2011-2012 by the Planning Commission of reducing the gap to 10 percentage points has not been achieved, it is heartening that the reduction has been to the order of almost 6 percentage points.

2.2.8. Urban Poverty

Uttar Pradesh has been making serious efforts in improving its poverty level; however the poverty level of the state stands at around 37.7%, which is comparatively high as against national level of 29.8%.

The state has implemented a large number of programmes and schemes to improve the socio-economic conditions of the poor. Uttar Pradesh has introduced Poverty and Social Monitoring System (PSMS) in 1999, to measure and monitor the progress in key areas related to poverty and living standards of the people of the state.

Uttar Pradesh among all Indian states is one of the major states where the incidence of poverty is considerable. Uttar Pradesh emerges in the forefront of all states signifying all indices. Poverty is a condition created by unjust society, denying people access to and control over the resources that

[7] Census 2011 Data from www.censusindia.gov.in

they need to live a fulfilled life. Uttar Pradesh also lives majorly (78%) in villages. Around 37% people in Uttar Pradesh and 39% people of rural Uttar Pradesh live below poverty. Only around 32% of urban Uttar Pradesh live below the poverty line in the year 2009-10.

Poverty is a condition created by unjust society, denying people access to and control over the resources that they need to live a fulfilled life. Uttar Pradesh is one of the seven poorest states in India.

The table below shows the poverty scenario in Uttar Pradesh as per Tendulkar Methodology (2009-10), Planning Commission.

Table 2.13: Percentage of Population below Poverty Line

Year	Uttar Pradesh (%)			India (%)		
	Rural	Urban	Combined	Rural	Urban	Combined
2004-05	42.7	34.1	40.9	42.0	25.5	37.2
2009-10	39.4	31.7	37.7	33.8	20.9	29.8

Urban poverty in Uttar Pradesh is an issue because frequent draughts have been a major reason of rural to urban migration of population. The agriculture, which is the major occupation of people in rural areas, has hit badly due to frequent draughts. Agriculture contribution to state GDP has fallen. The poor migrants get failed to integrate into the urban labour market are contributing to the rising levels of urban poverty. Urban poverty is significant in Uttar Pradesh with about a fourth of the urban population living below the poverty line and mostly is in slums. It is estimated for the year 2009-10 that 137.3 lakh persons comprising 30.9 per cent of the urban population of the state live below the poverty line. The rural poverty line for Uttar Pradesh in 2009-10 was estimated as Rs.663.7 and urban as Rs.799.9 (Rs. per capita per month).

The vulnerabilities of urban dwellers differ in significant ways from those of their rural counterparts. These distinct vulnerabilities are associated with number of factors like their dependence on a monetized economy, the prohibitive cost of food and basic services for poor people in cities, the huge range of environmental and health hazards, the pervasiveness of substandard housing and tenure insecurity, and the exposure of poor communities to crime and violence. There are also numerous social problems associated with living in the slums including illicit brews resulting in drunkenness, casual sex leading to sexual exploitation of women and girls, insecurity, child abuse and a high prevalence of HIV/AIDS. Inhabitants also experience high rates of unemployment and of school dropouts.

To make matters worse, levels of vulnerability are likely to heighten with the effects of climate change, especially since the urban poor often live in marginalized areas that are subject to flooding, water logging etc. The vulnerabilities of the urban poor are further aggravated by an inadequate policy, institutional and legislative framework including the lack of an appropriate land-use policy, an inappropriate housing legislative framework, and poor land management and administration approaches that are insensitive to the informal settlements.

Urban poverty is a multidimensional condition, subject to cultural, social and local influences. Urban poverty is getting more complicated with the urbanization. The urban poverty is characterized by several deprivations like limited access to employment opportunities and income, inadequate and insecure housing and services, limited access to services like health, nutrition, water, sanitation etc., unhealthy environments and poor social infrastructure support mechanism, poor urban governance and weak policy framework to address the vulnerability and risks of urban poor. Cities generate more opportunities for employment but the insufficient economic growth of urban areas can increase the proportion of urban poverty.

The ST and SC groups had a higher proportion of persons at low levels of consumption than the general population. The brunt of urban poverty is largely borne by socially excluded groups of the society, which belongs to scheduled castes, Scheduled tribes and other backward castes. A higher proportion of urban poor families are from disadvantaged social groups such as scheduled castes and other backward castes. The extent of poverty among the socially excluded groups (SC and ST) is continues to be higher.

Report of the Committee on slum Statistics /Census, MHUPA, 2010. The report has stated that the slum population count in the 2001 census is underestimating of the actual count. It has been estimated that the state of Uttar Pradesh would be having about 25% of State's urban population living in the slums in 2001. As per the report, the slum population is estimated to be about 111 lakh for the year 2012 and the same would be about 124 lakh in the year 2017.

2.2.9. Human Development Index

Uttar Pradesh has been classified as a state ranking very low on human development. India Human Development Report 2011 shows that poverty head count ratio was 37.7 per cent of the population. HDI for the state is 0.380 for the year 2007-08 and IHDI for the state is 0.307 as per the India Human Development Report 2011, IAMR and Planning Commission. It has been ranked 15 out of 19.

2.2.10 Inadequacy of Basic Amenities

Urbanization has impacted the urban regions of the state in varied manner. The major impacts of rapid urbanization are air pollution, drainage, changing land-use, congestion, degradation of water bodies, decline in water table etc. The continual rural to urban migration of people toward cities is not only building pressure over the city infrastructure manifold but also making environment unhealthy and unsafe for human habitation. Rampant and unplanned urbanization has created a gap between demand and supply of urban basic services, including, housing, water, health, sanitation, education and other urban infrastructure. Total housing shortage in urban areas of Uttar Pradesh has increased. A large proportion of the shortage is likely to be in the category of EWS/LIG (Economically Weaker Section/ Low Income Group) Housing. Therefore, shortage of affordable housing is emerging as a major challenge for the government and is sought to be tackled through a series of measures and policy guidelines set down for this purpose.

The worst outcome of urbanization and housing shortage in the state is the unplanned and prolific growth of slums in the cities. Urban slums represent the worst of urban poverty and inequality. The world has recognized the condition of slum and has sought to improve the living environment and condition of cities and towns.

The Government of India has introduced a Rajiv Awas Yojana for the slum dwellers and the urban poor on the lines of the Indira Awas Yojana for the rural poor for various states including Uttar Pradesh. The schemes for affordable housing through partnership and the scheme for interest subsidy for urban housing has been dovetailed into the Rajiv Awas Yojana which would extend support under JNNURM to States that are willing to assign property rights to people living in slum areas. The Government's effort would be to create a slum free India in five years through the Rajiv Awas Yojana.

As per AHS, following major deficiencies were observed in urban areas:

- 12% of the houses are Kachcha or semi- pucca;
- About 16% are living in rented houses;
- 2.5% had no improved source of drinking water;
- 15% are without access to latrines and people go for open defecation;
- 35% Households do not have a separate kitchen in their houses.
- 9% Households do not have electricity in their houses.
- 14% Households use kerosene as main source of light.

Vulnerability of Urban Poor

The divide of urban poor and urban non poor is getting wider because of the unequal access to urban basic services. The poor people migrate to cities with the hope of better living standard, better access to facilities and better job opportunities. But lack of paying capacity and unaffordable housing in prime locations of urban areas compel poor migrants to live in low income areas, where they are exposed to different socio-economic and environmental risks, which adversely affects their health. The urban poor are as deprived of benefits of urban areas as their rural counterparts. The health of the slum communities is considerably worse off than the non poor in urban area and is comparable to the rural figures.

The growth of slums is a sign of people's inability to afford land and shelter through the normal market mechanism and the failure of the public sector to ensure equitable access of the same to the poor. Slum housing lacks in term of tenure, structure & access to services are which is deprived of civic amenities. Slums are marked with characteristics like overcrowding, precarious living conditions, environmental hazards, improper sanitation, air pollution due to accumulation of waste and open defecation, limited access to safe drinking water and other basic services like toilet, health etc.

The problem of housing, water and sanitation are prime problems that would require serious interventions. Access to basic amenities in slums and shanty towns is relatively poor as compared to general conditions in urban areas in the state.

The vulnerability of urban poor can be read through the reanalyzed data of NFHS III. The poor show of health indicators and access to public health facilities give a glimpse of vulnerability of urban poor. The health conditions and healthcare service coverage among this section of the population is masked by the urban average figures. The urban public healthcare infrastructure, on which the poor are most dependent, is far from adequate.

Utilization of antenatal services in Uttar Pradesh is low due to lack of awareness of available services and also due to lack of felt need for such services. Among urban poor, the maternal and child health indicators are further low. Among urban poor, 98 percent of mothers are not receiving complete ANC, IFA consumption for 90 days or more is just 6 percent, 55.3 percent mothers are anaemic and most of the deliveries (83.3 percent) are occurring at home. In case of child health, the complete immunization is just 15 percent, 63.5 percent children have stunted growth, whereas 48.5 percent are underweight. The figures for mortality and morbidity are also very adverse, when we talk about the urban poor. The neonatal mortality is 50 infant mortality is 86.2 and Under 5 mortality is 110.

2.3 Vital Rates

2.3.1 Crude Birth Rate, Crude Death rate & Natural Growth Rate

The major cause of population growth is natural growth in population. The improved health services and health awareness in the state has been able to bring down the mortality to a great extent. The CBR was 32.2 live births per thousand populations in 2001 and has declined to 28.3 in 2010. The same is true for the urban areas of the state, where CBR has declined from 27.0 in 2001 to 24.2 in 2010. During the span of 2001 to 2010, fall in CBR at state level is of 3.9 percent where as at urban level it is 2.8 percent. The crude death rate, as well, shows a fall of 2 percent at state level and 1.5 percent at urban level.

Table 2.14: CBR, CDR, Natural Growth Rate and IMR of Uttar Pradesh State and Urban Areas

Year	Crude birth rate (CBR)		Crude death rate (CDR)		Natural Growth rate		Infant mortality rate (IMR)	
	State	Urban	State	Urban	State	Urban	State	Urban
2001	32.2	27	10.1	7.8	22	19.2	82	62
2004	30.8	26.2	8.8	6.2	22	20	72	53
2005	30.4	26.5	8.7	6.8	21.7	19.7	73	54
2006	30.1	26	8.6	6.6	21.4	19.3	71	53
2007	29.5	25.5	8.5	6.5	21	18.9	69	51
2008	29.1	25.1	8.4	6.6	20.7	18.4	67	49
2009	28.7	24.7	8.2	6.5	20.5	18.3	63	47
2010	28.3	24.2	8.1	6.3	20.3	17.9	61	44
2011	27.8	23.7	7.9	6.1	20.0	17.7	57	41
2012	27.4	23.5	7.7	6.0	19.7	17.5	53	39

Sample Registration System, ORGI, Government of India

2.3.2 Child (0-6 years) Sex Ratio

The child sex ratio at 899 in the state is below the national average of 914 and the state is therefore counted with states having little worse child sex ratio. In census 2011, the child sex ratio is showing a dip of 17 points at state level and of 11 points in urban areas, when comparing the last Census.

Table 2.15: Child Sex Ratio of State and its Urban Areas

Year	2001	2011
Child (0-6 years) Sex Ratio		
All India	927	914
Uttar Pradesh	916	899
Uttar Pradesh Urban	890	879

2.3.3 Infant and Child Mortality Rates

There has been a decline of 12 points in IMR for Uttar Pradesh during 2005-2010. In spite of the decline being slightly higher for males as compared to females, the levels remain slightly higher for females as compared to males. However, the trend in the decline for Uttar Pradesh is slightly higher than that for all India, though the difference in the level is by 14 points higher.

Table 2.16: Annual Estimates[8] of Infant Mortality Rate by Sex

Year	2005	2006	2007	2008	2009	2010
Total						
India	**58**	**57**	**55**	**53**	**50**	**47**
Uttar Pradesh	73	71	69	67	63	61
Male						
India	**56**	**56**	**55**	**52**	**49**	**46**
Uttar Pradesh	71	70	67	64	62	58
Female						
India	**61**	**59**	**56**	**55**	**52**	**49**
Uttar Pradesh	75	73	70	70	65	63

The Infant mortality rate separately for rural and urban areas is presented as under:

It is seen that the IMR in urban areas is much lower than that in rural areas. However, little more than two thirds of infant's deaths still occur during neo natal period i.e. within one month of birth. Thus, for further reductions in IMR the deaths during neo natal period need to be avoided.

Table 2.17: Infant, Neo-Natal and Post Neo-Natal Mortality Rates (2010-11)[9]

Uttar Pradesh	Total	Rural	Urban	Total	Rural	Urban
	AHS 2010-11			AHS 2011-12		
Infant Mortality Rate	**71**	**74**	**54**	**70**	**73**	**53**
Neo Natal Mortality Rate	**50**	**53**	**36**	**50**	**52**	**37**
Post Neo Natal Mortality Rate	**21**	**22**	**18**	**20**	**21**	**16**

[8] Sample Registration System
[9] Annual Health Survey

It is important to mention that the IMR for urban poor as per NFHS-3 data (reanalyzed) is 86.2 per thousand live births which was 13.5 points higher than the state urban (72.7).

One of the millennium development goal relates to reducing child mortality. The results on child mortality for different districts of Uttar Pradesh are presented as under:

Table 2.18: Under 5 Mortality Rates (2010-11)[10]

District	Total	Rural	Urban	District	Total	Rural	Urban
Saharanpur	99	109	62	Jhansi	61	76	43
Muzaffarnagar	72	80	50	Lalitpur	114	119	76
Bijnor	78	82	-	Hamirpur	65	67	59
Moradabad	82	85	78	Mahoba	71	76	63
Rampur	92	103	55	Banda	95	94	103
Jyotiba Phule Nagar	85	89	71	Chitrakoot	125	130	78
Meerut	66	67	64	Fatehpur	81	87	-
Baghpat	72	76	57	Pratapgarh	113	114	94
Ghaziabad	66	70	63	Kaushambi	128	129	122
Gautam Buddha Nagar	68	73	56	Allahabad	115	125	60
Bulandshahar	92	91	96	Barabanki	95	97	-
Aligarh	85	88	77	Faizabad	129	132	106
Hathras	82	81	84	Ambedkar Nagar	90	90	80
Mathura	61	71	42	Sultanpur	68	70	-
Agra	68	73	62	Bahraich	101	103	57
Firozabad	87	92	70	Shrawasti	142	142	-
Etah	93	98	-	Balrampur	128	130	81
Mainpuri	79	78	84	Gonda	97	99	-
Budaun	112	115	102	Siddharthnagar	121	122	111
Bareilly	107	122	72	Basti	109	110	85
Pilibhit	95	99	64	Sant Kabir Nagar	97	96	-
Shahjahanpur	106	115	-	Maharajganj	110	112	-
Kheri	117	123	-	Gorakhpur	82	87	65
Sitapur	120	121	112	Kushinagar	106	108	-
Hardoi	113	115	101	Deoria	93	92	100
Unnao	84	85	77	Azamgarh	95	96	81
Lucknow	60	86	38	Mau	97	100	85
Rae Bareli	81	83	-	Ballia	90	90	93
Farrukhabad	99	106	72	Jaunpur	101	100	108

[10] Annual Health Survey

Kannauj	99	101	90	Ghazipur	102	100	122
Etawah	83	86	72	Chandauli	108	107	120
Auraiya	86	92	52	Varanasi	101	111	87
Kanpur Dehat	97	101	-	Bhadohi	109	110	102
Kanpur Nagar	52	83	40	Mirzapur	111	112	108
Jalaun	96	96	97	Sonbhadra	96	105	-
				Uttar Pradesh	**94**	**101**	**68**

For the state as a whole the child mortality rate is 94, it being lower at 68 for urban areas. There are thirty-nine (out of seventy) districts with higher child mortality rates (more than 94) namely, Saharanpur, Budaun, Bareilly, Pilibhit, Shahjahanpur, Kheri, Sitapur, Hardoi, Farrukhabad, Kannauj, Kanpur Dehat, Jalaun, Lalitpur, Banda, Chitrakoot, Pratapgarh, Kaushambi, Allahabad, Barabanki, Faizabad, Bahraich, Shrawasti, Balrampur, Gonda, Siddharthnagar, Basti, Sant Kabir Nagar, Maharajganj, Kushinagar, Azamgarh, Mau, Jaunpur, Ghazipur, Chandauli, Varanasi, Sant Ravidas Nagar (Bhadohi), Mirzapur and Sonbhadra.

The U5 Mortality among urban poor (110.1) was 3.7 points higher than the state urban (96.4, NFHS-3).

2.3.4 Maternal Mortality Ratio

The maternal mortality ratio for different districts of Uttar Pradesh is presented as under:

Table 2.19: Maternal Mortality Ratio (2010-11)[11]

District	Value	District	Value	District	Value
Saharanpur	**337**	Hardoi	330	Ambedkar Nagar	451
Muzaffarnagar	337	Unnao	330	Sultanpur	451
Bijnor	339	Lucknow	330	Bahraich	434
Moradabad	339	Rae Bareli	330	Shrawasti	434
Rampur	339	Farrukhabad	267	Balrampur	434
Jyotiba Phule Nagar	339	Kannauj	267	Gonda	434
Meerut	225	Etawah	267	Siddharthnagar	412
Baghpat	225	Auraiya	267	Basti	412
Ghaziabad	225	Kanpur Dehat	267	Sant Kabir Nagar	412
Gautam Buddha Nagar	225	Kanpur Nagar	267	Maharajganj	412
Bulandshahar	225	Jalaun	241	Gorakhpur	354
Aligarh	371	Jhansi	241	Kushinagar	354

[11] Annual Health Survey

Hathras	371	Lalitpur	241	Deoria	354
Mathura	281	Hamirpur	306	Azamgarh	385
Agra	281	Mahoba	306	Mau	385
Firozabad	281	Banda	306	Ballia	385
Etah	371	Chitrakoot	306	Jaunpur	346
Mainpuri	281	Fatehpur	442	Ghazipur	346
Budaun	437	Pratapgarh	442	Chandauli	346
Bareilly	437	Kaushambi	442	Varanasi	346
Pilibhit	437	Allahabad	442	Bhadohi	308
Shahjahanpur	437	Barabanki	451	Mirzapur	308
Kheri	330	Faizabad	451	Sonbhadra	308
Sitapur	330			**Uttar Pradesh**	**345**

Though, the MMR has come down the MDG for MMR appears to be out of reach in near future. The districts with higher MMR (more than 345) are Aligarh, Hathras, Etah, Budaun, Bareilly, Pilibhit, Shahjahanpur, Fatehpur, Pratapgarh, Kaushambi, Allahabad, Barabanki, Faizabad, Ambedkar Nagar, Sultanpur, Bahraich, Shrawasti, Balrampur, Gonda, Siddharthnagar. Basti, Sant Kabir Nagar, Maharajganj, Gorakhpur, Kushinagar, Deoria, Azamgarh, Mau, Ballia, Jaunpur, Ghazipur, Chandauli and Varanasi.

2.4 Fertility

2.4.1 Age at Marriage

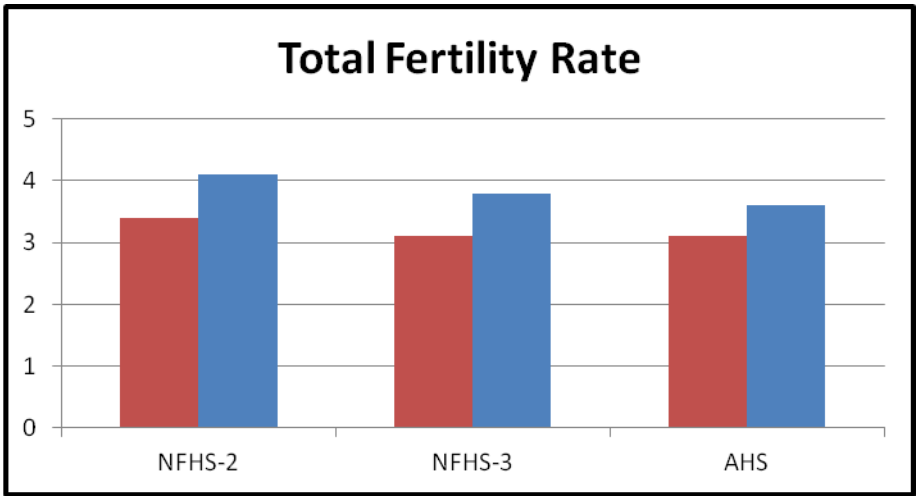
As per NFHS -3, the median age at first marriage is 16.2 years among women age 20-49 and 20.1 years among men age 25-49. On average, men get married four years later than women. More than half (59%) of women age 20-24 years got married before the legal minimum age of 18 and 51 percent of men age 25-29 years got married before the legal minimum age of 21.

But the mean age at marriage for females is 21 years as per recent held Annual Health survey (AHS). Men average age at marriage is just three years later. In urban Uttar Pradesh the respective mean ages for women and men are 22.4 years and 25.7 years respectively. About 9% of currently married women age 20-24 years got married before the legal minimum age of 18 and about 17 percent of men age 25-29 years got married before the legal minimum age of 21 as per recent large scale survey. The same for urban Uttar Pradesh are around 3 percent and little over 6 percent respectively.

2.4.2. Fertility Levels

As per NFHS-3, a woman in Uttar Pradesh had an average of 3.8 children in her lifetime. Fertility decreased by 0.3 children between NFHS-2 and NFHS-3. Fertility in Uttar Pradesh was second only to fertility in Bihar; in both states, at the then current fertility levels, a woman would have about four children during her lifetime compared with less than three children (2.7 children per woman) in India as a whole. Among births in the three years preceding the survey, 38 percent were of birth order four or higher. Fertility in rural areas was seen to be 4.1 children per woman, much higher than in urban areas where the fertility rate is 3.0 children per woman.

But recently (AHS) it has been observed that mean children ever born to women age 15-49 years are now 3.3 and out of which only 2.9 are surviving. The position in urban Uttar Pradesh is little better and the corresponding mean number of children are 3.1 and surviving ones are 2.8. For the women of age group 45-49 years, the mean children ever born are 5.1 (4.5 in urban areas). Thus the fertility is decreasing and inching towards the replacement level for the whole state as well.

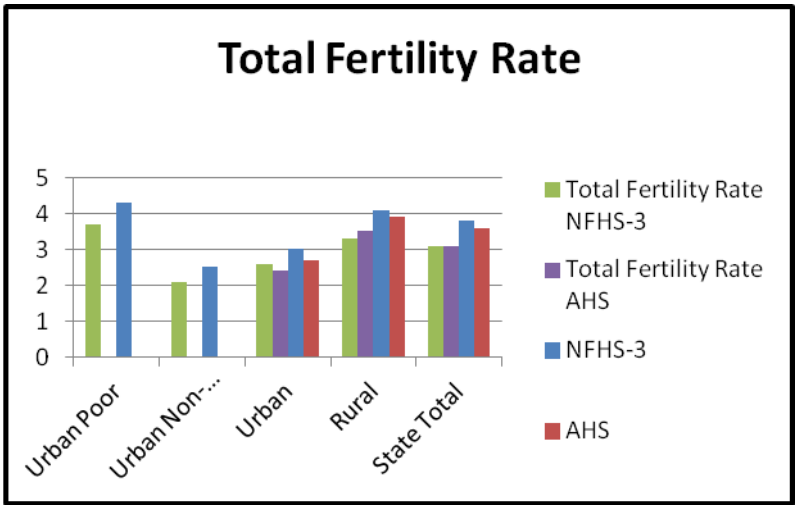


As per AHS, the total fertility in Uttar Pradesh State as a whole has been still 3.6 children per women and for rural areas it is 3.9, 1.2 higher than in urban areas where the fertility rate of 2.7 and the same is still more than the replacement level.

As per NFHS –3, fertility rates are higher for women in disadvantaged groups (4.5 for scheduled castes and 3.8 for other backward classes), than for women who are not in any of these groups (3.2). The total fertility rate for Muslims (4.3) is about half a child highe than the rate for Hindus (3.7).

As per NFHS-3, There are great differentials in fertility by wealth and education. At current fertility rates, women in the lowest wealth quintile will have 2.6 children more than women in the highest wealth quintile.

The results for urban poor and urban non poor along with aggregates for rural urban for NFHS-III is presented as under:



The Total fertility rate (children per woman) is 4.3 among urban poor, little less than one and half times of the urban figure of 3.0 and also higher than State figure of 3.8.

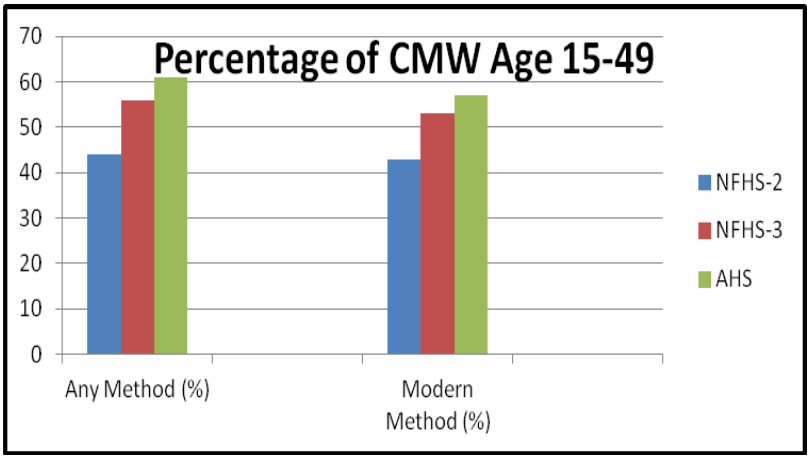
Around 53% of the women among urban poor had more than three births which is more than double of urban non-poor average (21.5 percent).

2.4.3. Birth intervals

The median interval between births in Uttar Pradesh is about 30 months. Sixty-four percent of non-first-order births occur within three years of a previous birth, including 13 percent of births that take place within 18 months of the last birth and 30 percent that take place within 24 months. Research shows that waiting at least three years between children reduces the risk of infant mortality. AHS has reported that live births taking place after 36 months is about 38.7 percent of Uttar Pradesh women and the same is to 35.9 percent of urban women.

2.5. Family Planning

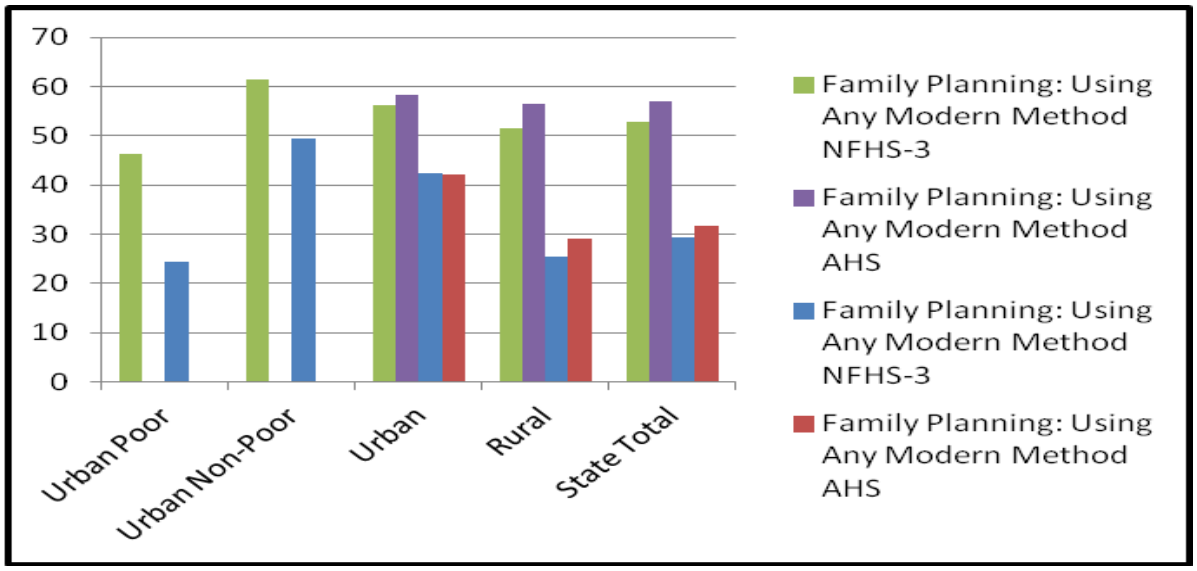
2.5.1. Contraceptive use



The contraceptive prevalence rate among currently married women age 15-49 is 44 percent at the time of NFHS-3, up from 27 percent at the time of NFHS-2. The same among currently married women has reached the level of 50 percent in (AHS, 2010-11). Female

sterilization dominates over the other modern methods.

The results for urban poor and urban non poor based on NFHS-III are presented graphically as under:



It is observed that for urban poor, the use of spacing methods is less than half the level of non poor.

2.5.2 Unmet need

Unmet need for family planning is defined as the percentage of currently married women who either want to space their next birth or stop childbearing entirely but are not using contraception. According to this definition, 21.2 percent of married women in Uttar Pradesh have an unmet need for family planning in NFHS-3, down from 25.4 percent in NFHS-2. Since NFHS-2, unmet need for spacing have declined by 2.7 percentage point and unmet need for limiting has decreased by 1.5 percentage point.

Currently, as per AHS, about thirty percent of married women in Uttar Pradesh have an unmet need for family planning. The unmet need for spacing and limiting methods is respectively 17% and 13%. The unmet need is over 8% less for urban Uttar Pradesh than in rural areas.

The unmet need for urban poor remains double level as compared to non poor, mainly for limiting.

3. Urban Health Scenario

The rapid urbanization coupled with influx of migrants has influenced the health parameters of urban population. Through the annual health survey (AHS-2010-11) detailed information has become available on chronic as well as acute morbidity together with the health seeking behaviour.

Further, on morbidity pattern and health seeking behaviour information is available through NSSO survey (61st Round: 2004-05) on the subject. Information on hospitalization during last one year is also available in this survey. Importantly, the information on health expenditure is available through NSSO (66th Round) of household consumption expenditure for the year 2009-10. This chapter presents the findings based on these data sources.

3.1 Morbidity and Health Seeking Behaviour

Based on Annual Health Survey (AHS) data, table below summarizes information on morbidity separately for acute and chronic illnesses

Table 3.1: Morbidity Per Lakh Population- Uttar Pradesh

Sex	Any type of Acute Illness			Symptoms Chronic Illness			Diagnosed Chronic Illness			Percentage Symptoms of Chronic Illness Diagnosed		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Person	12561	12959	11151	8380	8873	6633	7390	7722	6216	88.2	87.0	93.7
Male	12096	12491	10736	7234	7656	5784	6425	6709	5452	88.8	87.6	94.3
Female	13053	13448	11611	9593	10146	7575	8411	8780	7064	87.7	86.5	93.3

3.1.1. Morbidity Rates: Acute and Chronic (Based on NSSO & AHS Data)

Acute Morbidity Rates (Based on AHS Data)

The prevalence of Acute Illness in Uttar Pradesh was 12561 per lakh population i.e. around 12.56%. The prevalence was slightly higher in rural areas as compared to urban areas. Further, the prevalence of Acute Illness was observed slightly higher among females as compared to males. The trend was similar in both rural and urban areas.

As already mentioned, in the AHS the details on persons suffering from specific acute illnesses such as Diarrhoea, Acute Respiratory Infection **(**ARI) and Fever are available and are presented as under:

Table 3.2: Persons Suffering from Specific Acute Illness (Per 100,000 Populations)-Uttar Pradesh

Sex	Diarrhoea/ Dysentery			Acute Respiratory Infection (ARI)			Fever (All Types)		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Persons	1187	1258	934	3017	3267	2133	7571	7672	7217
Male	1203	1282	931	2883	3116	2081	7282	7394	6896
Female	1170	1234	937	3159	3424	2190	7878	7961	7574

The prevalence of fever alone was 7.57% it being higher in rural areas (7.67%) as compared to urban areas (7.2%). Diarrhoea/ Dysentery had prevalence of 1.19% it being again higher in rural areas (1.26%) as compared to urban areas (0.93%). The prevalence of ARI was 3.0%, it being higher in rural areas (3.27%) as compared to urban areas (2.13%).

These 3 diseases together account for about 93.7% of acute illnesses;

Table 3.3: Percentage Share of Diarrhoea, ARI and Fever in Acute Illnesses

Sex	Total	Rural	Urban
Persons	93.7	94.1	92.2
Male	94.0	94.4	92.3
Female	93.5	93.8	92.2

Chronic Morbidity Rates

The symptoms of chronic illness persisting for more than a month were reported by 8380 per lakh population i.e. 8.28%. These symptoms for chronic illness were reported less in urban areas as compared to rural areas. Here again the prevalence of symptoms was higher among females as compared to males in both rural and urban areas, of these symptoms over 88% were diagnosed. Importantly this percentage was higher in urban areas (94%) as compared to rural areas (87%). However, the gender differences were negligible.

In the AHS the details on persons suffering from specific chronic illnesses such as Diabetes Hypertension, Tuberculosis-(TB), Asthma and Arthritis are available which are presented as under:

Table 3.4: Persons Suffering from Specific Chronic Illness (Per 100,000 Populations)

Sex	Diabetes			Hypertension			Tuberculosis-TB			Asthma			Arthritis		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Person	287	194	619	498	409	815	290	303	243	565	607	420	996	1072	728
Male	325	220	687	368	295	621	327	347	260	644	698	458	738	822	450
Female	248	166	544	636	527	1030	250	257	225	482	511	377	1270	1334	1036

It is observed that the diseases like Diabetes and Hypertension have many times higher morbidity rates in urban areas as compared to rural areas for both the sexes respectively. However, Tuberculosis-(TB), Asthma & Arthritis are reported much higher in rural areas.

Importantly these five chronic illnesses account for only 36 percent of all chronic illnesses as could be seen from table below:

Table 3.5: Percentage share of 5 chronic illnesses Diabetes Hypertension, Tuberculosis-(TB), Asthma and Arthritis in all chronic illnesses

Sex	Total	Rural	Urban
Persons	35.7	33.5	45.4
Male	37.4	35.5	45.4
Female	34.3	31.8	45.5

Acute Morbidity Rates (Based on NSSO Data)

In the survey by NSSO for the year 2004-05, prevalence of morbidity estimated as proportion of ailing persons (PAP) during reference period of 15 days for Uttar Pradesh was estimated as 10.2 percent. The prevalence rate was broadly similar in urban areas and rural areas. However, prevalence rate was higher for female population (10.9%) as compared to male population (9.5%). The gender differences seem to have existed in both rural and urban areas. The morbidity rate was higher among other general castes as compared to rest may be because of higher health counselling. The broad trend revealed by AHS and NSSO is similar.

Table 3. 6: Number per 1000 of Persons Reporting Ailment (during the last 15 days) for the 2004-05 in Uttar Pradesh

	Rural			Urban			Combined		
Group	**Male**	**Female**	**Person**	**Male**	**Female**	**Person**	**Male**	**Female**	**Person**
ST	18	69	43	67	165	113	28	87	57
SC	92	101	96	92	94	93	92	100	96
OBC	89	101	95	84	106	94	88	102	95
Others	120	116	118	104	162	131	114	131	122
ALL	96	104	100	93	126	108	95	109	102

In the survey by NSSO the results have been provided according to the level of living measured in terms of monthly per capita expenditure. The results on PAP by MPCE class are presented in table as under:

Table 3.7: Number per 1000 of Persons Reporting Ailment during the last 15 days in 2004-05 According to MPCE Class in Uttar Pradesh

Rural				Urban			
MPCE Class	**Male**	**Female**	**Person**	**MPCE Class**	**Male**	**Female**	**Person**
0-235	69	69	69	**0-335**	56	92	74
235-265	63	61	62	**335-395**	89	91	90
265-320	76	85	81	**395-485**	82	72	77
320-365	96	75	85	**485-580**	79	124	101
365-410	87	105	96	**580-675**	101	138	119
410-460	93	93	93	**675-790**	92	94	93
460-520	104	125	115	**790-930**	124	163	142
520-605	116	116	116	**930-1100**	106	118	112
605-730	102	127	114	**1100-1380**	68	152	104
730-980	106	132	118	**1380-1880**	123	166	143
980-1285	121	144	132	**1880-2540**	109	134	121
1285+	147	181	163	**2540+**	98	230	158

The results presented on morbidity according to monthly per capita consumption expenditure indicate an increase in the morbidity with increase in level of living. This could be because of higher health consciousness among relatively better off resulting into higher self reporting.

3.1.2 Health Seeking Behaviour (Based on AHS Data)

Persons who are ailing do not always get their ailments medically treated. Based on AHS data Table below provides information on percentage of sick persons taking treatment i.e. health seeking behaviour.

Table 3.8: Health/ Treatment Seeking Behaviour

Sex	Taking treatment for Acute Illness from Any Source (%)			Percentage sought Medical Care for Chronic Illness			Getting Regular Treatment (%)		
	Total	**Rural**	**Urban**	**Total**	**Rural**	**Urban**	**Total**	**Rural**	**Urban**
Person	97.8	97.7	98.4	90.8	90.5	92.1	50.1	47.4	62.1
Male	97.9	97.8	98.4	90.6	90.2	92.2	51.4	48.6	63.3
Female	97.8	97.6	98.4	90.9	90.7	92.0	49.1	46.4	61.0

Around 98% reported taking treatment for acute illness. The differences in percentage sought treatment for acute illness showed no difference between rural and urban areas. Also, the health seeking behaviour did not differ between the male and female population. As to the chronic illnesses the percentage sought treatment was somewhat lower at 91%, as compared to 98% in case of acute illnesses. However, slightly higher proportion in urban areas availed treatment for chronic illnesses as compared to rural areas. As to the regularity of treatment, about 50% reported as taking regular treatment for chronic illnesses. Higher proportion in urban areas (62%) reported taking regular treatment as against 47% in rural areas. Importantly the gender differences in the health seeking behaviour were not significant.

It is of interest to know as to what extent the services of Government facilities are being utilized by the community. Following table provides the necessary details:

Table 3.9: Percentage Availing Treatment from Government Facilities (AHS Data)

Sex	Taking Treatment for Acute Illness from Government Source			Getting Regular Treatment for Chronic Illness from Government Source (%)		
	Total	Rural	Urban	Total	Rural	Urban
Person	3.8	3.5	4.9	9.9	8.9	13.8
Male	3.8	3.6	4.7	11.0	10.1	14.8
Female	3.8	3.5	5.2	8.9	8.0	13.0

The proportion availing treatment from government sources/ facilities was just 3.8% for acute illnesses and 9.9% for chronic illnesses. The proportion availing government services was somewhat higher in urban areas as compared to rural areas both for chronic and acute illnesses.
Similar information on health seeking behaviour is available through NSSO for 2004-05. Based on this data table below provides information on percentage of ailments treated.

Table 3.10: Percentage of Spells of Ailments Treated (Non-Institutional) During 15 Days and Percentage Distribution of Treated Spells of Ailments by Source of Treatment - Uttar Pradesh

	Rural			Urban		
Year	Spells of Ailments Treated (%)	Govt.	Pvt.	Spells of Ailments Treated (%)	Govt.	Pvt.
2004-05	77	10	90	88	13	87
1995-96		8	92		9	91
1986-87		NA	100		14	86

The percentage of ailing persons in Uttar Pradesh who got their ailments treated was 77% in rural and 88% in urban areas. Further, 10% in rural and 13% in urban utilized govt. facilities for their treatment. For 3 years for which information is available through NSSO, the proportion availing treatment from govt. sources is broadly similar in the urban and the rural areas.

3.1.3 Medical Expenditure (Based on NSSO Data)

Detailed data on medical expenditure is being collected in different rounds of NSSO devoted to households consumption expenditure. The results presented below are based on NSSO survey for the latest year 2009-10. Table below provides the broad details:

Table 3.11: Medical expenditure as % of total Expenditure-2009-10 Uttar Pradesh

	Rural		Urban	
	Value (Rs.)	**No. of Households Reporting consumption Per 1000 HHs**	**Value (Rs.)**	**No. of Households Reporting consumption Per 1000 HHs**
Institutional				
Medicine	10.79	98	10.53	93
X-ray, Pathological, Tests etc.	1.05	58	1.57	60
Doctor's/Surgeon's Fee	1.61	56	2.39	64
Family Planning Appliances	2.2	56	2.88	62
Other Medical Expenses	1.46	43	1.42	44
Institutional Sub Total	17.11	103	18.79	98
Non Institutional				
Medicine	43.86	799	48.25	776
X-ray, Pathological, Tests etc.	1.53	28	2.17	36
Doctor's/Surgeon's Fee	2.66	185	282	761
Family Planning Appliances	0.06	13	0.07	12
Other Medical Expenses	0.63	21	0.64	13
Non Institutional Sub Total	48.74	805	56.76	786
Total Inst. & non Inst.	65.85		75.55	
Total MPCE	899.1	1000	1573.91	1000
Medical Expenditure as % of Total Expenditure	7.3		4.8	

During 2009-10, Institutional medical expenditure was reported by 10.3% in rural and 9.8% in urban areas. The non-institutional medical expenditure was reported by 80.5% in rural and 78.6% in urban areas. The average institutional medical expenditure per capita was Rs. 17.71 in rural areas and

18.79 in urban areas. Similarly average non institutional medical expenditure per capita was Rs. 48.74 in rural areas and 56.76 in urban areas. Taking institutional and non institutional expenditure together this comes to Rs.65.85 in rural areas and Rs. 75.55 in urban areas. It is noted that the total per capita expenditure per month available was Rs. 899 in rural and 1574 in urban areas. Thus the medical expenditure as percentage of total expenditure is 7.3% in rural areas and 4.8% in urban areas. Importantly Medical non institutional is by far the largest components of medical expenditures accounting for about 75% of total medical expenditure in rural and urban areas.

Table 3.12: A Comparison of Medical Expenditure with Total MPCE for 2009-10 and 2004-05

Details of expenditure	Rural		Urban	
	2009-10	2004-05	2009-10	2004-05
Expenditure Medical Inst.	17.11	12.94	18.79	15.5
Expenditure Medical Non Inst.	48.74	35.37	56.76	38.81
Total Medical Expenditure	65.85	48.31	75.55	54.31
Total MPCE	899.1	532.63	1573.91	857.05
Medical Expenditure as % of total Expenditure	7.3	9.07	4.8	6.34

It would appear that though the absolute expenditure on health increased between 2004-05 to 2009-08 in urban areas, in terms of percentage of total MPCE it declined overtime.

Table 3.13: Expenditure per person per month 2009-10 by Decile classes - Uttar Pradesh Value (Rs.)

Decile Class of MPCE	Medical Expenditure (Inst)	Medical Expenditure (non-inst.)	Total Medial Expenditure	Total MPCE	Medical Expenditure as % of Total MPCE
Rural					
1	2.61	11.22	13.83	446.28	3.1
2	3.59	19.12	22.71	553.37	4.1
3	3.53	20.08	23.61	626.94	3.77
Bottom 3	**3.2**	**16.8**	**20.1**	**542.2**	**3.7**
4	5.67	24	29.67	691.79	4.29
5	6.72	28.55	35.27	758.79	4.65
6	8.14	32.82	40.96	834.49	4.91
7	15.61	46.01	61.62	918.89	6.71
Middle 4	**9.0**	**32.8**	**41.9**	**801.0**	**5.1**
8	13.68	55.1	68.78	1037.06	6.63
9	28.48	83.44	111.92	1212.68	9.23

10	83.18	167.25	250.43	1911.35	13.1
Top 3	**41.8**	**101.9**	**143.7**	**1387.0**	**9.7**
All	17.11	48.74	65.85	899.1	7.32
Urban					
1	2.01	15.19	17.2	512.68	3.35
2	2.25	20.33	22.58	660.71	3.42
3	6.92	24.14	31.06	786.08	3.95
Bottom 3	**3.7**	**19.9**	**23.6**	**653.2**	**3.6**
4	7.99	30.71	38.7	917.35	4.22
5	9.26	42.85	52.11	1055.5	4.94
6	21.58	47.22	68.8	1218.9	5.64
7	15.07	63.39	78.46	1432.86	5.48
Middle 4	**13.5**	**46.0**	**59.5**	**1156.2**	**5.1**
8	44.6	73.89	118.49	1758.64	6.74
9	35.72	110.57	146.29	2287.86	6.39
10	42.56	139.09	181.65	5104.23	3.56
Top 3	**41.0**	**107.9**	**148.8**	**3050.2**	**5.6**
All	18.79	56.76	75.55	1573.91	4.8

The results on medical expenditure by decile classes indicate that there is sharp increase with increase in MPCE not only in the absolute medical expenditure but also in share to total expenditure both in rural and urban areas. For bottom 3 deciles and the middle 4 deciles the total medical expenditure proportion to total MPCE in rural and urban areas are broadly of the same magnitude, However, for top 3 deciles the total medical expenditure proportion to total MPCE in rural areas remains higher than that in urban areas.

With a view to analyze the total expenditure by source, following table provides the necessary details.

Table 3.14: Average Medical Expenditure per Hospitalization Case and per Treated Person by Type of Hospital Along with Loss of Household Income Due to Hospitalization in Uttar Pradesh-2004-05

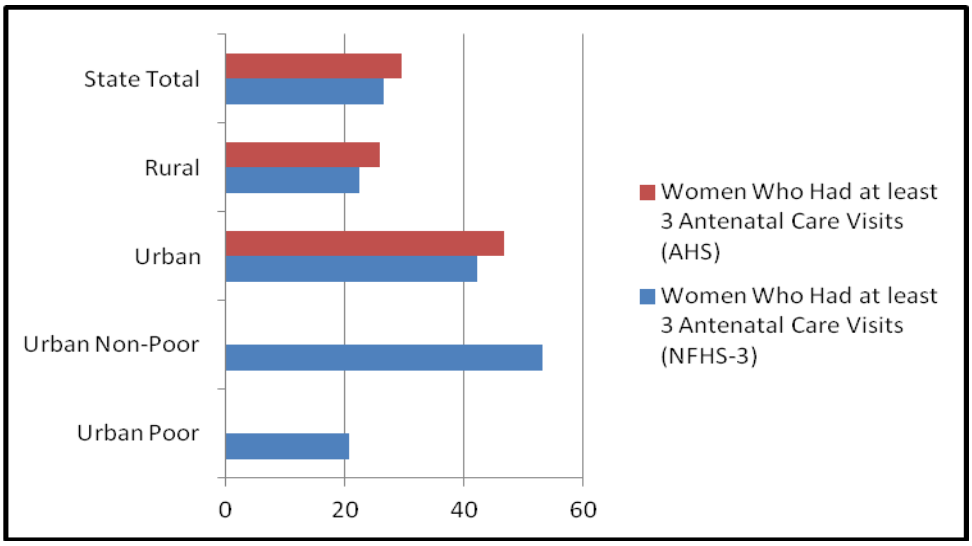
	Per Hospitalization		Per treated person	
Expenditure Details	**Rural**	**Urban**	**Rural**	**Urban**
Medical Expenditure in Government	7648	5144	10	9
Medical Expenditure in Private	9169	10351	326	303
Medical Expenditure in All	8765	8907	336	312
Other Expenditure	652	342	27	22
Total Expenditure	9417	9250	363	334
Loss of Households income	920	536	152	117

The average medical expenditure for hospitalized treatment from a public sector hospital was much lower than that from a private sector hospital in both rural and urban areas. The main reason being that the government institutions render a large amount of free or highly subsidized services to the people compared to the private institutions.

It is important to note that the average medical expenditure in all does not show any difference between rural and urban areas. This is because rural population avails the treatment in urban cities and towns from the similar facilities as by their urban counter parts**.**

3.2 Maternal Health

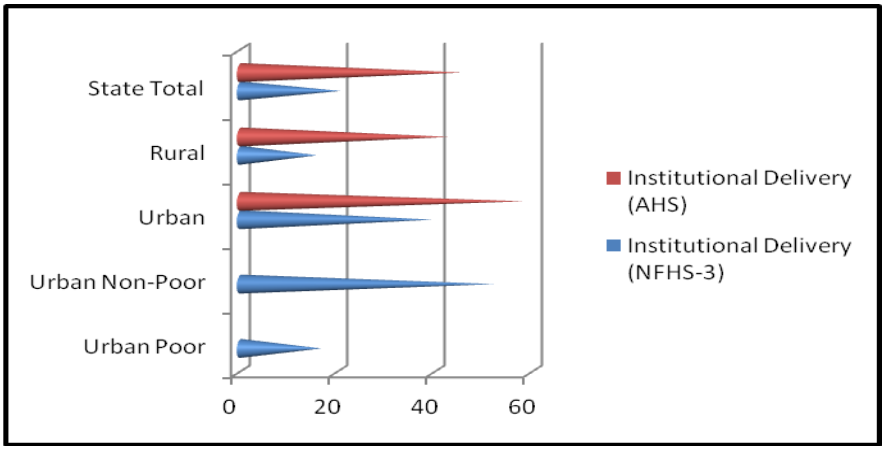
3.2.1. Antenatal Care



The proportion of Woman receiving 3 or more antenatal checkups showed onlylittle improvement from 27 percent in 2005-06 (NFHS-3) to 30 percent in 2010-11 (AHS). There has been virtually no improvement in urban areas. During 2005-06, for urban poor women receiving 3 or more ANC were more than half the level (20.7 percent) as compared to urban non poor (53.2 percent).

Women receiving full antenatal checkup still remains low at 3.9percent (AHS, 2010-11). As to specific components of ANC, the levels were much lower for urban poor as compared to urban non poor. Further, excepting for 3 or more ANC and consumption of IFA for 90 days or more, for other indicators there has been virtually no improvements for urban poor from NFHS-2 to NFHS-3.

3.2.2. Delivery Care



In the recent years (AHS, 2010-11), an institutional delivery have increased with rate and stands at 46 percent, it being 58 percent in urban and 43 percent in rural. Of the

54 percent home deliveries, about 40% of these were conducted by skilled health personal. Importantly, 29% of the institutional deliveries were caesareans mainly conducted in private institutions. The caesarean cases were higher (40 percent) in urban as compared to rural areas (25%).The corresponding figures for 2005-06 (NFHS-3) were 21 percent only, 40 percent in urban and 16 percent in rural. Here again, less than one-fifth of births among urban poor (16.7%) were Institutional which was much less than the urban average (39.5%).

It is important to note that 65 percent of cases, the stay in the hospital after delivery were less than 24 hours (68 percent in rural and 54 percent in Urban).

3.2.3. Postnatal care

Around two-third of the mothers received post natal check-up within 48 hours of delivery (67 percent in rural and 75 percent in urban). It is observed that 32 percent of newborns were not checked-up within 24 hours of birth in Uttar Pradesh.

3.2.4. Anemia among pregnant and lactating women

According to NFHS-3, about 50 percent of pregnant women had anemia. The percentage of severe anemia was 2 percent while the percentage of Mild and Moderate was 35 and 13 respectively. In case of lactating women, 58 percent of women had anemia.

The IFA consumption for 100 days or more during pregnancy in Uttar Pradesh continues to be low at 6.5 percentage. Even in urban areas it was only 12 percentages.

3.3 Child Health

3.3.1. Birth Registration

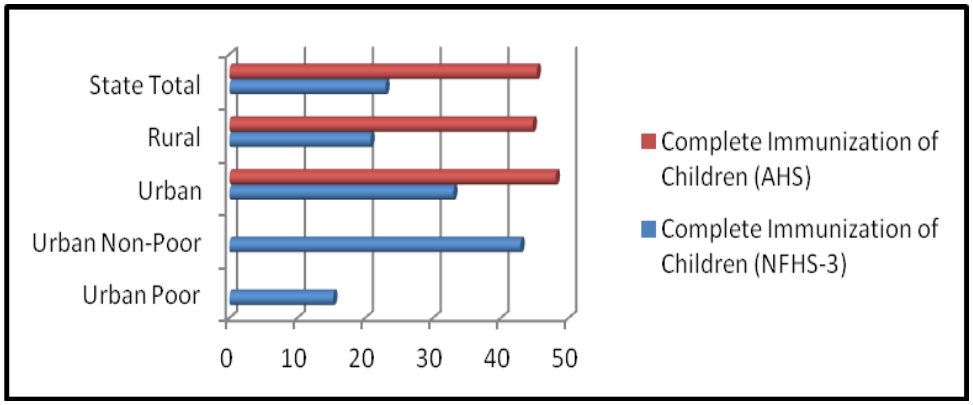
About 47 percent of births were registered in Uttar Pradesh (AHS, 2010-11), it being 45 percent in rural and 56 percent in urban. Based on this, 18 percent were reported to be having birth certificates in Uttar Pradesh (14 percent in rural and 35 percent in urban).

3.3.2. Birth Weight

For more than quarter of the births in Uttar Pradesh, weight was taken. Based on this 28 percent births were observed as low birth weight (less than 2.5 Kg). The proportion LBW was higher in rural as compared to urban.

3.3.3. Vaccination of children

During the year 2010-11 (AHS), over 45 percent children (12-23 months) were fully immunized. This indicates an improvement of 22 percentage points from 23 percent in 2005-06 (NFHS-3). The data for NFHS-3 analyzed for urban poor and non-poor indicated that among urban poor, the percentage of children receiving complete immunization was half of the urban average. Further, during 2005-06 only one-fourth of the children of urban poor received measles vaccine which was 19 points lower than the urban average. Boys are somewhat more likely than girls to be fully vaccinated (25% of boys compared with 21% of girls).



Importantly, though dropout rate from DPT1 to DPT3 was broadly similar for urban poor and non-poor, the left out rate was twofold for urban poor as compared to urban non-poor.

3.3.4. Childhood Illness

Children under 5 years of age among urban poor reported high prevalence of Diarrhea in last two week as compared to urban non poor and rural. Coupled with these children with diarrhea taken to health facility were lower 61 percent among urban poor as compared to 67 percent for urban non poor, but the same for rural was much lower at 52 percent level. Also, children with diarrhea receiving ORS were equal for both the urban poor and urban non poor (16%). Children with fever in last two weeks were higher magnitude for urban poor than for the urban non poor. Similarly for ARI, the differences in rural urban as well as urban poor non poor were nominal.

3.3.5. Breastfeeding

Children breastfeed within one hour of birth showed marked improvement during 2005-06 to 2010-11. The levels are less than half for urban poor (4.6%) as compared to non poor (11%) and also less than the level of rural areas (7%).

3.3.6. Infant Feeding

As high as 59 percent of children age 6-9 months did not receive supplementary food among urban poor, the corresponding figure for urban non poor was 47 percent and for rural 55 percent.

3.3.7. Children's Nutritional Status

As to the nutritional status of children, 48.5 percent of the children among urban poor were underweight as compared to 27 percent among urban non poor. But in terms of stunting the difference is much higher, the level being 63.5 percent for urban poor and 42 percent for urban non poor.

3.3.8. Anemia among children

Prevalence of anemia among children of the urban poor is much higher (78 percent) than urban non poor (68 percent) and even rural Uttar Pradesh (75 percent). The differences were larger when analyzed according to severity of anemia. Boys and girls are equally likely to have anemia.

3.4. Nutrition Intake

Following table provides information on nutrition intake per person per day and per consumer unit according to MPCE Deciles Classes based on NSSO survey.

Table 3.15: Nutrition Intake per Day - Uttar Pradesh (2008-09)

Rural						
MPCE	Per Capita Intake			Per consumer unit intake		
Deciles Class	Calorie	Protein	Fat	Calorie	Protein	Fat
1	1595	46.3	21.1	2015	58.5	26.7
2	1749	50.7	24.2	2181	63.2	30.2
3	1873	54.1	27.9	2346	67.8	35
4	1945	56.3	30.4	2416	69.9	37.7
5	1967	56.7	32.9	2448	70.5	41
6	2095	61.1	37.6	2568	75	46.1
7	2081	60.9	39.1	2555	74.8	48
8	2248	65.6	43.3	2760	80.6	53.2
9	2355	68.5	46.9	2917	84.9	58.1
10	2729	79.8	62.8	3334	97.5	76.7
All	2064	60	36.6	2557	74.3	45.4

Urban						
MPCE Deciles Class	Per Capita Intake			Per consumer unit intake		
	Calorie	Protein	Fat	Calorie	Protein	Fat
1	1532	45.1	22.7	1881	55.4	27.9
2	1648	48.9	26.1	2011	59.7	31.8
3	1679	49.7	29.5	2068	61.2	36.3
4	1773	52.9	33.6	2161	64.4	41
5	1828	53.9	38.1	2233	65.8	46.5
6	1882	55.5	41.8	2302	67.8	51.1
7	1935	56.5	44.3	2353	68.7	53.8
8	2110	61.3	51.4	2566	74.5	62.4
9	2249	65.5	61	2732	79.6	74.1
10	2597	73	74.8	3098	87.1	89.2
All	1923	56.2	42.3	2343	68.5	51.5

Table- 3.16: Per 1000 distribution of households with calorie intake as percent of RDA by MPCE Deciles Classes- Uttar Pradesh

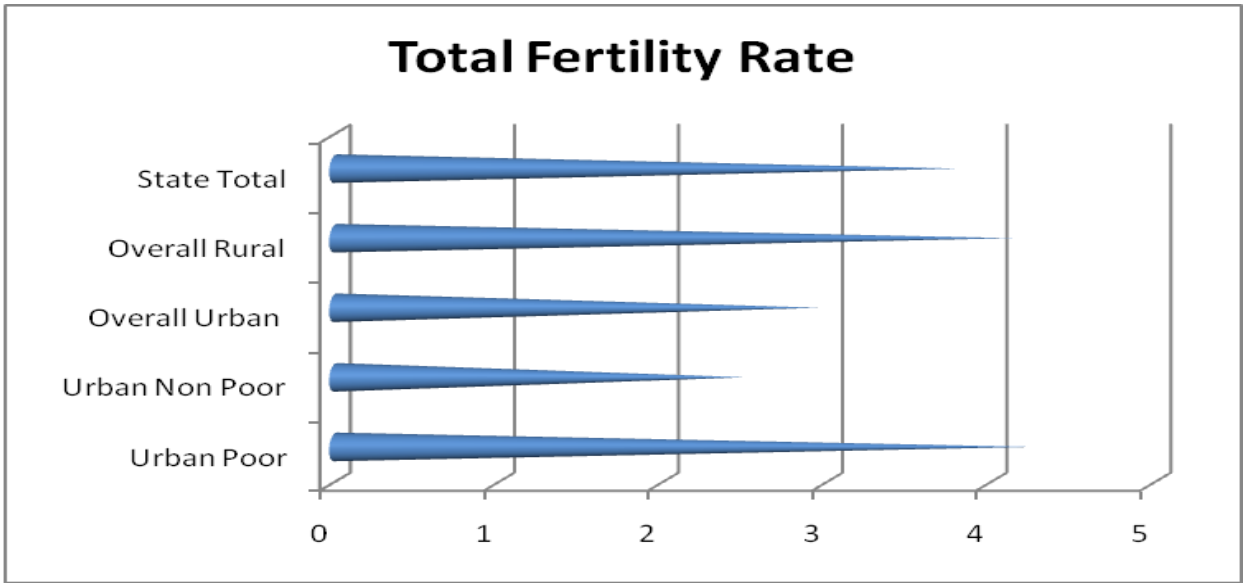
Rural									
Decile Class of MPCE	<70%	70-80%	80-90%	90-100%	100-110%	110-120%	120-150%	>150%	All
1	350	278	191	126	29	14	8	3	1000
2	187	252	230	184	83	42	21	1	1000
3	140	120	272	242	105	73	38	11	1000
4	89	168	230	234	149	75	50	5	1000
5	74	158	199	254	177	91	44	2	1000
6	71	84	195	228	158	101	147	17	1000
7	69	127	142	253	151	125	103	30	1000
8	29	65	131	217	189	152	165	52	1000
9	24	45	131	151	145	155	241	107	1000
10	26	35	68	106	119	118	292	236	1000
All	96	124	171	196	133	100	125	56	1000
Urban									
1	487	209	135	129	21	0	18	0	1000
2	364	285	150	90	72	34	5	0	1000
3	348	164	258	120	45	51	10	4	1000
4	208	244	245	161	67	55	15	4	1000
5	159	275	211	129	75	55	80	16	1000
6	174	159	267	134	132	73	49	13	1000
7	104	208	219	166	182	62	45	13	1000
8	32	90	297	163	170	102	137	9	1000
9	29	56	161	212	174	144	147	76	1000
10	3	12	242	101	123	123	251	145	1000
All	155	148	223	141	115	80	97	41	1000

There is a trend in the per capita nutrient take with increase in monthly per capita expenditure. Indicating that the per capita nutrient intake is much less for poor as compared to non poor.

It is of interest to know how the intake levels compare with the corresponding RDA values. Towards this, following tables provides the details on proportion of households consuming <70%, 70-80%, 80-90%, 90-100%, 100-110%, 110-120%, 120-150% and more than 150% of RDA, It is observed that among those in the lower decile Classes significantly larger proportion consumes even less than 70% of RDA. Further, those consuming more than 100% of RDA are mainly in the higher decile classes. This indicates that nutritional status of poors is worse of as compared to their rich counter parts.

3.5 Family Planning

Total Fertility Rate has been on the decline in Uttar Pradesh from 4.4 in 2003 to 3.4 in 2011. This decline however is not reflective of the high fertility rates among urban poor which stood at 4.25 in 2005-06 as NFHS 3. As stated earlier, the use of contraception among urban poor couples is very low at just 24.4 per cent. That family planning crucial for the health of women and children is widely accepted. Maternal and child health initiatives will therefore have to go hand in hand with efforts to inform and motivate couples to adopt a modern method of contraception, preferably a long-acting method if they have attained the desired family size.



NUHM in the state will take a two-pronged approach to take family planning services closer to people who have poor access. It will take the help of frontline health workers or ASHA to counsel and motivate couples to maintain the desired 3-year-gap between two births. This process must ideally start right from the time of registration of pregnancy so that by the time of delivery the couple has already made up their mind about a long-acting method of contraception.

At the same time health facilities will be strengthened and doctors trained in post-delivery family planning procedures to make the services more easily accessible.

3.6 Health care Delivery System

To meet the challenges in reaching health services to the urban poor NUHM will try to capitalise on the various resources available in the cities and towns. There is a vast pool of hospitals and clinics, including medical colleges and their hospitals. Then there is the pool of service providers available in cities and towns from traditional systems of medicine like Ayurveda, Homeopathy, Unani, among others; these can be roped in to improve the health service delivery mechanism in urban areas. The

private sector too will be engaged with to reach quality clinical services at subsidised rates to the slum residents. The cities and towns also have the advantage of various training institutes. These can also be put to good use to build the capacity of staff at various levels – from ASHAs to ANMs to doctors.

The existing government health system currently comprises of Urban Health Posts, Urban family Welfare Centers, District Women Hospitals, District Hospitals, combined Hospitals, Bal Mahila Chikitsalaya and Prasuti Grehs. The numbers of each vary by city and these facilities function at varying levels of effectiveness due to lack of committed investment of resources, particularly in terms of human resource. Urban Local Bodies also run some primary care centers and hospitals their ability to manage health services varies by cities.

Further there are many Health facilities run by ESI, Railways and armed forces that provide health care to specific populations.

3.7 Health indicators according to NFHS-3 (2005-06)

Indicators	Total	Urban	Urban Poor	Rural
Neonatal Mortality Rate	47.6	40.7	50	49.4
Infant Mortality Rate	72.7	64	86.2	74.8
Under-five Mortality Rate	96.4	82.4	110.1	100
Maternal Mortality Ratio	NA	NA	NA	NA
Total Fertility Rate	3.8	3	4.3	4.1
CPR	29.3	42.4	24.4	25.3
Unmet Need	21.2	15.1	29.9	23.1
Full Immunization (percentage)	23	33	15.3	20.8
3 ANC	26.6	42.1	20.7	22.5
Institutional Delivery	20.6	39.5	16.7	15.8
Anemia (Women 15-49 years)	49.9	48.7	55.3	50.3
Children with anemia (under 5 years)	73.9	71.4	77.6	74.6
Children who are stunted %	56.8	50.2	63.5	58
Children with diarrhea in the last two weeks who received ORS	12.5	15.9	16.0	11.9
Women who have heard of AIDS	45.2	72.2	41.9	35.8
Prevalence of Medically treated TB (per 100,000 persons)	425	321	532	468
*Annual Blood Examination Rate (ABER) for malaria	2.37	NA	NA	NA
*Malaria Annual Parasite Index (API) %	0.33	NA	NA	NA

*Dengue Case Fatality Rate	3.22	NA	NA	NA
*Annual New Smear Positive case detection rate Per lakh population	68	NA	NA	NA
Treatment success rate among new smear positive cases	NA	NA	NA	NA
Leprosy Prevalence Rate	NA	NA	NA	NA
No. of outbreaks reported under IDSP in past year	NA	NA	NA	NA

*Source PIP 2012-13, Reference period 2011

4. Details of cities/towns to be covered under NUHM as per census 2011

The following is the list of town and cities that will be covered under NUHM. These include the state capital, District Headquarters and all towns more than 50,000 population as per the NUHM guidelines. Total of 131 cities/towns will be covered in the 75 districts in Uttar Pradesh as per census 2011.

For planning, data has been obtained from the following sources:

1. Census of India, 2011
2. Annual Health Survey; 2010-11 and 2011-12
3. Sample Registration System, 2011
4. NSSO
5. National Family Health Survey-3 (NFHS-3) 2005-06
6. District Level Household Survey-3, (DLHS-3) 2007-08
7. Web based Health Management Information System of Government of Uttar Pradesh

The best available estimates of number of slums and slum populations have been used for NUHM planning. These include GIS mapping done the Government of Uttar Pradesh in 2009-10 in 14 cities, mapping done by DUDA for slum development programs such as JnNURM, Rajiv Awas Yojana, ISDP and IDSMT. The population data of the cities has been sourced from Census 2011 and the slum population data has been provided by the respective city teams who in-turn have sourced it from city based offices of DUDA or from the respective city National Polio Surveillance Project. It is expected that when slum mapping and house listing activities are undertaken once the NUHM activities are initiated, accurate data on number of slums and slum populations will be available.

Table 4.1 - Cities/Towns to be covered under NUHM as per 2011 census

Sl. No	District	Sl. No.	Name	Type of City /town	Total Urban Population (census 2011)	Urban Slum population	Implementing authority	Whether covered under JnNURM, BSUP, IDSMT
1	Agra	1	Agra (M Corp.)	DHQ	1,585,704	1,250,000	DHS	JnNURM, RAY
2	Aligarh	2	Aligarh (M Corp.)	DHQ	874,408	780,000	DHS	RAY
		3	Atrauli (NPP)		50,412	50,400	DHS	
3	Allahabad	4	Allahabad (M Corp. + OG)	DHQ	1,168,385	680,000	DHS	JnNURM, RAY
4	Bareilly	5	Bareilly (M Corp. + OG)	DHQ	904,797	338,005	DHS	RAY
		6	Faridpur (NPP)	Other	78,249	18,360	DHS	
		7	Baheri (NPP)	Other	68,413	68,410	DHS	
		8	Aonla (NPP)	Other	55,629	26,235	DHS	
5	Bijnor	9	Nagina (NPP)	Other	95,246	26,935	DHS	
		10	Bijnor (NPP)	DHQ	93,297	34,480	DHS	UIDSSMT
		11	Najibabad (NPP)	Other	88,535	15,835	DHS	
		12	Chandpur (NPP)	Other	83,441	14,400	DHS	
		13	Sherkot (NPP)	Other	62,226	11,130	DHS	
		14	Kiratpur (NPP + OG)	Other	61,946	14,500	DHS	
		15	Seohara (NPP + OG)	Other	53,296	14,840	DHS	
		16	Dhampur (NPP)	Other	50,997	9,590	DHS	
6	Budaun	17	Budaun (NPP)	DHQ	159,285	106,000	DHS	UIDSSMT
		18	Sahaswan (NPP)	Other	66,204	22,000	DHS	
		19	Ujhani (NPP)	Other	62,039	16,560	DHS	
7	Bulandshahar	20	Bulandshahr (NPP + OG)	DHQ	230,024	113,000	DHS	
		21	Khurja (NPP + OG)	Other	121,207	98,000	DHS	UIDSSMT
		22	Sikandrabad (NPP)	Other	81,028	45,150	DHS	
		23	Jahangirabad (NPP)	Other	59,858	27,800	DHS	
		24	Gulaothi (NPP)	Other	50,823	26,600	DHS	
8	Etawah	25	Etawah (NPP)	DHQ	256,838	49,040	DHS	RAY UIDSSMT
9	Farrukhabad	26	Farrukhabad-cum-Fatehgarh (NPP)	DHQ	276,581	190,000	DHS	

10	Firozabad	27	Firozabad (NPP)	DHQ	604,214	387,000	DHS	RAY UIDSSMT
		28	Shikohabad (NPP)	Other	107,404	24,425	DHS	
		29	Tundla (NPP)	Other	50,423	25,000	DHS	
11	GB Nagar	30	Noida (CT)	DHQ	637,272	554,000*	DHS	
		31	Greater Noida (CT)	Other	102,054	253,000*	DHS	
		32	Dadri (NPP)	Other	91,189	144,000*	DHS	
12	Ghaziabad	33	Ghaziabad (M Corp.)	DHQ	1,648,643	403,045	DHS	RAY UIDSSMT
		34	Loni (NPP)	Other	516,082	106,155	DHS	UIDSSMT
		35	Khora (CT)	Other	190,005	30,000	DHS	
		36	Modinagar (NPP)	Other	130,325	21,500	DHS	UIDSSMT
		37	Muradnagar (NPP)	Other	95,208	5,000	DHS	
13	Gorakhpur	38	Gorakhpur (M Corp.)	DHQ	673,446	450,000	DHS	RAY UIDSSMT
14	Hapur	39	Hapur (NPP)	DHQ	262,983	100,000	DHS	
		40	Pilkhuwa (NPP)	Other	83,736	45,000	DHS	
15	Hardoi	41	Hardoi (NPP + OG)	DHQ	197,029	53,000	DHS	
		42	Shahabad (NPP)	Other	80,226	7,500	DHS	
		43	Sandila (NPP)	Other	58,346	9,000	DHS	UIDSSMT
16	Jalaun	44	Orai (NPP + OG)	DHQ	190,575	53,000	DHS	
		45	Jalaun (NPP)	Other	56,909	7,500	DHS	
		46	Konch (NPP)	Other	53,412	10,000	DHS	
		47	Kalpi (NPP)	Other	51,670	7,500	DHS	
17	Jhansi	48	Jhansi (M Corp.)	DHQ	505,693	211,550	DHS	RAY UIDSSMT
		49	Mauranipur (NPP + OG)	Other	61,449	32,000	DHS	
18	JP Nagar	50	Amroha (NPP)	DHQ	198,471	62,500	DHS	
		51	Hasanpur (NPP)	Other	61,243	37,500	DHS	
		52	Gajraula (NP)	Other	55,048	31,500	DHS	
19	Kannauj	53	Kannauj (NPP)	DHQ	84,862	15,300	DHS	RAY UIDSSMT
		54	Chhibramau (NPP)	Other	60,986	13,000	DHS	
20	Kanpur Nagar	55	Kanpur (M Corp. + OG)	DHQ	2,768,057	637,000	DHS	JnNURM ,RAY
21	Kheri	56	Lakhimpur (NPP)	DHQ	151,993	12,500	DHS	UIDSSMT
		57	Gola Gokaran Nath (NPP)	Other	60,172	1,500	DHS	
22	Lucknow	58	Lucknow (M Corp.)	DHQ	2,817,105	1,097,710	DHS	JnNURM, RAY

23	Mathura	59	Mathura (NPP)	DHQ	349,909	282,285	DHS	JnNURM, RAY
		60	Vrindavan (NPP)	Other	63,005	63,000	DHS	UIDSSMT
		61	Kosi Kalan (NPP + OG)	Other	60,074	10,625	DHS	
24	Mau	62	Maunath Bhanjan (NPP)	DHQ	278,745	64,330	DHS	UIDSSMT
25	Meerut	63	Meerut (M Corp.)	DHQ	1,305,429	1,150,000	DHS	JnNURM, RAY
		64	Mawana (NPP)	Other	81,443	9,000	DHS	
		65	Sardhana (NPP)	Other	58,252	16,000	DHS	
26	Moradabad	66	Moradabad (M Corp.)	DHQ	887,871	432,500	DHS	RAY UIDSSMT
27	Muzaffarnagar	67	Muzaffarnagar (NPP)	DHQ	392,768	115,000	DHS	RAY UIDSSMT
		68	Khatauli (NPP)	Other	72,949	20,000	DHS	
		69	Budhana (NP + OG)	Other	53,722	10,500	DHS	
28	Rae Bareli	70	Rae Bareli (NPP)	DHQ	191,316	60,000	DHS	RAY UIDSSMT
29	Rampur	71	Rampur (NPP)	Other	325,313	125,000	DHS	RAY UIDSSMT
30	Saharanpur	72	Saharanpur (M Corp.)	DHQ	705,478	302,500	DHS	RAY
		73	Deoband (NPP)	Other	97,037	33,000	DHS	
		74	Gangoh (NPP)	Other	59,279	21,000	DHS	
31	Shahjahanpur	75	Shahjahanpur (NPP)	DHQ	329,736	218,460	DHS	RAY UIDSSMT
		76	Tilhar (NPP)	Other	61,444	41,100	DHS	
32	Sitapur	77	Sitapur (NPP)	DHQ	177,234	33,450	DHS	
		78	Laharpur (NPP)	Other	61,990	3,820	DHS	UIDSSMT
		79	Biswan (NPP)	Other	55,780	32,250	DHS	
		80	Mahmudabad (NPP)	Other	50,777	11,955	DHS	
33	Unnao	81	Unnao (NPP)	DHQ	177,658	43,500	DHS	UIDSSMT
		82	Gangaghat (NPP)	Other	84,072	33,500	DHS	
34	Varanasi	83	Varanasi (M Corp.)	DHQ	1,198,491	569,740	DHS	JnNURM
35	Ambedkarnagar	84	Ambedkarnagar (Mcorp+OG)	DHQ	111,447	15,000	DHS	
		85	Tanda	Other	95,516	50,000	DHS	
36	Amethi	86	Amethi(NP)	DHQ	13,849	7,000	DHS	
37	Auraiya	87	Auraiya (NPP)	DHQ	87,736	-	DHS	
38	Azamgarh	88	Azamgarh (NPP)	DHQ	110,983	46,000	DHS	UIDSSMT
		89	Azam Mubarakpur	Other	70,463	32,000	DHS	
39	Baghpat	90	Baghpat (NPP)	DHQ	50,310	87,000	DHS	UIDSSMT

		91	Baghpat Baraut (NPP)	Other	103,764	68,000	DHS	
40	Bahraich	92	Bahraich (NPP)	DHQ	186,223	75,000	DHS	
41	Ballia	93	Ballia (NPP)	DHQ	104,424	67,000	DHS	UIDSSMT
42	Balrampur	94	Balrampur (NPP + OG)	DHQ	82,488	36,000	DHS	UIDSSMT
43	Banda	95	Banda (NPP + OG)	DHQ	160,473	12,000	DHS	
44	Barabanki	96	Nawabganj (NPP + OG)	DHQ	81,486	7,500	DHS	UIDSSMT
45	Basti	97	Basti (NPP)	DHQ	114,657	54,500	DHS	UIDSSMT
46	Chandauli	98	Mughalsarai (NPP)	DHQ	109,650	23,000	DHS	
47	Chitrakoot	99	Chitrakoot Dham (Karwi) (NPP)	DHQ	57,402	11,000	DHS	
48	Deoria	100	Deoria (NPP)	DHQ	129,479	61,000	DHS	UIDSSMT
49	Etah	101	Etah (NPP)	DHQ	118,517	35,000	DHS	UIDSSMT
50	Faizabad	102	Faizabad (NPP)	DHQ	165,228	40,000	DHS	UIDSSMT
		103	Ayodhya (NPP)	Other	55,890	26,500	DHS	
51	Fatehpur	104	Fatehpur (NPP)	DHQ	193,193	63,000	DHS	UIDSSMT
52	Ghazipur	105	Ghazipur (NPP + OG)	DHQ	121,020	60,000	DHS	UIDSSMT
53	Gonda	106	Gonda (NPP)	DHQ	114,046	9,000	DHS	UIDSSMT
54	Hamirpur	107	Rath (NPP)	DHQ	100,514	23,000	DHS	
55	Hathras	108	Hathras (NPP + OG)	DHQ	143,020	61,000	DHS	
56	Jaunpur	109	Jaunpur (NPP)	DHQ	180,362	15,000	DHS	UIDSSMT
57	Kanpur Dehat	110	Akbarpur (NP)	DHQ	20,445	10,000	DHS	
58	kasganj	111	Kasganj (NPP)	DHQ	101,277	32,000	DHS	
59	Kaushambi	112	Manjhanpur (NP)	DHQ	16,457	2,025	DHS	
60	Kushinagar	113	Padrauna (NPP)	DHQ	49,723	25,000	DHS	
61	Lalitpur	114	Lalitpur (NPP)	DHQ	133,305	50,000	DHS	
62	Maharajganj	115	Maharajganj (NPP)	DHQ	33,930	26,500	DHS	
63	Mahoba	116	Mahoba (NPP)	DHQ	95,216	37,000	DHS	
64	Mainpuri	117	Mainpuri (NPP + OG)	DHQ	136,557	84,000	DHS	UIDSSMT
65	Mirzapur	118	Mirzapur-cum-Vindhyachal (NPP)	DHQ	234,871	58,000	DHS	UIDSSMT
66	Pilibhit	119	Pilibhit (NPP)	DHQ	127,988	61,000	DHS	
		120	Bisalpur (NPP)	Other	73,551	3,400	DHS	
67	Pratapgarh	121	Bela Pratapgarh (NPP)	DHQ	76,133	8,010	DHS	
68	Sambhal	122	Sambhal (NPP)	DHQ	220,813	37,000	DHS	UIDSSMT
		123	Chandausi (NPP)	Other	114,383	39,000	DHS	

69	Sant Kabir Nagar	124	Khalilabad (NPP)	DHQ	47,847	6,100	DHS	
70	Bhadohi (NPP)	125	Bhadohi (NPP)	DHQ	94,620	36,000	DHS	
71	Shamli	126	Shamli (NPP)	DHQ	107,266	43,000	DHS	
		127	Kairana (NPP)	Other	89,000	10,000	DHS	
72	Shrawasti	128	Bhinga (NP)	DHQ	23,780	4,950	DHS	
73	Sidharthnagar	129	Siddharthnagar (NPP)	DHQ	25,422	25,000	DHS	UIDSSMT
74	Sonabhadra	130	Sonbhadra (NPP)	DHQ	36,689	32,000	DHS	
75	Sultanpur	131	Sultanpur (NPP)	DHQ	107,640	76,533	DHS	
Total					**31,453,923**	**14,288,488**		

In case of city & towns falling under GB Nagar (indicated by *), slum population is forming a major proportion of the total urban population due to unprecedented out growth areas and conversion of rural areas into unplanned urban clusters which are barely covered by any health care facilities. Hence costs have been budgeted to reach these populations by outreach services.

The Cantonment Board areas in the districts of Agra, Bareilly, Kanpur, Lucknow and Meerut are not planned for inclusion under NUHM activities or resources as the population here is already receiving health services from the Army Hospitals and there is negligible slum population in these areas. Any vulnerable population in the Cantonment areas will be covered with outreach camps or under activities from the nearest town as the need may be.

In 2013-14 all districts will be covered under NUHM with all activities like setting up administrative and programme management systems. Activities such as GIS mapping and listing of slums and facilities will also be taken up. Orientation of Urban Local Bodies on Urban Health, the role of different government departments and urban stakeholders in improving urban health and provision under NUHM will be done. Establishment of U-PHC and CHC will be taken up.

For preparing this state plan for NUHM, existing data has been obtained from various sources but more city specific data will emerge once the mapping and listing activities and the base line surveys are carried out.

Districts Heath Society will be the implementing authority for NUHM under the leadership of the District Magistrate. District Program Management Units have been further strengthened to provide appropriate managerial and operational support for the implementation of the NUHM programme at the district level.

Urban Health Initiative (UHI), a Bill and Melinda Gates Foundation funded project is being implemented by FHI360 in 11 cities in Uttar Pradesh. UHI has teams in 11 cities and will support in implementation and monitoring of NUHM activities in the said cities.

Micronutrient Initiative (MI), is providing technical assistance on micronutrient programmes in three urban districts (Agra, Meerut and Kanpur).Besides this, MI is also supporting micronutrient activities (VAS programme, Diarrhoea management programme and IFA supplementation programme) in 27 districts intensively through divisional coordinators and technical support at state level.

HUP has presence in the EAG states and is providing technical assistance on issues of urban health to 8 states and the Ministry of Health &Family Welfare. The ministry has acknowledged the support of both HUP and NHRC in developing the guidelines for NUHM PIP.

The NUHM (Uttar Pradesh) mandates HUP to be its technical agency to Urban Health Cell for providing the technical assistance for effective implementation of NUHM, expand partnerships in Urban Health which would include engaging the commercial sector in Public Private Partnership (PPP) activities and promote Convergence of different Government urban health and development efforts. HUP shall coordinate and facilitate in the city health plans of the two cities of Lucknow and Kanpur.

State's Allocation under Urban RCH Component under NRHM-RCH Flexible Pool

The table below captures the amounts approved urban RCH component of the RCH Flexible Pool of NRHM. In 2012-13, a total of 131 urban health posts were approved for funding by GOI. An additional 100 health posts were approved in the Supplementary PIP for the year 20112-13. In the FY 2013-14 funding for continuing these health posts was approved till September 2013 (for six months).

Table 4: State's Allocation under Urban RCH Component under NRHM-RCH Flexible Pool:

FMR Code	Activity	Amount Approved in 2012-13 (amount in Lacs)	Amount Approved in 2013-14 (for 6 month) (amount in Lacs)
A.5	**URBAN RCH (focus on Urban slums)**	**2712.8**	**1210.67**
A.5.1	Identification of urban areas / mapping of urban slums and planning	0	
A.5.2	HR for urban health including doctors, ANMs, Lab techs	0	933.47

A.5.2.1	Doctors/MOs	878.76	498.96
A.5.2.2	Specialist	120.64	0
A.5.2.3	Dentists	0	0
A.5.2.4	ANM	263.63	137.21
A.5.2.5	Staff Nurse	439.38	228.69
A.5.2.6	LHV	0	0
A.5.2.7	LT	0	0
A.5.2.8	Pharmacists	0	0
A.5.2.9	Radiographers	0	0
A.5.2.10	OT Technician	0	0
A.5.2.11	Support staff	113.76	68.61
A.5.2.12	Others (pl specify)	6.79	
A.5.3	Operating expenses for UHP and UHC	404.86	277.2
A.5.4	Outreach activities	0	0
A.5.5	Others (pl specify)	165	0
A.5.5.1	Infrastructure support for Urban areas	0	0
	Drugs and consumables	320	0

Table 6: State's Allocation under Infrastructure Maintenance (Treasury Route) head of NRHM

FMR Code	Activity	Amount Approved in 2012-13 (Rs in Lacs)	Amount Approved in 2013-14 (Rs in Lacs)
	Infrastructure Maintenance		
1	Urban Family Welfare Centers (UFWCs) and Urban Revamping Scheme (Health Posts)	1217.79	3737.25

5. Key Issues for improving health care

The Eleventh Plan had suggested Governance reforms in public health system, such as Performance linked incentives and Devolution of powers and functions to local health care institutions and making them responsible for the health of the people living in a defined geographical area. NRHM's strategy of decentralization, PRI involvement, integration of vertical programmes, inter-sectoral convergence and Health Systems Strengthening has been partially achieved. Despite efforts, lack of capacity and inadequate flexibility in programmes forestall effective local level Planning and execution based on local disease priorities.

In order to ensure that plans and pronouncements do not remain on paper, NUHM UP would strive for system of accountability that shall be built at all levels, reporting on service delivery and system, district health societies reporting to state, facility managers reporting on health outcomes of those seeking care, and territorial health managers reporting on health outcomes in their area. Accountability shall be matched with authority and delegation; the NUHM shall frame model accountability guidelines, which will suggest a framework for accountability to the local community, requirement for documentation of unit cost of care, transparency in operations and sharing of information with all stakeholders. The state will incorporate the core principles of The National Health Mission of Universal Coverage, Achieving Quality Standards, Continuum of Care and Decentralized Planning.

Following would be the issues for the cities to address: City Health Planning, Public Private Partnership, Convergence, Capacity Building, Migration, Communitization, Strengthen Data, Monitoring and Supervision, Health Insurance, Information Dissemination and Focus on NCDs/ Life-Style Diseases.

The key overarching strategies under NUHM for 2013-14 include data based planning, strengthening of management and monitoring systems at the state and district level, improving the primary health care delivery system and community outreach through ASHAs, MAS and Urban Health and Nutrition Days(UHNDs).

The key activities at the state level will include planning, convergence with key urban stakeholders like Urban Development, SUDA, Women and Child Development, Basic Education, guidelines formulation, mapping and listing of slums and facilities, baseline survey at the community and facility level, monitoring for implementation as per plans and data review for process and outcome indicators.

The key activities at the district level will include convergence with key urban stakeholders, sensitization of ULBs on their role in urban health, strengthening UPHCs for provision of primary health care to urban poor, community outreach through selection, training and support to ASHAs and MAS, conducting UHNDs and outreach camps to get services closer to the community and reach complete coverage of slum and vulnerable populations.

6. Planning Activities

Prioritization of cities

All the 131 cities/ towns are being proposed under this plan, which qualify as per the NUHM guidelines. This plan covers a total urban population of 3,14,53,923 (census 2011) and total slum population of 1,42,88,488 (compiled from District plans) from the 131 cities/ towns .

Mapping and Listing of Slums and Health Facilities

GIS mapping and listing of slums was completed in 2009 in 14 cities (Agra, Aligarh, Allahabad, Hapur, Bareilly, Farrukhabad, Ghaziabad, Kanpur, Jhansi, Lucknow, Meerut, Saharanpur, Shahjahanpur, Varanasi) based on guidance from Government of India and with funding under NRHM. The GIS maps were prepared by Remote Sensing Applications Centre, Uttar Pradesh. This gave us fairly accurate lists and maps of slums in the 14 cities. ***GIS mapping of 38 cities have been initiated under Urban Development schemes like UIDSSMT and UI&G. 11 cities, out of 14 which have been mapped through GIS under NRHM are common, thus GIS mapping of 41 cities are initiated or completed in the state.***

Sl. No.	District	Name of Town	Total Population	GIS Mapping to be done under UD Schemes	GIS Mapping undertaken under NRHM
1	Agra	Agra (M Corp.)	15,85,704	Yes	yes
2	Aligarh	Aligarh (M Corp.)	8,74,408	Yes	yes
3	Allahabad	Allahabad (M Corp. + OG)	11,68,385	Yes	yes
4	Ballia	Ballia (NPP)	1,04,424	Yes	
5	Balrampur	Balrampur (NPP + OG)	82,488	Yes	
6	Bareilly	Bareilly (M Corp. + OG)	9,04,797		Yes
7	Basti	Basti (NPP)	1,14,657	Yes	
8	Bijnor	Bijnor (NPP)	93,297	Yes	
9	Bulandshahar	Khurja (NPP + OG)	1,21,207	Yes	
10	Deoria	Deoria (NPP)	1,29,479	Yes	
11	Etawah	Etawah (NPP)	2,56,838	Yes	
12	Faizabad	Faizabad (NPP)	1,65,228	Yes	
13	Farrukhabad	Farrukhabad-cum-Fatehgarh (NPP)	2,76,581		yes
14	Fatehpur	Fatehpur (NPP)	1,93,193	Yes	
15	Firozabad	Firozabad (NPP)	6,04,214	Yes	
16	Ghaziabad	Ghaziabad (M Corp.)	16,48,643	Yes	yes
17	Ghaziabad	Loni (NPP)	5,16,082	Yes	
18	Ghaziabad	Modinagar (NPP)	1,30,325	Yes	
19	Ghazipur	Ghazipur (NPP + OG)	1,21,020	Yes	
20	Gonda	Gonda (NPP)	1,14,046	Yes	
21	Gorakhpur	Gorakhpur (M Corp.)	6,73,446	Yes	
22	Hapur	Hapur (NPP)	2,62,983		Yes
23	Jaunpur	Jaunpur (NPP)	1,80,362	Yes	
24	Jhansi	Jhansi (M Corp.)	5,05,693	Yes	yes
25	Kannauj	Kannauj (NPP)	84,862	Yes	
26	Kanpur Nagar	Kanpur (M Corp. + OG)	27,68,057	Yes	yes

27	Kheri	Lakhimpur (NPP)	1,51,993	Yes	
28	Lucknow	Lucknow (M Corp.)	28,17,105	Yes	yes
29	Mathura	Mathura (NPP)	3,49,909	Yes	
30	Mathura	Vrindavan (NPP)	63,005	Yes	
31	Mau	Maunath Bhanjan (NPP)	2,78,745	Yes	
32	Meerut	Meerut (M Corp.)	13,05,429	Yes	yes
33	Moradabad	Moradabad (M Corp.)	8,87,871	Yes	
34	Muzaffarnagar	Muzaffarnagar (NPP)	3,92,768	Yes	
35	Saharanpur	Saharanpur (M Corp.)	7,05,478	Yes	yes
36	Sambhal	Sambhal (NPP)	2,20,813	Yes	
37	Shahjahanpur	Shahjahanpur (NPP)	3,29,736	Yes	yes
38	Sidharthnagar	Siddharthnagar (NPP)	25,422	Yes	
39	Sitapur	Laharpur (NPP)	61,990	Yes	
40	Unnao	Unnao (NPP)	1,77,658	Yes	
41	Varanasi	Varanasi (M Corp.)	11,98,491	Yes	yes
Total			**3,14,18,465**	**38**	**14**

GIS mapping will be taken up for the remaining 90 cities and towns. Budget is therefore being proposed for GIS mapping of only 90 cities and towns as per the prescribed norms.

Listing and Mapping of Households in slums and Key Focus Areas

Listing and mapping of households will provide accurate numbers for population their family size and composition residing in slums. Currently, estimates of population residing in slums are available from District Urban Development Agency (DUDA) and National Polio Surveillance Project as the immunization micro plans (under NPSP) provide updated estimates of slum and vulnerable populations and are expected to be fairly complete. The current plan for covering slums is based on the currently available data of urban population of each city.

Once the ASHA are deployed they will list all households and fill the Slum Health Index Registers (SHIR) including the number and details of family members in each household. This data will be compiled for each city and will provide the population composition of slums and key focus areas. This will also help the urban ASHA know her community better and build a rapport with the families that will go a long way in helping her advocate for better health behaviours and link communities to health facilities under the NUHM. It is expected that once the household mapping is completed in cities, the number of ASHAs will be reviewed and adjusted upwards or downwards and the geographical boundaries of the coverage area for each ASHA would be realigned. This is due to the reason that the actual population may be higher or lower than the original estimate used for planning.

Facility Survey for gaps in infrastructure, HR, equipment, drugs and consumables

Facility survey will be carried out in the public facilities to assess the gaps in infrastructure, human resource, equipment, drugs and consumables availability as against expected patient load. Further planning, particularly for UCHCs, will be based on these gaps. This work will be outsourced to a

research agency. Development Partners like Urban Health Initiative and Health of the Urban Poor projects will technically support this effort.

Baseline Survey

The state envisions monitoring progress in health indicators in urban areas and among urban poor over the period of implementation of NUHM. This proposed Baseline survey will generate data on the health and related indicators which will be reviewed during the course of implementation of the program to assess the impact of implementation and necessary course corrections can accordingly be made and use of resources can be optimised. It is envisaged that this exercise will be carried out in all the 131 cities and shall be outsourced to a suitable research agency which will carry out the survey within the given time frame.

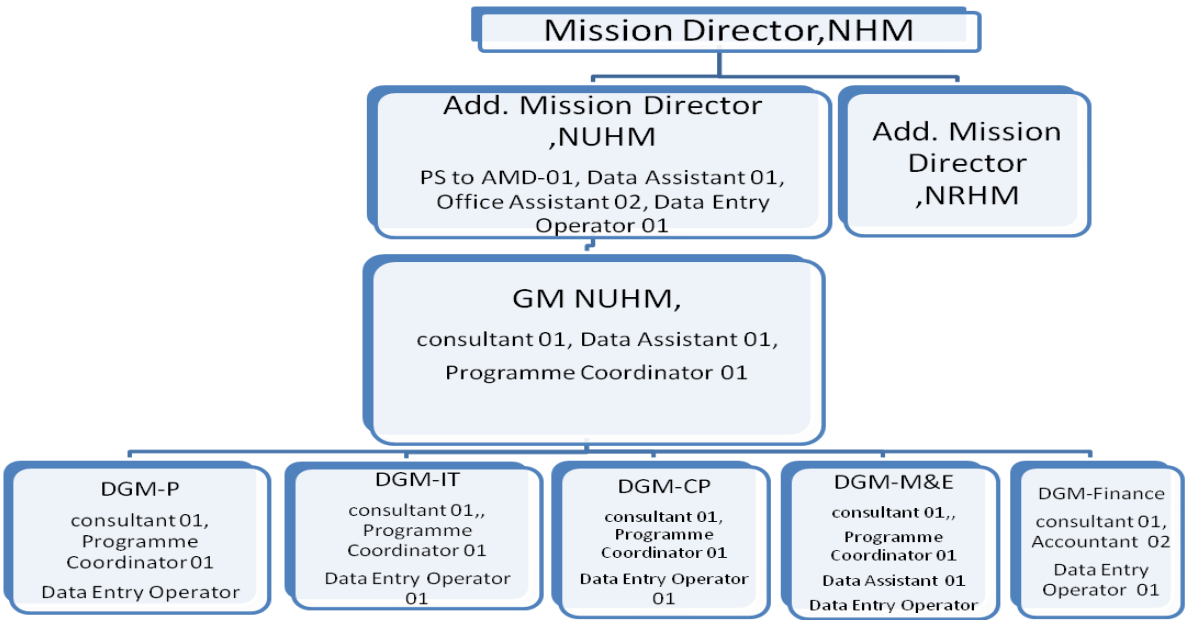
7. Programme Management Arrangements

State level

The Government of Uttar Pradesh has passed necessary resolutions for planning and implementation of the NUHM in the state. Accordingly, setting up of a State Program Management Unit for NUHM has been planned and approved. Pertinent points of resolution are -

1. The Government of Uttar Pradesh has passed a Resolution to include Ministries and Departments of Minority Affairs and Education as members of the existing State Health Society, State Health Mission, Governing Body and the Executive Committee.
2. State Programme Management Unit (SPMU) under the overall guidance of Mission Director NHM will be responsible for taking important decisions.
3. NUHM will be implemented by existing District Health Society with additional Stakeholders members such as DUDA.
4. NRHM & NUHM would be the two components of the National Health Mission (NHM). Mission Director, National Rural Health Mission would be Mission Director, National Health Mission, comprising both the sub-missions NRHM and NUHM.
5. Urban Health Cell is already in place and functional at the SPMU and at the Directorate Health & Family Welfare. These Cells will be further strengthened once the State PIP is approved. The following comprehensive structure is being proposed for State Urban Health Cell under NUHM:

Structure of State level Urban Health Cell



A position of Joint Director (Urban) exists at the office of Director General H&FW which will continue to support NUHM program implementation. Additional support in the form of HR, infrastructure etc. has also been proposed.

The Urban Health Cell at the state level is working closely with Development Partners for planning of NUHM, particularly Urban Health Initiative and Health of the Urban Poor projects and they will be supporting the state in the rolling out of the NUHM program in the state. Additional partners are being encouraged to support based on their specific expertise and urban presence.

District level

- Government Orders will be issued to the District Health Society for inclusion of Urban Local Bodies and District Urban Development Agency in 75 districts.
- After extensive deliberations the state plans to designate the District Health Society under the chairmanship of the District Magistrate as the implementing authority for NUHM in all 75 districts.
- Fund flow mechanisms have been set up and separate accounts will be opened at the state and in all districts for receiving the NUHM funds.
- Urban Health will be included as a key agenda item for review by the District Health Society with participation of city level urban stakeholders.
- An Additional / Deputy CMO has been designated as the nodal officer for NUHM at the district level. The District Program Management Unit will co-opt implementation of NUHM program in

the district and the District Program Manager will be nodal at DPMU level for NUHM activities . To support this the following additional staff and funds are proposed for strengthening the District Program Management Units for implementing NUHM:

a. Urban Health Coordinator, Accountant and Data Entry Operators according to the following norms:

District total Urban population	Additional Staff Proposed
Less than 1 lakh	1 Data Entry Operator
1lakh to 10lakhs	1 Urban Health Coordinator,1 Accountant and 1 Data Entry Operator
10lakh to 20lakhs	2 Urban Health Coordinator,2 Accountants and 2 Data Entry Operators
20lakh to 30lakhs	3 Urban Health Coordinator , 3 Accountants and 3 Data Entry Operators

b. Total 76 Urban Health Coordinators, 76 Accountants and 76 Data Entry Operators are being proposed in 61 Districts according to above norms. In rest of 14 Districts , 03 Districts (Shrawasti, Chitrakoot, Amethi,) are having population less than 1lakh and other 11 Districts (Barabanki, Siddarthnager, Maharajganj, Kaushambi Sonbadhra, Auraiya, Partapgarh, Kanpur Dehat , Kushinagar, Sant kabir nagar, Balrampur) are although having total district urban population more 1Lakh but in these districts only 01 city per district is being covered under NUHM and these cities are having urban population less than 01 lakh so in these districts only Data entry operators are being proposed to support in NUHM activities.
c. Mobility support as hired vehicle for each Urban Health Coordinator is being proposed.
d. A onetime expense for computers, printer and furniture for the above staff has been budgeted along with the recurring operations expenses.
e. District Programme Manager will be nodal for all NUHM activities so extra incentive and budget for 1 laptop to each DPM has been proposed for DPM
f. Onetime expenses have been budgeted for up-gradation of the office of Additional/ Deputy CMO and District Programme management Unit.

8. Strengthening Service Delivery Infrastructure

Urban-Primary Health Centres (U-PHCs)

Urban Primary Health Centres (U-PHCs) will be the most peripheral fixed health facilities for the urban areas under NUHM and are expected to serve as the first point of contact for the community. These will serve as the source of all primary health care services including preventive promotive and curative health care, providing referrals to the higher level facilities as needed for more specialized and in-patient care. Each U-PHC will cater to approx 50,000 populations with locations that enable access for urban poor communities. The timings for the U-PHCs will be customized to suit the needs of urban populations. IPHS guidelines for PHCs will be followed and quality assurance mechanisms will put in place.

Communication activities will be taken up at the UPHC level for popularising the presence of the UPHC and the special clinics and making the community aware about the timings of doctors' clinics. Signage boards that guide the patients from the main road and key transport hubs to the UPHC will be displayed. Citizens' Charter, Essential Drug List and Immunization Schedule and other entitlements under various government schemes such as JSY and JSSK. Health messages of safe motherhood, child care, family planning and control of common diseases will be displayed at the UPHCs for the community to demand timely and quality health services. Safe Motherhood booklet and Mother Child Protection Cards will be made available at the UPHCs for use by pregnant women. MAS trainings will include the list of services and drugs to be available to the community so that they can advocate for quality services for the urban poor.

Infrastructure for UPHCs

The underlying principal will be to strengthen existing and functional health facilities to convert them into Urban PHCs and new such facilities are being proposed as needed. All facilities catering to a population of 50,000 population henceforth will be called a UPHC. All earlier schemes and terminologies will not be applicable any more.

Suitable health facilities running in other government premises (DUDA, Nagar Nigam, State government building etc) will be attempted to be co-opted and all C & D-type UFWCs, Urban Health Posts and few PPCs will be taken up and the following budget estimates are being proposed –

1. If the building can be renovated, budget of Rs.10,00,000 has been proposed for renovation and up-gradation.
2. If the building is in a dilapidated condition, the UPHC will be run out of a rented premises and rent has accordingly been budgeted for 2013-14. The construction of new building for UPHC will be proposed in subsequent years.

Total Urban Health Posts and Urban Family Welfare centre and PPCs running from State budget, are being proposed for strengthening. 52 Urban Health facilities of health department and 67 Health facilities of DUDA, Nagar Nigam and the Labor Department, totaling to 119 are being proposed for renovation.

For facilities running in rented premises whether supported by NRHM or Government of UP

Those Urban Health Posts funded by State budget which are not within or close to the slums and do not have adequate space for up-gradation to UPHCs will be shifted to other rented premises located within or close to slums.

231Urban Health Posts were funded under Urban RCH in NRHM PIP for 2013-14. These will be upgraded as UPHCs in all districts and budget for HR, rental, medicines, consumables, untied grant.

Detail of Urban Health Facilities to be undertaken under NUHM

Detail of U-PHCs to be strengthened under NUHM 2013-14														
S. No.	District	S.No.	Name	Total Urban Population	Urban Health facility budgeted by State budget	NRHM Budgeted Urban Health Posts	Total Existing	New UPHCs proposed	State Govt Health Facilities		UHPs Budgeted under NRHM		New U-PHCs proposed		Total
									Strengthening for Govt building	Rent for Govt.	Strengthening for NRHM building	Rent for NRHM	Strengthening for NUHM building	Rent for NUHM building	
1	Agra	1	Agra (M Corp.)	1585704	15	9	24	8	5	10	0	9	0	8	32
		2	Aligarh (M Corp.)	874408	7	7	14	4	2	5	0	7	0	4	18
2	Aligarh	3	Atrauli (NPP)	50412	0	0	0	1	0	0	0	0	1	0	1
3	Allahabad	4	Allahabad (M Corp. + OG)	1168385	11	7	18	6	4	7	0	7	0	6	24
		5	Bareilly (M Corp. + OG)	904797	2	5	7	11	1	1	0	5	1	10	18
		6	Faridpur (NPP)	78249	0	0	0	2	0	0	0	0	0	2	2
		7	Baheri (NPP)	68413	0	0	0	1	0	0	0	0	0	1	1
4	Bareilly	8	Aonla (NPP)	55629	0	0	0	1	0	0	0	0	0	1	1
		9	Nagina (NPP)	95246	0	0	0	2	0	0	0	0	0	2	2
		10	Bijnor (NPP)	93297	0	1	1	1	0	0	0	1	0	1	2
		11	Najibabad (NPP)	88535	0	0	0	1	0	0	0	0	1	0	1
		12	Chandpur (NPP)	83441	0	0	0	1	0	0	0	0	1	0	1
		13	Sherkot (NPP)	62226	0	0	0	1	0	0	0	0	0	1	1
		14	Kiratpur (NPP + OG)	61946	0	0	0	1	0	0	0	0	0	1	1
5	Bijnor	15	Seohara (NPP + OG)	53296	0	0	0	1	0	0	0	0	0	1	1

		16	Dhampur (NPP)	50997	0	0	0	1	0	0	0	0	0	1	1
		17	Budaun (NPP)	159285	0	3	3	0	0	0	0	3	0	0	3
		18	Sahaswan (NPP)	66204	0	0	0	1	0	0	0	0	0	1	1
6	Budaun	19	Ujhani (NPP)	62039	0	0	0	1	0	0	0	0	0	1	1
		20	Bulandshahr (NPP + OG)	230024	0	4	4	0	0	0	0	4	0	0	4
		21	Khurja (NPP + OG)	121207	0	0	0	2	0	0	0	0	0	2	2
		22	Sikandrabad (NPP)	81028	0	0	0	1	0	0	0	0	0	1	1
		23	Jahangirabad (NPP)	59858	0	0	0	1	0	0	0	0	0	1	1
7	Bulandshahar	24	Gulaothi (NPP)	50823	0	0	0	1	0	0	0	0	0	1	1
8	Etawah	25	Etawah (NPP)	256838	0	6	6	0	0	0	0	6	0	0	6
9	Farrukhabad	26	Farrukhabad-cum-Fatehgarh (NPP)	276581	0	2	2	3	0	0	0	2	0	3	5
		27	Firozabad (NPP)	604214	2	4	6	6	2	0	0	4	0	6	12
		28	Shikohabad (NPP)	107404	0	0	0	2	0	0	0	0	0	2	2
10	Firozabad	29	Tundla (NPP)	50423	0	0	0	1	0	0	0	0	0	1	1
		30	Noida (CT)	637272	0	1	1	12	0	0	0	1	0	12	13
		31	Greater Noida (CT)	102054	0	0	0	2	0	0	0	0	0	2	2
11	GB Nagar	32	Dadri (NPP)	91189	0	0	0	2	0	0	0	0	0	2	2
		33	Ghaziabad (M Corp.)	1648643	9	10	19	14	0	9	0	10	0	14	33
		34	Loni (NPP)	516082	0	0	0	10	0	0	0	0	0	10	10
		35	Khora (CT)	190005	0	0	0	2	0	0	0	0	0	2	2
		36	Modinagar (NPP)	130325	0	0	0	3	0	0	0	0	0	3	3
12	Ghaziabad	37	Muradnagar (NPP)	95208	0	0	0	2	0	0	0	0	0	2	2
13	Gorakhpur	38	Gorakhpur (M Corp.)	673446	15	8	23	0	0	15	0	8	0	0	23
		39	Hapur (NPP)	262983	0	0	0	5	0	0	0	0	0	5	5
14	Hapur	40	Pilkhuwa (NPP)	83736	0	0	0	2	0	0	0	0	0	2	2

		41	Hardoi (NPP + OG)	197029	0	1	1	3	0	0	0	1	0	3	4
		42	Shahabad (NPP)	80226	0	0	0	1	0	0	0	0	0	1	1
15	Hardoi	43	Sandila (NPP)	58346	0	0	0	1	0	0	0	0	0	1	1
		44	Orai (NPP + OG)	190575	0	2	2	2	0	0	0	2	0	2	4
		45	Jalaun (NPP)	56909	0	0	0	1	0	0	0	0	0	1	1
		46	Konch (NPP)	53412	0	0	0	1	0	0	0	0	0	1	1
16	Jalaun	47	Kalpi (NPP)	51670	0	0	0	1	0	0	0	0	0	1	1
		48	Jhansi (M Corp.)	505693	9	3	12	0	2	7	0	3	0	0	12
17	Jhansi	49	Mauranipur (NPP + OG)	61449	0	0	0	1	0	0	0	0	0	1	1
		50	Amroha (NPP)	198471	0	3	3	1	0	0	0	3	0	1	4
		51	Hasanpur (NPP)	61243	0	0	0	1	0	0	0	0	1	0	1
18	J.P Nagar	52	Gajraula (NP)	55048	0	0	0	1	0	0	0	0	0	1	1
		53	Kannauj (NPP)	84862	0	2	2	0	0	0	0	2	0	0	2
19	Kannauj	54	Chhibramau (NPP)	60986	0	1	1	0	0	0	0	1	0	0	1
20	Kanpur Nagar	55	Kanpur (M Corp. + OG)	2768057	6	13	19	41	6	0	7	6	41	0	60
		56	Lakhimpur (NPP)	151993	0	2	2	1	0	0	0	2	0	1	3
21	Kheri	57	Gola Gokaran Nath (NPP)	60172	0	0	0	1	0	0	0	0	0	1	1
22	Lucknow	58	Lucknow (M Corp.)	2817105	11	26	37	19	8	3	6	20	8	11	56
		59	Mathura (NPP)	349909	0	4	4	3	0	0	0	4	0	3	7
		60	Vrindavan (NPP)	63005	0	0	0	1	0	0	0	0	0	1	1
23	Mathura	61	Kosi Kalan (NPP + OG)	60074	0	0	0	1	0	0	0	0	0	1	1
24	Mau	62	Maunath Bhanjan (NPP)	278745	0	2	2	3	0	0	0	2	0	3	5
		63	Meerut (M Corp.)	1305429	8	11	19	7	5	3	0	11	0	7	26
25	Meerut	64	Mawana (NPP)	81443	0	0	0	1	0	0	0	0	0	1	1

		65	Sardhana (NPP)	58252	0	0	0	1	0	0	0	0	0	1	1
26	Moradabad	66	Moradabad (M Corp.)	887871	13	13	26	0	1	12	0	13	0	0	26
		67	Muzaffarnagar (NPP)	392768	0	2	2	6	0	0	0	2	0	6	8
		68	Khatauli (NPP)	72949	0	0	0	1	0	0	0	0	0	1	1
27	Muzaffarnagar	69	Budhana (NP + OG)	53722	0	0	0	1	0	0	0	0	0	1	1
28	Rae Bareli	70	Rae Bareli (NPP)	191316	0	1	1	3	0	0	0	1	0	3	4
29	Rampur	71	Rampur (NPP)	325313	3	1	4	2	0	3	0	1	0	2	6
		72	Saharanpur (M Corp.)	705478	9	8	17	0	5	4	0	8	0	0	17
		73	Deoband (NPP)	97037	0	0	0	2	0	0	0	0	0	2	2
30	Saharanpur	74	Gangoh (NPP)	59279	0	0	0	1	0	0	0	0	0	1	1
		75	Shahjahanpur (NPP)	329736	7	3	10	0	0	7	0	3	0	0	10
31	Shahjahanpur	76	Tilhar (NPP)	61444	0	0	0	1	0	0	0	0	0	1	1
		77	Sitapur (NPP)	177234	0	1	1	2	0	0	0	1	0	2	3
		78	Laharpur (NPP)	61990	0	0	0	1	0	0	0	0	0	1	1
		79	Biswan (NPP)	55780	0	0	0	1	0	0	0	0	0	1	1
32	Sitapur	80	Mahmudabad (NPP)	50777	0	0	0	1	0	0	0	0	0	1	1
		81	Unnao (NPP)	177658	0	3	3	0	0	0	0	3	0	0	3
33	Unnao	82	Gangaghat (NPP)	84072	0	0	0	2	0	0	0	0	0	2	2
34	Varanasi	83	Varanasi (M Corp.)	1198491	15	9	24	0	0	15	0	9	0	0	24
		84	Ambedkarnagar (Mcorp+OG)	111447	0	2	2	0	0	0	0	2	0	0	2
35	Ambedkarnagar	85	Ambedkarnagar Tanda	95516	0	1	1	1	0	0	0	1	0	1	2
36	Amethi	86	Amethi(NP)	13849	0	0	0	0	0	0	0	0	0	0	0
37	Auraiya	87	Auraiya (NPP)	87736	0	1	1	0	0	0	0	1	0	0	1
		88	Azamgarh (NPP)	110983	0	1	1	0	0	0	1	0	0	0	1
38	Azamgarh	89	Azam Mubarakpur	70463	0	1	1	0	0	0	0	1	0	0	1

		90	Baghpat Baraut (NPP)	103764	0	1	1	1	0	0	0	1	0	1	2
39	Baghpat	91	Baghpat (NPP)	50310	0	1	1	0	0	0	0	1	0	0	1
40	Bahraich	92	Bahraich (NPP)	186223	0	1	1	2	0	0	0	1	2	0	3
41	Ballia	93	Ballia (NPP)	104424	0	1	1	1	0	0	0	1	0	1	2
42	Balrampur	94	Balrampur (NPP + OG)	82488	0	1	1	0	0	0	0	1	0	0	1
43	Banda	95	Banda (NPP + OG)	160473	0	1	1	0	0	0	0	1	0	0	1
44	Barabanki	96	Nawabganj (NPP + OG)	81486	0	1	1	0	0	0	0	1	0	0	1
45	Basti	97	Basti (NPP)	114657	0	2	2	0	0	0	0	2	0	0	2
46	Chandauli	98	Mughalsarai (NPP)	109650	0	0	0	2	0	0	0	0	0	2	2
47	Chitrakoot	99	Chitrakoot Dham (Karwi) (NPP)	57402	0	1	1	0	0	0	1	0	0	0	1
48	Deoria	100	Deoria (NPP)	129479	0	3	3	0	0	0	0	3	0	0	3
49	Etah	101	Etah (NPP)	118517	0	1	1	1	0	0	0	1	0	1	2
		102	Faizabad (NPP)	165228	0	5	5	0	0	0	0	5	0	0	5
50	Faizabad	103	Ayodhya (NPP)	55890	0	0	0	1	0	0	0	0	1	0	1
51	Fatehpur	104	Fatehpur (NPP)	193193	0	1	1	3	0	0	0	1	0	3	4
52	Ghazipur	105	Ghazipur (NPP + OG)	121020	0	2	2	0	0	0	0	2	0	0	2
53	Gonda	106	Gonda (NPP)	114046	0	2	2	0	0	0	0	2	0	0	2
54	Hamirpur	107	Rath (NPP)	100514	0	1	1	1	0	0	0	1	1	0	2
55	Hathras	108	Hathras (NPP + OG)	143020	0	1	1	2	0	0	0	1	1	1	3
56	Jaunpur	109	Jaunpur (NPP)	180362	0	1	1	2	0	0	0	1	0	2	3
57	Kanpur Dehat	110	Akbarpur (NP)	20445	0	0	0	0	0	0	0	0	0	0	0
58	Kasganj	111	Kasganj (NPP)	101277	0	1	1	1	0	0	0	1	0	1	2
59	Kaushambi	112	Manjhanpur (NP)	16457	0	1	1	0	0	0	0	1	0	0	1
60	Kushinagar	113	Padrauna (NPP)	49723	0	1	1	0	0	0	1	0	0	0	1
61	Lalitpur	114	Lalitpur (NPP)	133305	0	1	1	1	0	0	0	1	0	1	2
62	Maharajganj	115	Maharajganj (NPP)	33930	0	1	1	0	0	0	0	1	0	0	1

63	Mahoba	116	Mahoba (NPP)	95216	0	2	2	0	0	0	0	2	0	0	2
64	Mainpuri	117	Mainpuri (NPP + OG)	136557	0	3	3	0	0	0	1	2	0	0	3
65	Mirzapur	118	Mirzapur-cum-Vindhyachal (NPP)	234871	0	1	1	3	0	0	0	1	0	3	4
66	Pilibhit	119	Pilibhit (NPP)	127988	0	1	1	1	0	0	0	1	1	0	2
		120	Bisalpur (NPP)	73551	0	0	0	1	0	0	0	0	0	1	1
67	Pratapgarh	121	Bela Pratapgarh (NPP)	76133	0	1	1	0	0	0	0	1	0	0	1
68	Sambhal	122	Chandausi (NPP)	114383	0	0	0	2	0	0	0	0	0	2	2
		123	Sambhal (NPP)	220813	0	0	0	3	0	0	0	0	0	3	3
69	Sant Kabir Nagar	124	Khalilabad (NPP)	47847	0	2	2	0	0	0	0	2	0	0	2
70	Bhadohi (NPP)	125	Bhadohi (NPP)	94620	0	1	1	0	0	0	0	1	0	0	1
71	Shamli	126	Shamli (NPP)	107266	0	0	0	2	0	0	0	0	0	2	2
		127	Kairana (NPP)	89000	0	0	0	1	0	0	0	0	0	1	1
72	Shrawasti	128	Bhinga (NP)	23780	0	0	0	0	0	0	0	0	0	0	0
73	Sidharthnagar	129	Siddharthnagar (NPP)	25422	0	1	1	0	0	0	0	1	0	0	1
74	Sonabhadra	130	Sonbhadra (NPP)	36689	0	1	1	0	0	0	1	0	0	0	1
75	Sultanpur	131	Sultanpur (NPP)	107640	0	2	2	0	0	0	0	2	0	0	2
				3,14,53,923	142	231	373	265	41	101	18	213	60	205	638

- Total Urban population – 3,14,53,923
- Total Urban health functional from State Budget reported by Districts -142 (134 Urban Health Posts and 8 UFWCs)
- Urban Health Posts under Urban RCH under NRHM -231
- Total new Urban Health Posts proposed -265
- No of Govt. health facilities proposed for Up- gradation to U-PHCs- 119 (41 UHPs State budget+ 18 UHPs under NRHM+ 60 new health facilities)
- No of Urban -PHCs proposed in rented buildings- 519(101 UHPs from State budget + 213 under NRHM + 205 new health facilities)
- Total Urban-PHCs proposed - 638

The following staff is proposed for each Urban PHC:

1. 2 Doctors (MBBS) will be hired for each UPHC and will run daily out-patient clinic, ensure supplies and provide overall management.
2. 2 Staff Nurses to support Doctor to run routine OPD and special clinics. It is envisaged that each nurse will be given specific responsibilities for RMNCH, family planning, adolescent, geriatric counselling. They will also support clinical services such as insertion of IUCDs.
3. 1 Lab Technician will conduct the basic lab and diagnostic tests such as Complete Blood Count, blood sugar, urine tests, sputum AFB tests, VDRL, peripheral smear for malaria and other tests as needed.
4. 1 Pharmacist will dispense medicines, administer injections and fluids in case of emergency. He will be responsible for maintaining inventory for equipments, drugs and other commodities.
5. 3 Support staff (1 Ayah, 1 Ward Boy and 1 Sweeper cum *Chowkidar*) who will be responsible for cleanliness and security of the UPHC and the required support to the clinical staff.
6. The Urban Health Coordinators being proposed in the cities/ towns will be responsible for:
    - Supervision of ASHAs.
    - Coordination and oversight for UNHDs.
    - Coordination for outreach sessions to reach out to vulnerable populations.
    - Coordination with local elected representatives for leadership in health.
    - Any activities conducted in campaign mode such as Bal Swasthya Poshan Maah, Pulse Polio rounds, school health, adolescent etc.

Rogi Kalyan Samitis (RKS) will be constituted at each UPHC according to GoI guideline . Members will take the lead in ensuring quality and services to the community as per the guidelines and norms. Each RKS will have a separate account in which the untied grant will be transferred.

Urban-Community Health Centres (U-CHCs)

Urban Community Health Centres (U-CHCs) are envisaged to provide in-patient and specialized care to urban population and are planned for about 2.5 lakh population each. The state proposes to strengthen 8 existing urban hospitals as U-CHCs in the state capital as follows and plan more extensively for U-CHCs in the subsequent years –

Sl. No.	District	Number and names of health facility to be upgraded to U-CHCs
1.	Lucknow	8 Bal Mahila Chiiktsalayas and Prasuti Grahs will be supported with specialist doctors

- Facilities are functional as first referral unit for all UHPs in urban areas of Lucknow city and providing Maternal and child health services . Under NUHM these are being proposed for Up-gradation as U-CHCs by providing specialists, staff nurses, support staff , data assistants and drivers for ambulances and infrastructure strengthening (renovation, computer for each BMC, untied grant and drugs)

9. Strengthening Outreach to urban slums

There is a three pronged strategy for outreach under NUHM:

I. **Intensifying the reach of ANMs**
II. **Urban ASHAs**
III. **Mahila Arogya Samitis (MAS)**
IV. **Urban Health and Nutrition Days**
V. **Outreach Camps**
VI. **School Health Services**
VII. **IEC/BCC Activities**

i) ANMs

The ANMs will be headquartered at the U-PHCs and will cater to a population of about 10,000 each. They will work in close cooperation with the ASHAs and AWWS in their area of coverage and refer for institutional care to U-PHCs, U-CHCs and other hospitals in the cities.

157 ANMs are already posted in some government Urban Health Posts in the urban areas of the cities selected for implementation in 2013-14 and will continue to be paid by the Government of Uttar Pradesh. The remaining ANM posts (05 per UPHC) i.e. 3020 will be hired on the contractual basis as per the details below:

No of ANMs to be recruited under NUHM

Sl.	District	Sl.	Name	Population	Total ANMs required (1 per 10,000 population)	Existing no. of ANMs posted in urban area	Gap based on urban population to be hired on contract	Total ANMs
1	Agra	1	Agra (M Corp.)	1,585,704	159	0	160	160
2	Aligarh	2	Aligarh (M Corp.)	874,408	87	12	78	90
		3	Atrauli (NPP)	50,412	5	0	5	5

3	Allahabad	4	Allahabad (M Corp. + OG)	1,168,385	117	30	90	120
4	Bareilly	5	Bareilly (M Corp. + OG)	904,797	90	11	79	90
		6	Faridpur (NPP)	78,249	8	6	4	10
		7	Baheri (NPP)	68,413	7	0	5	5
		8	Aonla (NPP)	55,629	6	3	2	5
5	Bijnor	9	Nagina (NPP)	95,246	10	0	10	10
		10	Bijnor (NPP)	93,297	9	0	10	10
		11	Najibabad (NPP)	88,535	9	0	5	5
		12	Chandpur (NPP)	83,441	8	0	5	5
		13	Sherkot (NPP)	62,226	6	0	5	5
		14	Kiratpur (NPP + OG)	61,946	6	0	5	5
		15	Seohara (NPP + OG)	53,296	5	0	5	5
		16	Dhampur (NPP)	50,997	5	0	5	5
6	Budaun	17	Budaun (NPP)	159,285	16	0	15	15
		18	Sahaswan (NPP)	66,204	7	0	5	5
		19	Ujhani (NPP)	62,039	6	0	5	5
7	Bulandshahar	20	Bulandshahr (NPP + OG)	230,024	23	0	20	20
		21	Khurja (NPP + OG)	121,207	12	0	10	10
		22	Sikandrabad (NPP)	81,028	8	0	5	5
		23	Jahangirabad (NPP)	59,858	6	0	5	5
		24	Gulaothi (NPP)	50,823	5	0	5	5
8	Etawah	25	Etawah (NPP)	256,838	26	0	30	30
9	Farrukhabad	26	Farrukhabad-cum-Fatehgarh (NPP)	276,581	28	0	25	25
10	Firozabad	27	Firozabad (NPP)	604,214	60	6	54	60
		28	Shikohabad (NPP)	107,404	11	0	10	10
		29	Tundla (NPP)	50,423	5	0	5	5
11	GB Nagar	30	Noida (CT)	637,272	64	0	65	65
		31	Greater Noida (CT)	102,054	10	0	10	10
		32	Dadri (NPP)	91,189	9	0	10	10
12	Ghaziabad	33	Ghaziabad (M Corp.)	1,648,643	165	0	165	165
		34	Loni (NPP)	516,082	52	0	50	50
		35	Khora (CT)	190,005	19	0	10	10
		36	Modinagar (NPP)	130,325	13	0	15	15
		37	Muradnagar (NPP)	95,208	10	0	10	10
13	Gorakhpur	38	Gorakhpur (M Corp.)	673,446	67	0	115	115

14	Hapur	39	Hapur (NPP)	262,983	26	0	25	25
		40	Pilkhuwa (NPP)	83,736	8	0	10	10
15	Hardoi	41	Hardoi (NPP + OG)	197,029	20	0	20	20
		42	Shahabad (NPP)	80,226	8	0	5	5
		43	Sandila (NPP)	58,346	6	0	5	5
16	Jalaun	44	Orai (NPP + OG)	190,575	19	0	20	20
		45	Jalaun (NPP)	56,909	6	0	5	5
		46	Konch (NPP)	53,412	5	0	5	5
		47	Kalpi (NPP)	51,670	5	0	5	5
17	Jhansi	48	Jhansi (M Corp.)	505,693	51	28	32	60
		49	Mauranipur (NPP + OG)	61,449	6	0	5	5
18	JP Nagar	50	Amroha (NPP)	198,471	20	0	20	20
		51	Hasanpur (NPP)	61,243	6	0	5	5
		52	Gajraula (NP)	55,048	6	0	5	5
19	Kannauj	53	Kannauj (NPP)	84,862	8	0	10	10
		54	Chhibramau (NPP)	60,986	6	0	5	5
20	Kanpur Nagar	55	Kanpur (M Corp. + OG)	2,768,057	277	22	278	300
21	Kheri	56	Lakhimpur (NPP)	151,993	15	0	15	15
		57	Gola Gokaran Nath (NPP)	60,172	6	0	5	5
22	Lucknow	58	Lucknow (M Corp.)	2,817,105	282	0	280	280
23	Mathura	59	Mathura (NPP)	349,909	35	10	25	35
		60	Vrindavan (NPP)	63,005	6	0	5	5
		61	Kosi Kalan (NPP + OG)	60,074	6	0	5	5
24	Mau	62	Maunath Bhanjan (NPP)	278,745	28	0	25	25
25	Meerut	63	Meerut (M Corp.)	1,305,429	131	8	122	130
		64	Mawana (NPP)	81,443	8	0	5	5
		65	Sardhana (NPP)	58,252	6	0	5	5
26	Moradabad	66	Moradabad (M Corp.)	887,871	89	0	117	117
27	Muzaffarnagar	67	Muzaffarnagar (NPP)	392,768	39	0	40	40
		68	Khatauli (NPP)	72,949	7	0	5	5
		69	Budhana (NP + OG)	53,722	5	0	5	5
28	Rae Bareli	70	Rae Bareli (NPP)	191,316	19	7	13	20
29	Rampur	71	Rampur (NPP)	325,313	33	0	30	30
30	Saharanpur	72	Saharanpur (M Corp.)	705,478	71	9	76	85
		73	Deoband (NPP)	97,037	10	0	10	10
		74	Gangoh (NPP)	59,279	6	1	4	5

31	Shahjahanpur	75	Shahjahanpur (NPP)	329,736	33	0	50	50
		76	Tilhar (NPP)	61,444	6	0	5	5
32	Sitapur	77	Sitapur (NPP)	177,234	18	0	15	15
		78	Laharpur (NPP)	61,990	6	0	5	5
		79	Biswan (NPP)	55,780	6	0	5	5
		80	Mahmudabad (NPP)	50,777	5	0	5	5
33	Unnao	81	Unnao (NPP)	177,658	18	0	15	15
		82	Gangaghat (NPP)	84,072	8	0	10	10
34	Varanasi	83	Varanasi (M Corp.)	1,198,491	120	0	120	120
35	Ambedkarnagar	84	Ambedkarnagar (Mcorp+OG)	111,447	11	0	10	10
		85	Ambedkarnagar Tanda	95,516	10	0	10	10
36	Amethi	86	Amethi(NP)	13,849	1	0	1	1
37	Auraiya	87	Auraiya (NPP)	87,736	9	0	5	5
38	Azamgarh	88	Azamgarh (NPP)	110,983	11	0	5	5
		89	Azam Mubarakpur	70,463	7	0	5	5
39	Baghpat	90	Baghpat (NPP)	50,310	5	0	5	5
		91	Baghpat Baraut (NPP)	103,764	10	0	10	10
40	Bahraich	92	Bahraich (NPP)	186,223	19	0	15	15
41	Ballia	93	Ballia (NPP)	104,424	10	0	10	10
42	Balrampur	94	Balrampur (NPP + OG)	82,488	8	2	6	8
43	Banda	95	Banda (NPP + OG)	160,473	16	0	8	8
44	Barabanki	96	Nawabganj (NPP + OG)	81,486	8	0	5	5
45	Basti	97	Basti (NPP)	114,657	11	0	10	10
46	Chandauli	98	Mughalsarai (NPP)	109,650	11	0	10	10
47	Chitrakoot	99	Chitrakoot Dham (Karwi) (NPP)	57,402	6	0	5	5
48	Deoria	100	Deoria (NPP)	129,479	13	0	15	15
49	Etah	101	Etah (NPP)	118,517	12	0	10	10
50	Faizabad	102	Faizabad (NPP)	165,228	17	0	25	25
		103	Ayodhya (NPP)	55,890	6	0	5	5
51	Fatehpur	104	Fatehpur (NPP)	193,193	19	0	20	20
52	Ghazipur	105	Ghazipur (NPP + OG)	121,020	12	0	10	10
53	Gonda	106	Gonda (NPP)	114,046	11	0	10	10
54	Hamirpur	107	Rath (NPP)	100,514	10	0	10	10
55	Hathras	108	Hathras (NPP + OG)	143,020	14	0	15	15
56	Jaunpur	109	Jaunpur (NPP)	180,362	18	0	15	15
57	Kanpur Dehat	110	Akbarpur (NP)	20,445	2	0	2	2

58	Kasganj	111	Kasganj (NPP)	101,277	10	0	10	10
59	Kaushambi	112	Manjhanpur (NP)	16,457	2	0	3	3
60	Kushinagar	113	Padrauna (NPP)	49,723	5	0	5	5
61	Lalitpur	114	Lalitpur (NPP)	133,305	13	0	10	10
62	Maharajganj	115	Maharajganj (NPP)	33,930	3	0	3	3
63	Mahoba	116	Mahoba (NPP)	95,216	10	0	10	10
64	Mainpuri	117	Mainpuri (NPP + OG)	136,557	14	0	15	15
65	Mirzapur	118	Mirzapur-cum-Vindhyachal (NPP)	234,871	23	2	18	20
66	Pilibhit	119	Pilibhit (NPP)	127,988	13	0	10	10
		120	Bisalpur (NPP)	73,551	7	0	5	5
67	Pratapgarh	121	Bela Pratapgarh (NPP)	76,133	8	0	5	5
68	Sambhal	122	Sambhal (NPP)	220,813	22	0	15	15
		123	Chandausi (NPP)	114,383	11	0	10	10
69	Sant Kabir Nagar	124	Khalilabad (NPP)	47,847	5	0	6	6
70	Bhadohi (NPP)	125	Bhadohi (NPP)	94,620	9	0	5	5
71	Shamli	126	Shamli (NPP)	107,266	11	0	10	10
		127	Kairana (NPP)	89,000	9	0	5	5
72	Shrawasti	128	Bhinga (NP)	23,780	2	0	2	2
73	Sidharthnagar	129	Siddharthnagar (NPP)	25,422	3	0	2	2
74	Sonabhadra	130	Sonbhadra (NPP)	36,689	4	0	5	5
75	Sultanpur	131	Sultanpur (NPP)	107,640	11	0	10	10
Total				**31,453,923**	**3145**	**157**	**3020**	**3177**

Training of ANMs will be conducted to orient them about their role in the urban areas, reaching out to slum and vulnerable population, guidelines under major national health programs, screening for common life style diseases, interpersonal skills, infection prevention practices and record keeping. Training modules will be developed for the same and all ANMs in the city will be covered.

The key tasks for the ANM will be:

a) Preventive and Promotive health care to households through outreach, weekly health camps in slums
b) ANC and immunization clinics at the U-PHCs
c) Conduct Urban Health Nutrition Days at AWCs in her area
d) Support ASHA for house of house visits for behaviour change

II) Urban ASHAs

The urban ASHA will work on the pattern of rural ASHA and serve as the link between urban poor and health services. There is an ASHA planned for 200 – 500 slum households each and will be assigned such that all slums are covered. These frontline workers will be trained as per the ASHA training modules. The existing training modules for rural ASHAs and the pool of trainers created already will be used for the same. Any specific content on urban contexts, if created for capacity building of ASHAs, the same shall be included in the training plan and content.

Urban ASHAs will conduct the house listing in their assigned area and record the details of all families, married women of reproductive age, pregnant women and children as per the questionnaires which be prescribed or developed. This will help them build rapport with the community and also gain a good understanding of the health needs in her area. It is expected that the actual population listed by the ASHAs may be higher or lower than the population originally used for planning and ASHA selection and assignment. These will be adjusted over time with the objective of providing complete coverage to the slum residents.

The ASHAs will start providing services once they are trained and have completed the mapping of households and Slum Household Index Register (SHIR). They will then be paid incentives based on their performance for the following activities:

a) Organize Urban Health and Nutrition Days
b) Organize outreach camps
c) Organize monthly meeting of MAS
d) Attend the monthly meeting at UPHC
e) Organize community meeting for strengthening preventive and promotive aspects
f) Maintain records as per norms like SHIR, meeting minutes, outreach camp register
g) Additional immunization incentives for achieving complete immunization in her area
h) Incentives built in schemes such as JSY, RNTCP, NVBDCP, Family Planning, Home based newborn care etc.

III) Mahila Arogya Samitis (MAS)

Mahila Arogya Samitis will function as empowered groups of women that will enable the urban poor communities to access their health entitlements under the various government schemes. Each MAS will consist of 10-12 women from about 50-100 households with an elected chairperson, treasurer and will be supported by the ASHA. MAS will serve as catalysts for behaviour change in communities in their area for practising healthy behaviours and accessing

preventive, promotive and curative health services. They will also advocate with the government system for accessible and quality health care for urban poor. Capacity of existing community based institutions will be built to evolve to MAS and if needed new MAS can be set up.

The state will orient and train MAS in priority cities and will provide an annual untied grant of Rs.5000 to each MAS for mobilization, sanitation and hygiene and emergency health care needs. This will serve as seed money for a revolving fund to be managed by the MAS. The MAS will work closely with the ASHA in the area and serve to improve the health indicators in their area.

No of Urban ASHAs and MAS proposed by city :

Sl.	District	Sl.	Name	Population	Urban Slum population (In Lakhs)	Number of MAS 2013-14	Number of ASHAs 2013-14
1	Agra	1	Agra (M Corp.)	1,585,704	1,250,000	1246	623
2	Aligarh	2	Aligarh (M Corp.)	874,408	780,000	780	390
		3	Atrauli (NPP)	50,412	50,400	50	25
3	Allahabad	4	Allahabad (M Corp. + OG)	1,168,385	680,000	680	340
4	Bareilly	5	Bareilly (M Corp. + OG)	904,797	338,005	340	170
		6	Faridpur (NPP)	78,249	18,360	18	9
		7	Baheri (NPP)	68,413	68,410	68	34
		8	Aonla (NPP)	55,629	26,235	26	13
5	Bijnor	9	Nagina (NPP)	95,246	26,935	26	13
		10	Bijnor (NPP)	93,297	34,480	40	20
		11	Najibabad (NPP)	88,535	15,835	16	8
		12	Chandpur (NPP)	83,441	14,400	14	7
		13	Sherkot (NPP)	62,226	11,130	12	6
		14	Kiratpur (NPP + OG)	61,946	14,500	16	8
		15	Seohara (NPP + OG)	53,296	14,840	16	8
		16	Dhampur (NPP)	50,997	9,590	10	5
6	Budaun	17	Budaun (NPP)	159,285	106,000	106	53
		18	Sahaswan (NPP)	66,204	22,000	22	11
		19	Ujhani (NPP)	62,039	16,560	16	8
7	Bulandshahar	20	Bulandshahr (NPP + OG)	230,024	113,000	112	56
		21	Khurja (NPP + OG)	121,207	98,000	98	49
		22	Sikandrabad (NPP)	81,028	45,150	44	22

		23	Jahangirabad (NPP)	59,858	27,800	28	14
		24	Gulaothi (NPP)	50,823	26,600	26	13
8	Etawah	25	Etawah (NPP)	256,838	49,040	74	37
9	Farrukhabad	26	Farrukhabad-cum-Fatehgarh (NPP)	276,581	190,000	182	91
10	Firozabad	27	Firozabad (NPP)	604,214	387,000	388	194
		28	Shikohabad (NPP)	107,404	24,425	24	12
		29	Tundla (NPP)	50,423	25,000	20	10
11	GB Nagar	30	Noida (CT)	637,272	554,000	554	277
		31	Greater Noida (CT)	102,054	253,000	264	132
		32	Dadri (NPP)	91,189	144,000	144	72
12	Ghaziabad	33	Ghaziabad (M Corp.)	1,648,643	403,045	406	203
		34	Loni (NPP)	516,082	106,155	106	53
		35	Khora (CT)	190,005	30,000	30	15
		36	Modinagar (NPP)	130,325	21,500	22	11
		37	Muradnagar (NPP)	95,208	5,000	6	3
13	Gorakhpur	38	Gorakhpur (M Corp.)	673,446	450,000	616	308
14	Hapur	39	Hapur (NPP)	262,983	100,000	92	46
		40	Pilkhuwa (NPP)	83,736	45,000	46	23
15	Hardoi	41	Hardoi (NPP + OG)	197,029	53,000	54	27
		42	Shahabad (NPP)	80,226	7,500	6	3
		43	Sandila (NPP)	58,346	9,000	8	4
16	Jalaun	44	Orai (NPP + OG)	190,575	53,000	54	27
		45	Jalaun (NPP)	56,909	7,500	18	9
		46	Konch (NPP)	53,412	10,000	16	8
		47	Kalpi (NPP)	51,670	7,500	14	7
17	Jhansi	48	Jhansi (M Corp.)	505,693	211,550	210	105
		49	Mauranipur (NPP + OG)	61,449	32,000	22	11
18	JP Nagar	50	Amroha (NPP)	198,471	62,500	62	31
		51	Hasanpur (NPP)	61,243	37,500	38	19
		52	Gajraula (NP)	55,048	31,500	32	16
19	Kannauj	53	Kannauj (NPP)	84,862	15,300	16	8
		54	Chhibramau (NPP)	60,986	13,000	12	6
20	Kanpur Nagar	55	Kanpur (M Corp. + OG)	2,768,057	637,000	650	325

21	Kheri	56	Lakhimpur (NPP)	151,993	12,500	16	8
		57	Gola Gokaran Nath (NPP)	60,172	1,500	2	1
22	Lucknow	58	Lucknow (M Corp.)	2,817,105	1,097,710	1132	566
23	Mathura	59	Mathura (NPP)	349,909	282,285	282	141
		60	Vrindavan (NPP)	63,005	63,000	8	4
		61	Kosi Kalan (NPP + OG)	60,074	10,625	12	6
24	Mau	62	Maunath Bhanjan (NPP)	278,745	64,330	64	32
25	Meerut	63	Meerut (M Corp.)	1,305,429	1,150,000	1150	575
		64	Mawana (NPP)	81,443	9,000	10	5
		65	Sardhana (NPP)	58,252	16,000	16	8
26	Moradabad	66	Moradabad (M Corp.)	887,871	432,500	460	230
27	Muzaffarnagar	67	Muzaffarnagar (NPP)	392,768	115,000	114	57
		68	Khatauli (NPP)	72,949	20,000	20	10
		69	Budhana (NP + OG)	53,722	10,500	10	5
28	Rae Bareli	70	Rae Bareli (NPP)	191,316	60,000	56	28
29	Rampur	71	Rampur (NPP)	325,313	125,000	124	62
30	Saharanpur	72	Saharanpur (M Corp.)	705,478	302,500	400	200
		73	Deoband (NPP)	97,037	33,000	34	17
		74	Gangoh (NPP)	59,279	21,000	22	11
31	Shahjahanpur	75	Shahjahanpur (NPP)	329,736	218,460	220	110
		76	Tilhar (NPP)	61,444	41,100	42	21
32	Sitapur	77	Sitapur (NPP)	177,234	33,450	34	17
		78	Laharpur (NPP)	61,990	3,820	6	3
		79	Biswan (NPP)	55,780	32,250	32	16
		80	Mahmudabad (NPP)	50,777	11,955	12	6
33	Unnao	81	Unnao (NPP)	177,658	43,500	44	22
		82	Gangaghat (NPP)	84,072	33,500	36	18
34	Varanasi	83	Varanasi (M Corp.)	1,198,491	569,740	570	285
35	Ambedkarnagar	84	Ambedkarnagar (Mcorp+OG)	111,447	15,000	22	11
		85	Ambedkarnagar Tanda	95,516	50,000	48	24
36	Amethi	86	Amethi(NP)	13,849	7,000	8	4
37	Auraiya	87	Auraiya (NPP)	87,736	-	0	0
38	Azamgarh	88	Azamgarh (NPP)	110,983	46,000	46	23

		89	Azam Mubarakpur	70,463	32,000	32	16
39	Baghpat	90	Baghpat (NPP)	50,310	87,000	8	4
		91	Baghpat Baraut (NPP)	103,764	68,000	68	34
40	Bahraich	92	Bahraich (NPP)	186,223	75,000	74	37
41	Ballia	93	Ballia (NPP)	104,424	67,000	68	34
42	Balrampur	94	Balrampur (NPP + OG)	82,488	36,000	40	20
43	Banda	95	Banda (NPP + OG)	160,473	12,000	12	6
44	Barabanki	96	Nawabganj (NPP + OG)	81,486	7,500	8	4
45	Basti	97	Basti (NPP)	114,657	54,500	56	28
46	Chandauli	98	Mughalsarai (NPP)	109,650	23,000	24	12
47	Chitrakoot	99	Chitrakoot Dham (Karwi) (NPP)	57,402	11,000	12	6
48	Deoria	100	Deoria (NPP)	129,479	61,000	64	32
49	Etah	101	Etah (NPP)	118,517	35,000	36	18
50	Faizabad	102	Faizabad (NPP)	165,228	40,000	40	20
		103	Ayodhya (NPP)	55,890	26,500	30	15
51	Fatehpur	104	Fatehpur (NPP)	193,193	63,000	76	38
52	Ghazipur	105	Ghazipur (NPP + OG)	121,020	60,000	60	30
53	Gonda	106	Gonda (NPP)	114,046	9,000	10	5
54	Hamirpur	107	Rath (NPP)	100,514	23,000	24	12
55	Hathras	108	Hathras (NPP + OG)	143,020	61,000	60	30
56	Jaunpur	109	Jaunpur (NPP)	180,362	15,000	18	9
57	Kanpur Dehat	110	Akbarpur (NP)	20,445	10,000	16	8
58	Kasganj	111	Kasganj (NPP)	101,277	32,000	32	16
59	Kaushambi	112	Manjhanpur (NP)	16,457	2,025	6	3
60	Kushinagar	113	Padrauna (NPP)	49,723	25,000	22	11
61	Lalitpur	114	Lalitpur (NPP)	133,305	50,000	6	3
62	Maharajganj	115	Maharajganj (NPP)	33,930	26,500	26	13
63	Mahoba	116	Mahoba (NPP)	95,216	37,000	38	19
64	Mainpuri	117	Mainpuri (NPP + OG)	136,557	84,000	84	42
65	Mirzapur	118	Mirzapur-cum-Vindhyachal (NPP)	234,871	58,000	60	30
66	Pilibhit	119	Pilibhit (NPP)	127,988	61,000	62	31
		120	Bisalpur (NPP)	73,551	3,400	6	3
67	Pratapgarh	121	Bela Pratapgarh (NPP)	76,133	8,010	8	4

68	Sambhal	122	Sambhal (NPP)	220,813	37,000	36	18
		123	Chandausi (NPP)	114,383	39,000	40	20
69	Sant Kabir Nagar	124	Khalilabad (NPP)	47,847	6,100	8	4
70	Bhadohi (NPP)	125	Bhadohi (NPP)	94,620	36,000	36	18
71	Shamli	126	Shamli (NPP)	107,266	43,000	44	22
		127	Kairana (NPP)	89,000	10,000	10	5
72	Shrawasti	128	Bhinga (NP)	23,780	4,950	6	3
73	Sidharthnagar	129	Siddharthnagar (NPP)	25,422	25,000	24	12
74	Sonabhadra	130	Sonbhadra (NPP)	36,689	32,000	32	16
75	Sultanpur	131	Sultanpur (NPP)	107,640	76,533	90	45
Total				**31,453,923**	**14,288,488**	**14560**	**7,280**

In year 2013-14, out of 5 MAS per ASHA , only 2 MAS per ASHA have been proposed .

IV) Urban Health Sanitation and Nutrition Days

Urban Health and Nutrition Days will be organized at each Anganwadi center at least once a month. UHNDs will be organized by close coordination between Anganwadi worker, ASHA and ANM and provide services at the doorstep of the urban slum community. In case there are no Anganwadi centers, the ANM can find a common place in the community to conduct the UHND in coordination with the ASHA. The services will include the following:

1. Early registration of pregnancies, antenatal care for pregnant women including IFA, TT, BP, counselling for nutrition during pregnancy, birth preparedness and ANC check-up
2. Screening and referrals of high risk pregnancies
3. Creating awareness about government schemes such as JSY and JSSK and promoting institutional deliveries
4. Routine immunization for children including Vitamin A administration
5. Treatment of minor ailments including diarrhoea and ARI among children
6. Growth Monitoring for children under six years for early identification of malnourished children and counselling and referral as needed
7. Counselling for IYCF, care during pregnancy, family planning
8. Distribution of condoms and pills, counselling for IUCD and ligation to women who have completed their families
9. IFA supplementation and deworming for adolescents

10. Awareness about safe drinking water and sanitation practices, distribution of chlorine tablets as needed

Supplies for UHNDs will be procured and supplied by the UPCs where the ANM is based. The ANM can refer cases that need medical attention to the UPHC OPD or the special clinics being run there. The reports generate from the UHNDs will be included in the UPHC performance and all pregnant women registered will be entered in MCTS by HMIS/ MCTS Operator based on the information provided by the ANM after each UHND..

V) Outreach Camps

Special Outreach Camps will be planned with two main objectives:

a. Reach out to vulnerable populations/ slums that are may not access services at UPHCs or UHNDs such as the homeless, rag pickers, street children, rickshaw pullers, constructions, brick and lime kiln workers, sex workers and other temporary migrants with health services that are responsive to their special health needs.
b. Provide more specialised health care services closer to the community for specific preventive and promotive care based on epidemiological and population needs. Some examples of such activities include:
    i. Chronic Lung diseases in factories
    ii. Skin cancer screening in industries where there is exposure to carcinogenic agents
    iii. Screening and treatment for RTIs and STIs among sex workers
    iv. Screening and referral for cataract among the elderly
    v. Screening and referral for TB among high risk populations
    vi. Screening and treatment for vector borne diseases such as malaria, dengue, Japanese Encephalitis, Acute Encephalitic Syndrome in and after the monsoons.

A panel of specialists comprising of various specialists such as gynaecologists, paediatricians, general physicians, ophthalmologists, dermatologists, chest physicians, epidemiological and occupational diseases will be developed at the city level. As per the need required specialists will be engaged for outreach camps.

The human resource and supplies will be provided for special outreach camps based on the objective and the target population planned to be served. The ANM will take lead in overall organization of the special outreach camps in her area with support from the Urban Health

Coordinator. Specialists from the specialists panel created at the city level will be used for these outreach camps and additional specialists may be hired if needed. Reports for these special outreach camps will be compiled as part of the UPHC performance and reported.

No. Of UHNDs and outreach camps proposed by Cities

Sl. No.	District	Sl.no	Name	Population	Urban Slum population	No. of UHNDs planned	No. of special outreach camps
1	Agra	1	Agra (M Corp.)	1585704	1250000	1250	160
		2	Aligarh (M Corp.)	874408	780000	780	88
2	Aligarh	3	Atrauli (NPP)	50412	50400	50	6
3	Allahabad	4	Allahabad (M Corp. + OG)	1168385	680000	680	116
		5	Bareilly (M Corp. + OG)	904797	338005	338	90
		6	Faridpur (NPP)	78249	18360	18	8
		7	Baheri (NPP)	68413	68410	68	7
4	Bareilly	8	Aonla (NPP)	55629	26235	26	5
		9	Nagina (NPP)	95246	26935	27	10
		10	Bijnor (NPP)	93297	34480	74	9
		11	Najibabad (NPP)	88535	15835	16	8
		12	Chandpur (NPP)	83441	14400	14	8
		13	Sherkot (NPP)	62226	11130	11	6
		14	Kiratpur (NPP + OG)	61946	14500	15	6
		15	Seohara (NPP + OG)	53296	14840	15	6
5	Bijnor	16	Dhampur (NPP)	50997	9590	10	6
		17	Budaun (NPP)	159285	106000	126	16
		18	Sahaswan (NPP)	66204	22000	22	7
6	Budaun	19	Ujhani (NPP)	62039	16560	17	6
		20	Bulandshahr (NPP + OG)	230024	113000	133	23
		21	Khurja (NPP + OG)	121207	98000	98	12
		22	Sikandrabad (NPP)	81028	45150	45	8
		23	Jahangirabad (NPP)	59858	27800	28	6
7	Bulandshahar	24	Gulaothi (NPP)	50823	26600	27	5
8	Etawah	25	Etawah (NPP)	256838	49040	49	26
9	Farrukhabad	26	Farrukhabad-cum-Fatehgarh (NPP)	276581	190000	190	28
		27	Firozabad (NPP)	604214	387000	487	60
		28	Shikohabad (NPP)	107404	24425	24	10
10	Firozabad	29	Tundla (NPP)	50423	25000	25	5
		30	Noida (CT)	637272	554000	554	88
		31	Greater Noida (CT)	102054	253000	253	151
11	GB Nagar	32	Dadri (NPP)	91189	144000	144	53
12	Ghaziabad	33	Ghaziabad (M Corp.)	1648643	403045	403	168

		34	Loni (NPP)	516082	106155	150	52
		35	Khora (CT)	190005	30000	30	20
		36	Modinagar (NPP)	130325	21500	22	13
		37	Muradnagar (NPP)	95208	5000	112	10
13	Gorakhpur	38	Gorakhpur (M Corp.)	673446	450000	450	67
		39	Hapur (NPP)	262983	100000	100	26
14	Hapur	40	Pilkhuwa (NPP)	83736	45000	45	8
		41	Hardoi (NPP + OG)	197029	53000	53	20
		42	Shahabad (NPP)	80226	7500	20	8
15	Hardoi	43	Sandila (NPP)	58346	9000	20	6
		44	Orai (NPP + OG)	190575	53000	113	19
		45	Jalaun (NPP)	56909	7500	10	6
		46	Konch (NPP)	53412	10000	10	5
16	Jalaun	47	Kalpi (NPP)	51670	7500	10	5
		48	Jhansi (M Corp.)	505693	211550	212	51
17	Jhansi	49	Mauranipur (NPP + OG)	61449	32000	32	6
		50	Amroha (NPP)	198471	62500	123	20
		51	Hasanpur (NPP)	61243	37500	38	6
18	JP Nagar	52	Gajraula (NP)	55048	31500	40	6
		53	Kannauj (NPP)	84862	15300	15	8
19	Kannauj	54	Chhibramau (NPP)	60986	13000	13	0
20	Kanpur Nagar	55	Kanpur (M Corp. + OG)	2768057	637000	637	277
		56	Lakhimpur (NPP)	151993	12500	13	16
21	Kheri	57	Gola Gokaran Nath (NPP)	60172	1500	10	6
22	Lucknow	58	Lucknow (M Corp.)	2817105	1097710	1098	282
		59	Mathura (NPP)	349909	282285	282	35
		60	Vrindavan (NPP)	63005	63000	63	6
23	Mathura	61	Kosi Kalan (NPP + OG)	60074	10625	11	6
24	Mau	62	Maunath Bhanjan (NPP)	278745	64330	114	28
		63	Meerut (M Corp.)	1305429	1150000	1150	130
		64	Mawana (NPP)	81443	9000	69	8
25	Meerut	65	Sardhana (NPP)	58252	16000	16	6
26	Moradabad	66	Moradabad (M Corp.)	887871	432500	490	88
		67	Muzaffarnagar (NPP)	392768	115000	115	40
		68	Khatauli (NPP)	72949	20000	20	8
27	Muzaffarnagar	69	Budhana (NP + OG)	53722	10500	11	6
28	Rae Bareli	70	Rae Bareli (NPP)	191316	60000	66	20
29	Rampur	71	Rampur (NPP)	325313	125000	225	33
		72	Saharanpur (M Corp.)	705478	302500	353	70
		73	Deoband (NPP)	97037	33000	33	10
30	Saharanpur	74	Gangoh (NPP)	59279	21000	21	6
31	Shahjahanpur	75	Shahjahanpur (NPP)	329736	218460	218	33

		76	Tilhar (NPP)	61444	41100	41	6
		77	Sitapur (NPP)	177234	33450	33	18
		78	Laharpur (NPP)	61990	3820	4	5
		79	Biswan (NPP)	55780	32250	32	5
32	Sitapur	80	Mahmudabad (NPP)	50777	11955	12	5
		81	Unnao (NPP)	177658	43500	74	18
33	Unnao	82	Gangaghat (NPP)	84072	33500	34	8
34	Varanasi	83	Varanasi (M Corp.)	1198491	569740	770	120
		84	Ambedkarnagar (Mcorp+OG)	111447	15000	42	4
35	Ambedkarnagar	85	Ambedkarnagar Tanda	95516	50000	50	2
36	Amethi	86	Amethi(NP)	13849	7000	7	1
37	Auraiya	87	Auraiya (NPP)	87736	0	0	0
		88	Azamgarh (NPP)	110983	46000	46	2
38	Azamgarh	89	Azam Mubarakpur	70463	32000	32	1
		90	Baghpat (NPP)	50310	87000	68	1
39	Baghpat	91	Baghpat Baraut (NPP)	103764	68000	87	2
40	Bahraich	92	Bahraich (NPP)	186223	75000	75	7
41	Ballia	93	Ballia (NPP)	104424	67000	67	10
42	Balrampur	94	Balrampur (NPP + OG)	82488	36000	36	8
43	Banda	95	Banda (NPP + OG)	160473	12000	62	5
44	Barabanki	96	Nawabganj (NPP + OG)	81486	7500	8	2
45	Basti	97	Basti (NPP)	114657	54500	55	5
46	Chandauli	98	Mughalsarai (NPP)	109650	23000	23	2
47	Chitrakoot	99	Chitrakoot Dham (Karwi) (NPP)	57402	11000	11	2
48	Deoria	100	Deoria (NPP)	129479	61000	61	12
49	Etah	101	Etah (NPP)	118517	35000	35	2
		102	Faizabad (NPP)	165228	40000	40	5
50	Faizabad	103	Ayodhya (NPP)	55890	26500	27	2
51	Fatehpur	104	Fatehpur (NPP)	193193	63000	63	2
52	Ghazipur	105	Ghazipur (NPP + OG)	121020	60000	60	4
53	Gonda	106	Gonda (NPP)	114046	9000	9	1
54	Hamirpur	107	Rath (NPP)	100514	23000	23	2
55	Hathras	108	Hathras (NPP + OG)	143020	61000	217	10
56	Jaunpur	109	Jaunpur (NPP)	180362	15000	200	8
57	Kanpur Dehat	110	Akbarpur (NP)	20445	10000	23	2
58	Kasganj	111	Kasganj (NPP)	101277	32000	32	2
59	Kaushambi	112	Manjhanpur (NP)	16457	2025	18	0
60	Kushinagar	113	Padrauna (NPP)	49723	25000	25	3
61	Lalitpur	114	Lalitpur (NPP)	133305	50000	50	3
62	Maharajganj	115	Maharajganj (NPP)	33930	26500	27	1
63	Mahoba	116	Mahoba (NPP)	95216	37000	37	4

64	Mainpuri	117	Mainpuri (NPP + OG)	136557	84000	84	5
65	Mirzapur	118	Mirzapur-cum-Vindhyachal (NPP)	234871	58000	58	8
66	Pilibhit	119	Pilibhit (NPP)	127988	61000	61	4
		120	Bisalpur (NPP)	73551	3400	10	3
67	Pratapgarh	121	Bela Pratapgarh (NPP)	76133	8010	8	1
68	Sambhal	122	Sambhal (NPP)	220813	37000	37	10
		123	Chandausi (NPP)	114383	39000	39	4
69	Sant Kabir Nagar	124	Khalilabad (NPP)	47847	6100	6	0
70	Bhadohi (NPP)	125	Bhadohi (NPP)	94620	36000	36	5
71	Shamli	126	Shamli (NPP)	107266	43000	43	1
		127	Kairana (NPP)	89000	10000	10	1
72	Shrawasti	128	Bhinga (NP)	23780	4950	5	0
73	Sidharthnagar	129	Siddharthnagar (NPP)	25422	25000	25	0
74	Sonabhadra	130	Sonbhadra (NPP)	36689	32000	32	0
75	Sultanpur	131	Sultanpur (NPP)	107640	76533	77	2
Total in a Month						**15797**	**3033**
Total in Six Month				**31453923**	**14288488**	**94782**	**18198**

VI) School Health Services

School health programme under NUHM will be an important component to provide not only the preventive and curative services to children in overall health development of the urban communities.

These 64 teams have been formed to implement the School Health Program on the basis of the number of government primary schools and have not been adopted by all the districts, depending upon their capacities.

Teams comprising of a Doctor, ANM/ GNM and an Ophthalmic Assistant who would be provided a mobility support and a fund to undertake their identified activities to undertake the following major services –

- General health check-up including eye check-up and provision of free spectacles
- Screening for various diseases
- Referral to higher facilities
- Distribution of IFA and de-worming tab

Team will visit to each primary school twice in a year (6 monthly) as per School health programme guideline under NRHM. Report will be compiled at U-PHC level .

Innovation in School Health Programme in Lucknow: It is envisaged that the active involvement of children in the program will enable them to be change agents for themselves as well as communities by taking home good knowledge and practices in terms of preventive health

care activities. It is planned that children will be engaged through innovative and creative actions to make the learning more entertaining and educative.

The programme also plans to involve children innovatively in preventive health care activities to make them a change agent for themselves and their families and communities.

An activity called **SEEKH** (Systematic Effort to Ensure Knowledge on Health) will be implemented in urban government primary schools for active involvement of children based on two way education and learning package.

Process: To ensure participation of each and every child in proposed activity, the following process and flow is planned for implementation:

- A booklet on primary health information and good health practices will be developed for school going children.
- A school health team will be visit to school for health checkup which will distribute the booklet to students of all the classes who will be required to read the booklet preferably in 45 minutes.
- The reading will be followed by filling up a small questionnaire preferably in 15 minutes.
- All the students participating in the activity will receive a badge with an attractive tagline.
- The top scoring children will be awarded.
- To demonstrate, this initiative will be implemented in select urban schools of Lucknow in 2013-14 and will then be replicated in other schools locally and in other cities.

VII) IEC/BCC Activities

- National Urban Health Mission is new activity so it needs more IEC. To provide information regarding health services and to change in health seeking behaviour in our target population, strong BCC and IEC activities are required.
- To implement the BCC action plan, State realizes the need of establishing a fully functional IEC Bureau under Family Welfare Directorate and IEC cell at SPMU level. GM, NUHM will coordinate with IEC/BCC cell under FW directorate and GM, IEC at SPMU level to implement programmes related activities.

IEC activities at facility and community level:

- **Facility level:** Budget for visibility of U-PHCs and printing of other IEC material has proposed
- **Community level:** Budget for printing of Safe Motherhood Booklet and MCP card and other IEC material for communicable and non communicable disease has been proposed.

- Budget for Wall painting of massage regarding NUHM at each AWC other prominent places for convergence has been proposed.
- Budget for NUHM hoarding (01 hoarding at 50,000 to 1,00,000 urban population) has been proposed .

IEC strategy in Lucknow District:

Health indicators of people living in slums are poor. Demand generation IEC activities would be designed specifically to facilitate behaviour change, particularly for adoption of family planning methods as well as other maternal, child health and adolescent health behaviours that are directly linked to RCH objectives. It is suggested that strategies would;

(a) Focus on IEC for behaviour change in RCH;

(b) Establish linkages, and if necessary, enhance selected activities of other schemes that provide benefit to the project beneficiaries.

State HUP programme officer will support to develop a strategy for IEC/BCC based on the local situation in Lucknow city. Private sector and NGO partnerships for IEC may also be promoted, particularly where potential partners with skills and proven experience and credentials in IEC/BCC are available. The IEC plans would especially focus on interpersonal or group communication plans, include a description of expected behaviour change in different audience segments, and an outline of an IEC plan, with benchmarks for monitoring implementation and estimated budget. IEC plans would focus on building community awareness and knowledge enhancing skills to practice healthy behaviours, and strengthening confidence to access health services.

The department needs to frame aggressive marketing strategies coupled with accessible, friendly and quality health services to draw in more numbers in order to re-establish and counter the non-public sector dominance in the urban health sector. The strategy thus drawn would include a vibrant IEC plan designed specifically to generate demand with the support of existing cadres which would facilitate change in practice and behaviour.

During the year, IEC strategies covering urban contexts would be developed, field tested and then applied to cover RCH. The IEC plans should especially focus on interpersonal or group communication which would include a description of expected behaviour change in different community segments. For effective tracking its implementation, benchmarks and milestones should be developed. Budget for IEC strategy has been proposed in Luknow city health plan.

10. Convergent Actions in NUHM

NUHM will promote both inter-sectoral as well as intra-sectoral convergence to complement resources and efforts for higher population level impact. The convergent actions can be grouped as:-

- Coordination with existing state level health programs and schemes including State AIDS Control Program
- Convergence with other departments and ministries
- Convergence with non-government and academic institutions

NRHM is supporting many programmes for heath improvements for rural populations; some of these also provide benefits and services to the urban populations. These programs have detailed program and financial guidelines, reporting formats and implementation and monitoring systems. NUHM would aim to provide similar benefits to urban populations with a clear focus on health indicators improvement. All programs at the city level will be integrated under the umbrella of the city health plan. The programs that will be integrated include JSY, JSSK, RI, Family Planning, Rashtriya Baal Swasthya Karyakram, Vitamin A supplementation program (BSPM), National Disease Control Programs (RNTCP, IDSP, NVBDCP, NPCB etc.) under the umbrella of City Health Plan are well integrated at all levels.The objective of convergence would be optimal utilization of resources and ensuring availability of all services at one point (U-PHC) thereby, enhancing their utilization by the urban population

NUHM would also strive to revitalize local health traditions and mainstream AYUSH to strengthen the Public Health System at all levels like Co-location of an existing AYUSH dispensary in Urban PHCs/CHCs, wherever feasible.

Coordination with the State AIDS Program will help target urban poor for creating awareness about HIV/AIDS prevention and ensuring easy availability of condoms. Technical support will be sought from SACS for training of nurses in counselling pregnant women for PPTCT of HIV infection and high risk populations for HIV testing at the UPHCs. SACS support will be sought for orientation trainings of ANMs and Medical Officer for HIV/AIDS prevention and RTI / STI diagnoses and treatment. SACS will be called upon to provide technical support for setting up systems for rapid diagnostics for RTIs/STIs and HIV / AIDS as appropriate at the UPHCs. Some of the UPHCs can possibly be evolved to ART centres over time.

Convergence with other departments and ministries

Departments Urban Development and Urban Employment and Poverty Alleviation

Jawaharlal Nehru National Urban Renewal Mission

Jawaharlal Nehru National Urban Renewal Mission is being run by the Department of Urban Development for providing better infrastructure and basic services to urban poor. There are two schemes under its ambit Basic Services to the Urban Poor (BSUP) that strengthens provision of better housing and water sanitation services to the urban poor. As environmental hygiene and safe drinking water can play a crucial role in prevention of many communicable diseases NUHM will work closely with these schemes at the state and city level. City level planning, implementation and monitoring will involve this department closely and it has been included in the State Health Mission, State Health Society and District Health Society. Similarly the City Development Plans (CDPs) of JnNURM cities (Basic Services component) would also be taken into account for avoiding duplication of efforts and resources. Under JnNURM at the city level as part of the City development plans GIS based physical mapping of the slums is being undertaken. The City level planning process would also leverage the GIS based mapping wherever completed. The community centers being created under the Integrated Housing and Slum Development Programmes (IHSDP) will be used as sites for conducting fixed outreach session.

Rajiv Awas Yojana (RAY)

Rajiv Awas Yojana aims at creating a slum free India by bringing existing slums within the formal system and enabling them to avail the same level of basic amenities as the rest of the town. GIS based physical mapping of the slums and the spatial representation of the socio-economic profile of slums (Slum MIS) is being undertaken under RAY. This will be useful for detailed city planning and convergent action.

Department of Urban Employment and Poverty Alleviation is running Swarn Jayanti Shahri Rozgar Yojana (SJSRY) in Uttar Pradesh. The community level structures being proposed under NUHM can be strengthened by effectively aligning them with the SJSRY structures such as Community organizer, Neighbourhood Groups, Development of Women and Children in Urban Areas (DWCUA) Groups and Neighbourhood Committees (NHC).

Department of Child Development and Nutrition

Department of Child Development and Nutrition leads the Integrated Child Development Services Scheme which is the largest government program for addressing malnutrition. The state of Uttar

Pradesh has sanctioned the State Nutrition Mission and is committed to improving maternal and child nutrition indicators in the state. NUHM at the state and city level will collaborate actively at different levels for convergent actions:

Community Level

- UHNDs will be organized at the AWCs by ASHAs, AWWs and ANMs with support of MAS
- ASHAs and AWWs can make joint home visits for counselling for maternal and child health
- ASHAs, MAS and AWWs can hold joint meetings with pregnant and lactating women and women with children under 3 years to discuss care and nutrition during pregnancy, breastfeeding and IYCF
- AWW , MAS and ASHA can work together to update household level information for targeted home visits for behaviour change

City/District Level

District level counterparts of the Department of Child Development and Nutrition are already members of the DHS. NUHM will support regular analysis of urban nutrition indicators and review of activities to improve the same.

State Level

Department of Child Development and Nutrition is already a member of the State Health Society. Officials of SPMU, Directorate of Family Welfare and Department of Child Development and Nutrition will coordinate regularly for planning for improvement for urban maternal and child nutrition indicators. Development partners with technical expertise will be included for support. Necessary guidelines, tools and monitoring formats and mechanisms as needed will be developed /adapted for urban areas and shared with city level NUHM staff.

Department of Primary Education

State level convergence will be sought with the Department of Primary Education to cover the schools with the following activities:

- Health education activities
- Health check-ups of school children and treatment of minor ailments
- Referral for any diseases requiring specialised care or corrective surgery
- Training of teachers for early diagnosis of symptoms

- Creating awareness about safe drinking water and environment sanitation among children and school authorities

Schools in and near the slums will be covered on priority basis and more frequently if needed. Urban Health Coordinator will be responsible for coordinating the school health activities in their area.

Member of Parliament Local Area Development Scheme (MPLADS):

Minister-in-charge for the district is chairperson of the District Health Mission. All Members of Parliament (MPs) and Members of Legislative Assemblies (MLAs) of the constituency are members of the District Health Mission. All these elected representatives and municipal councillors (MCs) can take a leadership role in improving urban health and can specially help in allocating freehold land to the health department for UPHCs and UCHCs.

Role of Urban Local Bodies

NUHM envisions Urban Local Bodies (ULB) to be active partners in planning and management of the urban health programmes. The Draft National Slum Policy reinforces the emphasis in the 74th Constitutional Amendment on de-centralized participatory structures such as Ward Committees and Municipal Planning Committees in support of local initiatives by community groups. This Policy stresses, inter-alia, a priority role for local bodies in the discharge of functions listed in the Twelfth Schedule viz:

- Slum improvement and up-gradation,
- Urban poverty alleviation,
- Regulation of land use and construction of buildings,
- Provision of urban amenities, and
- Public health and sanitation including provision of water supply.

The improvement of physical infrastructure and services such as water supply, drainage and sanitation will support the improvement of health status of urban poor. Urban Local Bodies are important stakeholders in NUHM and are members of the District Health Society. ULBs in some cities are running health facilities and have some health personnel working with them. City level planning will involve ULBs closely for up-gradation of ULB owned and run health facilities to UPHCs and UCHCs as appropriate. ULB owned buildings/ land will be co-opted for building new UPHCs and UCHCs. ULBs have a major role in waste disposal, which is an important health issue for urban areas. ULBs have been the lead for prevention of vector borne diseases by controlling vector breeding by fogging.

Minority Affairs: Convergence with Multisectoral Development Programme Scheme:

Under this scheme districts have been identified which are relatively backward and falling behind the national average in terms of socioeconomic and basic amenities indicators. Districts specific plans have been prepared for provision of better infrastructure for school, sanitation, housing ,drinking water and electricity supply, so in the town covered under MsDP, NUHM will leverage the health infrastructure and Anganwadi Centre created under this programme for provision of health care services to the urban poor population.

11. Public Private Partnership

As evident from various studies, India's public sector health services need major reforms that require active support from private and social sector. There is considerable existing capacity among private providers, which needs to be explored and operationalized. Public Private Partnership (PPP) is clearly a new avenue which is today increasingly being acknowledged by the government as an area of cooperation for developing a healthy society as a whole.

Many states in India such as Tamil Nadu, Karnataka, Andhra Pradesh and West Bengal as well as Uttar Pradesh have successfully implemented PPP Models in Health Sectors. Government of India in its various policy and plan documents (e.g. National Health Policy, 2002; National Commission on Macroeconomics in Health, 2005, Eleventh Five Year Plan 2007-2012, High Level Expert Group on Universal Health Care, 2011), has emphasized the importance by stating the following:

- Desire to utilize private resources for addressing public health goals.
- Liberalization of the insurance sector to provide new avenues for health financing.
- Redefining the role of the state from being just a provider, to being both provider and a financer of health services.

Various National programmes as well as National Rural Health Mission (NRHM) further reiterated the need for partnership with the private sector at the community level and develop specific guidelines for engaging the private sector.

The government hopes that partnership with the private sector would help in:

- Improving health infrastructure in the state (e.g. investment in high end diagnostic facilities),
- Improving the availability of human health resources (e.g. medical colleges, training of nurses and paramedical staff),

- Strengthening quality and capacity of public health system to deliver services (e.g. capacity building, co-location of services),
- Improving access to Government schemes and provides financial protection to the poor (from catastrophic illness).

The state health department has a rich experience of implementing several schemes in collaboration with NGOs for providing curative, promotional and preventive health services under UPHSDP phase 1. These include:

- Contracting out of non-clinical services (initiated under UPHSDP-1)
- Hospital Waste Management (under UPHSDP-1 and NRHM)
- Voucher Scheme for Maternal Health Services (under SIFPSA)
- Mobile Health Clinic for remote areas of the state to be initiated by NRHM
- Emergency Medical Transport Services initiated by NRHM etc.

The state intends to strengthen the existing partnerships with the private sector as well as expand the scope of services that could be brought under the ambit of Public-Private Partnership. The institutional system will also strengthen implementation of existing regulations related to the private sector through providing a policy driven, transparent and efficient administrative support that would reassure the private sector that PPP is a long term strategy in health sector that would protect the interests of all stakeholders.

The main objectives of the PPP (Public Private Partnership) are:

- Promote harmonious and planned growth of the private sector that would be accountable in delivering affordable, quality health services in the state.
- Create conducive climate for private sector investment in creating and augmenting health infrastructure in an accelerated manner.
- Leverage the strengths of the private sector to overcome the weaknesses of the public health system in delivering quality health services to the people of the state, particularly the poor and the underserved sections of the state.
- Leverage the technical and managerial capacity of the private sector to provide cost effective tertiary care services, either from their own premises or by managing government hospitals.
- Leverage the strengths of the NGOs and community based organisations to provide a range of preventive, promotional services at the primary levels.
- Leverage the strengths of indigenous practitioners to improve referral links, and inculcate rational clinical practices.

The National Urban Health Mission explicitly stated *"In view of presence of larger number of private (for profit and not for profit) health service providers in urban areas, public – private partnerships particularly with not for profit service providers will be encouraged.*

NUHM at the state level will also support innovations in public health to address city and population specific needs. However, clear and monitorable Service Level Agreements (SLAs) will have to be developed for engagement with Private Sector.

Broad norms for engaging private partners and NGOs in Strengthening Health Services for the Urban Poor in the state:

- **Strengthen the delivery of services;** Mission will hire the specialist doctors to provide special health services at U-PHC or outreach based on needs on reimbursement basis
- **Potential private partners should be identified and tapped optimally** to improve the quality and health status of urban poor, by capitalizing on the skills of potential partners, encouraging pooling of resources, and supplementing Government's efforts and resources.
- **Appropriate mechanisms for partnering** (or entering into agreement) with the private sector need to be considered, including accreditation methods (for ensuring quality), memorandum of understanding, reporting and monitoring systems etc.
- **Considerable existing capacity among private providers** (NGOs, medical practitioners and other agencies), which would be explored, fruitfully exploited and operationalised.

Presence of active NGOs in several cities in the state presents a unique and powerful opportunity to extend the reach of health services through various ways of outreach and enhancing utilization by raising community demand for the existing services.

- To increase demand and utilization, **involving NGOs in outreach** and referral in the urban poor settings would be a viable option.
- **Establishment of regional diagnostic centers** through public private partnerships (PPP)
- To **develop systems of accrediting private practitioners** for public health goals. These could be for a range of services. Need for transparency in developing protocols, and costs. Community organizations to exercise key role in roll-out of such partnerships. Non Governmental Organizations to build capacity in community organizations to handle such partnerships
- **Strengthening preventive and promotive action for improved health and nutrition** and prevention of diseases at the community level, the State would also provide a framework for pro-active partnership with NGOs/civil society groups

Corporate Social Responsibility (CSR)

Corporate Social Responsibility (CSR) implies that companies go beyond commercial obligations and invest in developmental projects for social, economic and environmental returns.

The Government of India has always been recommending that the corporate sector should play a proactive role in promoting inclusive growth and social and economic development. In this context, The Ministry of Corporate Affairs and the Department of Public Enterprises, Government of India has recently issued guidelines for CSR for the corporate sector and public sector enterprises (PSUs), respectively. To ensure wider coverage of health services, the Government of India has been encouraging the participation of the corporate sector in these efforts. Indeed, the Eleventh Plan specifically recognizes the contribution of the private sector in providing all levels of health care through partnerships with the government.[12]

The government has recommended the allocation of a specific proportion of a company's net profit as the budget for CSR activities; as a result, it is expected that corporate sector enterprises would have large funds available for CSR programs.

Under the recently passed Companies Act 2012, the Government of India has now mandated every company having net worth of rupees of five hundred crore or more, or turnover of rupees one thousand crore or more, or net profit of rupees five crore or more during any financial year, the following provisions under the corporate social responsibility, that: :

- Shall constitute a Corporate Social Responsibility Committee and formulate a CSR policy
- Shall ensure that the company spends, in every financial years, at least two percent of the average net profits of the company made during the three immediately preceding financial years
- Shall give the preference to the local area and area around it where it operates
- Activities which may be included by companies in their corporate social responsibility policies:
    - Eradicating extreme hunger and poverty
    - Promotion of education
    - Promoting gender equality and empowering women
    - Reducing child mortality and improving maternal health
    - Combating human immunodeficiency virus, acquired immune deficiency syndrome, malaria and other diseases
    - Ensuring environmental sustainability

[12] ROLE OF THE CORPORATE SECTOR IN PROMOTING FAMILY HEALTH IN UTTAR PRADESH;RAMNIK AHUJA, DEBASIS BHATTACHARYA, ROOPALI BHARGAVA AND DEEPIKA GANJU; http://medind.nic.in/jah/t10/s1/jaht10s1p119.pdf

- Employment enhancing vocational skills
- Social business projects
- Contribution to the Prime Minister's National Relief Fund or any other fund set up by the Central Government or the State Governments for socio-economic development and relief and funds for the welfare of the Scheduled Castes, the Scheduled Tribes, other backward classes, minorities and women; and
- Such other matters as may be prescribed

The above mandate provides ample opportunities to MoHFW, and State Governments to for leveraging CSR funds and partner with the private and public enterprises to address the Health of the Urban Poor under the aegis of NUHM at state and city level.

Further, the industry associations such as the Confederation of Indian Industry (CII), the Federation of Indian Chambers of Commerce and Industry (FICCI), the Associated Chambers of Commerce and Industry (ASSOCHAM) and Indian Industries Association (IIA) can play a key role in bringing together these CSR efforts to improve the health and health determinants in Uttar Pradesh.

It is noticeable that there are about 1,700 industries located across the state. Of these, 62 are large-scale, 366 are medium-scale and 1,281 are small-scale industries (*Large-scale industries: turnover of* Rs. *1,000 million or more, medium-scale industries: turnover of* Rs. *50 million-1,000 million, small-scale industries: turnover between* Rs. *1 million - 50 million)*[13]

These companies will potentially be roped in to complement state efforts to promote health services in urban areas either by developing joint health initiatives or strengthening the state health services at primary level in the surrounding areas of establishment. Partnering with the corporate sector in Uttar Pradesh can be immensely beneficial in improving health outcomes because they can cover large populations in their surrounding areas by their resources through linkages with existing government health services and they have the potential to leverage the funds to generate infrastructure support as well as deliver services.

12. City Health plans

Decentralized district-based health planning has been done in Uttar Pradesh because of the large inter-district variations. In city health plan urban population of census 2011 is being used and Urban slum population from DUDA , NPSP (HRA household)etc. In the absence of vital data at the district level, the State level estimates are being used for formulating district level plans as well as

[13]Government of Uttar Pradesh, 2008: Infrastructure and Industrial Development Department

setting the milestones thereof. At present, none of the Surveys provide estimates of core vital indicators on fertility and mortality at district level. The National Family Health Survey (NFHS-3, 2005-06) conducted with periodicity of five years focuses on urban and urban poor and these data are old need to be updated for proper planning .There has, therefore, been a surge in demand from various quarters, in recent years, to generate timely and reliable statistics at the district level for informed decision making in the health sector.

13. Training

ULB, Medical and Paramedical staff, Urban ASHAs and MAS will be trained. The trainings will have to be followed by periodic refresher trainings to keep these frontline health workers motivated. NUHM will engage with development organisations to develop the training modules and facilitate the trainings.

14. Monitoring & Evaluation

The M&E systems would also capture qualitative data to understand the complexities in health interventions, undertake periodic process documentation and self evaluation cross learning among the Planning Units to be made more systematic.

The Monitoring and Evaluation framework would be based on triangulation of information. The three components would be Community Based Monitoring, HMIS for reporting and feedback and external evaluations.

15. Base line survey:

The NUHM aims to strengthen the bridge between households, communities, and the government's health and health determinant provisioning system primarily by mobilizing families and communities to more fully engage to avail the services mandated under the mission, to improve household and community health practices, ultimately leading to improved key reproductive, maternal, neonatal and child health (RMNCH) outcomes.

To set benchmarks and assess achievement during the life cycle of the program the state would conduct a baseline household health survey in all the 131 identified and listed cities

Objective of the baseline

1. To assess following prevalent behaviours and practices in various RMNCH and WASH (water, sanitation and hygiene) issues and preferred choice of providers in seeking treatment
2. To understand the health risks and vulnerability situation among urban poor
3. To understand the context of the program for expected behaviour change through addressing those constructs
4. To provide evidence to modify program design and re-strategize for better outcomes, if necessary

The baseline would take into account the Standard Living Index (SLI) with logical representation from slum and non-slum communities and would allocate weight age specifically to household factors and to women and children.

The following factors would be considered in covering the target population -

1. The expected baseline value of key behavioural indicators
2. Possibility to detect the magnitude of desired change
3. Confidence level
4. Statistical power
5. Design effect

Although a deeper and concerted view would be taken at the time of intricate planning before the baseline is conducted centrally by the state, a logical sample size (considering factors of households and women & children) has been drawn for estimating the numbers and costs thereof –

Pop. Range	Sample Size	@ Rs.	Cost per city	Nos. of cities	Amount (Rs.)
Over 5 lakhs	2,000	1,500	30,00,000	16	4,80,00,000
Below 5 lakhs	1,500	1,500	22,50,000	115	25,87,50,000
Total				**131**	**30,67,50,000**

16. State level indicators & targets

Processes & Inputs			
Indicators	**Baseline number**	**Number Proposed (2013-14)**	**Number Achieved (2013-14)**
1. Number of Mahila Arogya Samiti (MAS) to be formed	**0**	**14560**	
2. Number of MAS members to be trained	**0**	**145600**	
3. Number of Accredited Social Health Activists (ASHAs) to be selected and trained	**0**	**7280**	
4. Number of ANMs to be recruited		**3020**	
5. Number of UPHCs to be made operational	**0**	**638**	
6. Number of UCHCs to be made operational	**0**	**8**	
7. No. of RKS to be created at UPHC and UCHC	**0**	**638**	
8. Number of city PMUs to be established (personnel recruited and office space provided)**	**0**	**75**	
9. Number of cities to be covered under NUHM	**0**	**131**	
10. Population to be covered under NUHM**	**0**	**31418465**	
11. No. of slums to be covered under NUHM	**0**	**-**	
12. Slum population to be covered under NUHM**	**0**	**14288488**	

* Year 2013-14 being the baseline year, the indicators for these NUHM components would be zero.

17. Suggestive Activity Plan under NUHM for the state and cities

No.	Activity	Responsibility		Months : October'13 - March'14					
		State level	City level	Oct.	Nov.	Dec	Jan	Feb	Mar
1	**Establishment of Platform for Convergence at state level**								
2	**Preparation & finalization of Guidelines for various urban health systemic and programmatic components**								
3	**Induction of state level staff for Urban Health Cell**								
4	**Induction of city level staff for Urban Health program**								
5	**Meeting of DHS for establishment of City Program Management Committee (UH)**								
6	**Sensitization of new probable members on NUHM**								
7	**Identification of NGOs for their role under NUHM**								
8	**Establishment & orientation of City Program Management Committee (UH)**								
9	**Identification of groups, collectives formed under various govt. programs (like NHG under SJSRY, self help groups etc.) for MAS**								
10	**Organize meetings with women in slums where no groups could be identified**								
11	**Formation and restructuring of groups as per MAS guidelines**								
12	**Orientation of MAS members**								
13	**Selection of ASHAs**								
13a	- Selection of local NGOs for ASHA selection facilitation								
13b	- Listing of local community members as facilitators by NGOs								
13c	- Listing of probable ASHA candidates and finalize selection								
14	**Convergence meeting with govt. stakeholders**								
15	**Mapping & listing exercise (for health facilities and slums)**								

15a	- Mapping of all urban health facilities (public & pvt.) for services								
15b	- Mapping of slums (listed and unlisted)								
15c	- House listing of slums/ poor settlements								
16	**Planning for strengthening of health facilities/ services**								
	- Health Facility Assessment (of public facilities including listing of public facility wise infra & HR requirement)								
17	**Baseline survey of urban poor/ slums (KFAs)**								
	(to determine vulnerability, morbidity pattern & health status)								
18	**Meetings of RKS for all the public health facilities under NUHM**								
19	**Identification of alternate/ suitable locations for UPHCs under various urban devp. Programs**								
20	**Strengthening of public health facilities**								
	- Selection, training and deployment of HR in pub. health facilities								
21	**IEC activities**								
22	**Outreach camps & UHNDs** (from existing UHPs)								
23	**Empanelment of Private Health Facilities for health care provisioning**								
24	**Involvement of CSR activities**								

18. Proposed Health Care Delivery System in Urban Areas of the State

Services	Community level			U-PHC	U-CHC
	U-ASHA & MAS	Urban Health & Nutrition Day(UHND)	Outreach camps		
Maternal Health	Counselling & behaviour changes , mobilization for ANC care	ANC registration, ANC care, identification of danger sign and referral for institutional delivery and follow up	ANC registration, ANC care, identification of danger sign and referral for institutional delivery and follow up	ANC registration, ANC care, identification of danger sign and referral for institutional delivery and follow up, PNC care initial management of complicated delivery cases and referral,	Delivery (normal and complicated), management of complicated maternal and gynae cases , hospitalization & surgical intervention including blood transfusion
Child care	Home based new born care, postnatal visit, counselling for newborn care, exclusive breast feeding , complementary feeding , identification of danger signs, referral and follow-up, distribution of ORS	counselling for newborn care, exclusive breast feeding , complementary feeding , identification of danger signs, referral and follow-up, distribution of ORS, immunization	counselling for newborn care, exclusive breast feeding , complementary feeding , identification of danger signs, referral and follow-up, distribution of ORS, immunization	Diagnosis and treatment of childhood illnesses , referral of acute and chronic illness , identification and referral of neonatal sickness	Management of complicated paediatric/neonatal cases, hospitalization, surgical intervention, blood transfusion
Family Planning	Counselling & distribution of OCPs/CCs/ referral for sterilization, follow-up of contraceptives related complication	Counselling & distribution of OCPs/CCs/ referral for sterilization, follow-up of contraceptives related complication	Counselling & distribution of OCPs/CCs/ referral for sterilization, follow-up of contraceptives related complication	Distribution of OCPs/CCs ,IUD insertion , referral for sterilization, management of contraceptives related complication	Sterilization operation , fertility treatment
RTI/STI	Referral , community level follow-up for ensuring adherence to treatment regime of cases undergoing	Referral , community level follow-up for ensuring adherence to treatment regime of cases undergoing	Referral , community level follow-up for ensuring adherence to treatment regime of cases undergoing	Symptomatic diagnosis and primary treatment and referral of complicated cases	Management of complicated cases , hospitalization

	treatment	treatment	treatment		
Nutrition deficiency disorder	Promotion of exclusive breast feeding, complementary feeding, nutrition supplement to identified children and PW , promotion of iodized salt	Promotion of exclusive breast feeding, complementary feeding, nutrition supplement to identified children and PW , promotion of iodized salt, height and weight measurement, distribution of therapeutic dose of IFA	Promotion of exclusive breast feeding, complementary feeding, nutrition supplement to identified children and PW , promotion of iodized salt, height and weight measurement, distribution of therapeutic dose of IFA, screening of malnourished children and treatment and referral	Diagnosis and treatment of seriously deficient patient , referral of acute deficiency	Management of acute deficiency cases , hospitalization , treatment , rehabilitation of severe under nutrition
National disease control programme	Counselling for practices for vector control and protection	Counselling for practices for vector control and protection	Counselling for practices for vector control and protection, slide collection , testing	Diagnosis and treatment , referral of terminally ill cases	Hospitalization and treatment of terminally ill cases
Chest infection (TB/Asthma)	Symptomatic search and referral for check-up	Symptomatic search and referral for check-up, ensuring adherence to DOTs , other treatment	Symptomatic search and referral for check-up, ensuring adherence to DOTs , other treatment	Diagnosis and treatment , referral of complicated cases	Management of complicated cases
Cardiovascular disease	Symptomatic search and referral	BP measurement , symptomatic search and referral , follow-up of under treatment patients	BP measurement , symptomatic search and referral , follow-up of under treatment patients	Diagnosis and treatment , referral of complicated cases	Management of complicated cases
Diabetes	Symptomatic search and referral	Blood/ urine sugar test , Symptomatic search and referral	Blood/ urine sugar test , Symptomatic search and referral	Diagnosis and treatment , referral of complicated cases	Management of complicated cases
Cancer	Symptomatic search and referral	Symptomatic search and referral	Symptomatic search and referral, first aid	Identification and referral, follow-up of under treatment patie	Diagnosis and treatment ,hospitalization if needed

Trauma care (burns and injuries)		First aid and referral	First aid and referral	First aid emergency , resuscitation ,	Case management and hospitalization , physiotherapy and rehabilitation
Other surgical intervention	Not applicable	Not applicable	Not applicable	Identification and referral	Hospitalization and surgical intervention
Other support services –IEC/BCC, counselling	IPC , wall writing , wall posters , women groups discussion, individual and group counselling	Urban Health and Nutrition day individual and group counselling	Outreach health camps / fairs / special screening camps individual and group counselling	Distribution of health education material patient and attendant counselling	Distribution of health education material patient and attendant counselling
Personal and social hygiene	IEC on hygiene , community mobilization for cleanliness drives, disinfection of water source	IEC on hygiene , community mobilization for cleanliness drives, disinfection of water source	IEC on hygiene , community mobilization for cleanliness drives, disinfection of water source	Not applicable	Not applicable
Diagnostic facility	Not applicable	Blood and urine test by disposable kit	Blood and urine test by disposable kit	Basic laboratory test	Basic and specific laboratory test, X-rays and Ultrasound
Vital Events reporting	Applicable	Applicable	Applicable	Applicable	Applicable

19. Justification of Physical Norms and costs

FMR. Code no.	Component	Unit	No. Of units	Justification of physical norms	Rates	Justification of costs
1	**Planning & Mapping**					
1.1	**Metro cities**	Metro	0	GIS mapping has been done in 38 cities by Urban Development department and 14 cities by RSAC under NRHM of which 11 are common (Total 41 cities) in the remaining 90 cities GIS mapping has been proposed, in which mapping of listed, unlisted slum and health facility mapping will be done.	15 lakhs	(30 Towns/Cities @ Rs 05 Lakhs per cities , 60 Towns / Cities @ Rs 02 Lakhs per city
1.2	**Million+ cities**	10 lakh +cities	7		10 lakhs	
1.3	**Cities (1 lakh to 10 lakh population)**	Cities 1lakh-10 Lakhs	58		05 lakhs	
1.4	**Towns (50,000 to 1 lakh population)**	Cities < 1lac	66		02 lakhs	
2	**Programme Management**	**1 State and 75 Districts**	**76 units**			
2.1	**SPMU & Directorate FW**	State Urban Health Cell	State Urban Cell at SPMU and Directorate FW	Since UP is a big State so urban health cells have been established in SPMU as well as in Directorate FW . Directorate FW will be responsible for implementation and monitoring of the programme	Detailed structure of NUHM cell is in PIP draft under programme management head	Within 6 % of NUHM budget Similar to NRHM norm for Programme management Cost
2.2	**DPMU**	District Urban Health Cell	Strengthening of 75 DPMU and office of Nodal Officer, Urban Health in the form of extra human resource mobility support and operational expenses	**Allocation of HR –** **District having total Urban population more than 20 lakhs (4)** 3 Urban Health Coordinators 3 Accountants 3 Data Entry Operators **District having total Urban population 10 lakhs- 20 lakhs (7)** 2 Urban Health Coordinators 3 Accountants 2 Data Entry Operators	**Proposed Salaries:** UHC salary @ Rs. 30,000/- pm Accountant salary @ Rs. 18,000/- pm DEO salary @ Rs. 10,000/- pm.	Under 6 % of NUHM budget Similar to NRHM norm for Programme management Cost

				District having total Urban population 1 lakh -10 lakhs (50) 1 Urban Health Coordinator 1 Accountant 1 Data Entry Operator **District having total Urban population of towns covered under NUHM below 1 lakh (14)** 1 Data Entry Operator	Incentive to DPM @ Rs 8000/- pm for preparatory activity of NUHM Rs 25000/-pm for hired vehicle for UHC	
2.3	**City PMU**	Not proposed				
3	**Training & Capacity Building**					
3.1	**Orientation of Urban Local Bodies (ULB)**					
	Metro cities	Metro	0	As per census 2011 cities/ towns population orientation in all 131 cities will be done	Rs 5 lakhs	given in PIP framework
	Million+ cities	10 lakh +cities	7		Rs 3 lakhs	
	Cities (1 lakh to 10 lakh population)	cities 1-10 Lakhs	56		Rs 1 lakh	
	Towns (50,000 to 1 lakh population)	Cities < 1lac	68		Rs 0.50 lakh	
3.2	**Training of ANM/ paramedical staff**	ANMs and Staff Nurses (Govt and contractual)	4,466 ANMs and Staff Nurses (2 Staff Nurses and 5 ANMs per U-PHC)	Modules will be prepared and training will be conducted on these modules	Rs 5000 per person per year	given in PIP framework
3.3	**Training of Medical Officers**	Medical officer (Govt and contractual)	1276	Modules will be prepared and training will be conducted on these modules	Rs 10000 per person per year	given in PIP framework
3.5	**Orientation of MAS**	A group of 10-12 Women from the community per 50-100 slum household	14560	Modules will be prepared and training will be conducted on these modules	Rs 10000 per MAS per year	given in PIP framework

3.6	**Selection & Training of ASHA**	Per 200-500 slum household	7280	Modules will be prepared and training will be conducted on these module	Rs 10000 per ASHA per year	given in PIP framework
3.7	**Other Trainings/Orientations**					
3.7.1	**Stakeholders Workshop for Orientation about NUHM**	DUDA, Local Body, ICDS, Education ,NGOs etc	131 Towns/ cities in 75 Districts	All DHQs and towns/cities	Rs 1,00,000 for District HQ and Rs 10,000 for Town /City	Whole day workshop along with technical sessions
3.7.2	**Quarterly Multi-sectoral convergence Meeting**	DUDA, Local Body, ICDS, Education ,NGOs etc	131 Towns/ cities in 75 Districts	All DHQs and towns/cities	Rs 10,000 for DHQ and Rs 5,000 for Towns/cities	Quarterly Multi-sectoral planning and review meetings
3.7.3	**Launch of NUHM**		75 districts	75 districts	Rs 1,00,000 per District	
4	**Strengthening of Health services**					
4.a	**Human resource**	HMIS / MCTS operator, one for 1 UPHC.	638 U-PHCs	1 HMIS/MCTS DEO on each U-PHC for data feeding & reporting	Rs 10,000 pm	As per NRHM norms
4.b	**Infrastructure**	One Computer System ,data card ,storing disk and printer	638 U-PHCs	One Computer System along data card ,storing disk , printer, Computer table, Computer chair, one for 1UPHCs to be used for HMIS / MCTS data entry	Rs 70,000 per U-PHCs one time	Approximate cost under NRHM
4.1	**Outreach services/camps/UHNDs**					
4.1.1	**UHNDs**	01 UHND per month on AWC (Aganwadi centre)	15797 UHNDs per month	ANMs will perform outreach services on each AWC, if AWC are not in city she will conduct 1 Outreach session per month to cover about 1000 slum population	Rs 1500 per UHND	This includes the cost towards tentage and IEC
4.1.2	**Special outreach camps in slums/ vulnerable areas**	One outreach camp per 10,000 urban population per month	3033 sessions per month	Special screening camp and mobile camp to unreached areas	@ Rs.10,000 per outreach camp.	Stated in PIP framework (this include hiring of Doctor, paramedical, Drugs, IEC and mobility to team)

4.2	**ANM/LHV**					
4.2.1	**Salary support for ANM/LHV**	05 ANM per U-PHC	3020 ANMs	Outreach camp & UHND , she will cover 10,000 urban population	Rs 10,000 per month	as per approved norms under NRHM
4.2.2	**Mobility support for ANM/ LHV**	157 Govt. ANMs and 3020 are Contractual ANMs	3177	Mobility support to ANM	Rs 500/month per ANM	all ANMs contractual as well as on government payroll. (as in PIP frame work)
4.3	**Urban PHC (UPHC)**					
4.3.1	**Renovation/up-gradation of existing facility to UPHC**					
4.3.1.1	**For Government owned buildings**	Renovation of Govt. Urban Health Posts to upgrade to a U-PHC (Health , DUDA, Nagar Nigam , Labour)	119 (52 Health Department and 67 from DUDA, Nagar Nigam & Labour deptt.etc)	As per GoI guideline	Rs 10,00,000 (one time)	one time expenditure for building renovation (as in PIP frame work)
4.3.1.2	**For Equipments**	For each U-PHC (Govt. and under NRHM)	638 UPHCs	As per need according to IPHS norm	Rs 3,00,000 per U-PHC	one time activity for UPHCs for purchase of equipments
4.3.2	**Building of new UPHC**					Not proposed
4.3.3	**Operating cost support for running UPHC (other than untied grants and medicines & consumables)**				Rs.20 lakhs per annum per UPHC	As per norms given in framework
4.3.3.1	**Human Resource**					
4.3.3.1.1	**MO salary**	02 M.B.B.S doctor at each U-PHC	1203 MOs on contractual and 73 MOs from Govt.	(after excluding the no of Govt. Medical Officer who are posted in UHPs)	2 MOs per UPHC @ Rs 36,000 pm	as per NRHM norms
4.3.3.1.2	**Salary of paramedical & nursing staff (Staff Nurse/ Lab**	02 Staff Nurses , 01 Pharmacist , 01 Lab Technician at each U-PHC	638 UPHCs	(after excluding the no. of Govt. Workers who are posted in UHP)	2 Staff Nurses per UPHC @ Rs 16,500 pm, 1 Pharmacist per	as per NRHM norms

	Technician/ Pharmacist/ Other)				UPHC @ Rs 16,500 pm; 1 Lab Tech. @ Rs 11,880 pm	
4.3.3.1.3	**Salary of support staff (non clinical staff)**	3 Support staff for 1 UPHC	638 UPHCs	(after excluding the no of Govt. Worker who are posted in UHPs)	Rs 5,000 pm per support staff	as per NRHM norms
4.3.3.1.5	**Office Expenses**	For each UPHC	638 UPHCs	For electricity, water, telephone , stationary etc	Rs 10,000 pm	as estimated
4.3.3.2	**Others (e.g. hiring of premises/mobile PHC)**	For rent of UPHC	519 UPHCs	(Govt. Running in rented building , under NRHM and new U-PHCs	Rs 15000 pm per U-PHCs for 519 UPHCs	It is estimated it will be calculated on DM circle rate
4.3.4	**Untied grants to UPHC**	For each U-PHC	638 UPHCs		Rs 2,50,000 per year	As per PIP framework
4.3.5	**Medicines & Consumables for UPHC**	For each U-PHC	638 UPHCs		Rs.12,50,000per year per UPHC	As per PIP framework
4.4	**Urban CHC (UCHC)**					
4.4.1	**Capital cost support for new UCHC**	Proposed in Lucknow	08 Urban Health Facilities	08 BMCs in Lucknow, for renovation, One Computer System along data card ,storing disk , printer, Computer table, Computer chair and other furniture for Data Assistant Operating cost for ambulances	(Computer with printer @Rs 70000 per BMC (Total 8 computer) + Operational and maintenance of ambulance Rs. 15000/ per month per ambulance for 8 ambulance.	
4.4.2	**Human Resource**	Specialists, Staff Nurses, Support staff, Driver etc.	Specialists and other staff	**Additional support –** Specialists 40 @ 48,000 pm Staff Nurses 24 @ Rs. 16,500 pm, Support staff 48 @ Rs. 5,000 pm, Drivers 24 @ Rs. 8500/-pm Data Assistant 8 @ Rs 10000/-pm Operational cost for Ambulance	As per NRHM norms	The BMCs will functions as U-CHCs

4.4.3	**Untied grants for UCHC**		08 BMCs		Rs 5,00,000	As per PIP framework
4.4.4	**Medicines & Consumables for UCHC**		08 BMCs		Rs 12,50,000	As per PIP framework
4.5	**School Health Programme**					
4.5.1	**Human Resource**	School health team	64 School health teams as proposed in the city/ town PIPs	Max upto 2-3 teams depending upon the need; One team consisting of 1 M.B.B.S doctor, 1 ANM/ GNM & 1 Ophthalmic Assistant	1 doctor @ 36,000 pm 1 ANM/ GNM @ 10,000 pm & 1 Ophthalmic Assistant @ 11,880 pm	As per NRHM norms
4.5.2	**Other School Health services**	01 Hired vehicle to each team	64	one per School Health Team	Rs 25,000 pm,	As per NRHM norms
4.5.3	**Drugs & consumable, contingency**		64	For stationary , School Kit to team , drugs	Rs 8000/ per team per month	As proposed by Districts
4.6	**IEC/BCC**					
4.6.1	**ASHA Kit, Flip Book, Slum HIR, dress to ASHA, Bag, ID, Pen, handouts for community**	To each U-ASHA (after selection and training)	7280	7280 U-ASHAs	Rs 2,000 per ASHA	one time to each U-ASHA
4.6.2	UPHC Citizen's charter, ED List, Immunization Schedule, Signage	To each U-PHC	638	638 U-PHCs	Rs 20,000 per U-PHC	One time to each U-PHC
4.6.3	Safe Motherhood Booklet, MCP Card and other IEC material etc at U-PHC.	To each PW at the time of ANC registration and IEC material to U-PHC for communicable and non communicable disease	9,59,000 PW and 638 U-PHC	1500 sets of MCP Card and Safe Motherhood booklet to be printed per UPHC Safe Motherhood, Booklet, MCP Card and IEC material for U-PHC (GoI Prototype of these booklet and Immunization card and IEC material on communicable and non communicable diseases will be provided to districts	Rs.37/- per booklet and MCP card Rs 30,000/- for per U-PHC for printing of other IEC material @ Rs 3/- per household on communicable and non	Booklet cost form open market , Card cost as per NRHM norms (Districts will print these booklet and cards and IEC material either by tender or by open market survey)

					communicable diseases	
4.6.4	Family Health Card	To each slum household	28,34,817	Family Health Card to be printed for all slum households (Prototype will be provided to districts)	Estimated cost Rs 10/- per card	Districts will print these cards either by tender or by open market survey
4.6.5	Communication material and wall painting at AWCs	For each AWC as convergence activity	15,069	Wall painting , poster on each AWC on massages of NUHM (Prototype will be provided to districts)	Estimated cost Rs 1000/- per AWC	Will be done according to approved Govt. norms
4.6.6	NUHM Hording	For IEC and awareness	372 Hoarding	01 NUHM hoarding on 50000-100000 urban population (Prototype will be provided to districts)	Rs 20,000/- per hoarding Including printing & installation.	As per NRHM norms
5	Regulation & Quality Assurance					
6	Community Processes					
6.1	MAS/community groups	To each MAS as untied grant	14,560	As given in PIP framework	Rs.5000 per year per MAS	As per PIP framework
6.2	ASHA (urban)	For U-ASHA incentives	7,280	As given in PIP framework	Approx. Rs.2000 pm per ASHA	As per PIP framework
6.3	NGO support for community processes				Rs 3000/- per meeting	Quarterly community processes meeting
7	Innovative Actions & PPP					
8	Monitoring & Evaluation					
8.1	Baseline/end line surveys	Baseline survey	In 131 cities	To be carried out centrally from State level :	For 16 cities with pop. over 5 lakhs @ Rs. 30 lakhs per city For 115 cities with pop. below 5 lakhs @ Rs. 22.50 lakhs per city	Estimated cost (cost suggested by HUP health partner)
8.3	IT based monitoring initiatives					

20. Proposed State level NUHM Budget for 2013-14 (6 month)

Head	Unit Cost	Target	Months	Total	Remarks
Human Resource					
Additional Mission Director	1.5	1	6	9.00	
General Manager	1.25	1	6	7.50	01 GM NUHM has been appointed
Deputy General Managers	0.8	5	6	24.00	01 DGM NUHM has been appointed on deputation, 01 DGM M& E,01 IT,01 CP ,01Finance have been proposed
Consultants	0.5	7	6	21.00	07 consultants have been proposed
Regional Coordinators	0.5	4	6	12.00	04 regional Coordinators are being proposed for supervision
Programme Coordinator	0.3	6	6	10.80	06 Programme Coordinators are being proposed
Accountant	0.3	2	6	3.60	02 Accountants are being proposed for finance cell
Data Assistant	0.255	4	6	6.12	04 Data Assistants are being proposed
PS to the AMD	0.4	1	6	2.40	01 PS to AMD
Support staff to AMD	0.12	2	6	1.44	02 support staff to AMD
Data Entry Operators	0.1	6	6	3.60	06 Data Entry operators
Support Staff	0.7	10	6	42.00	10 support staff to different cell under NUHM
Total				**143.46**	
Office Operational Expenses					
Renovation for NUHM office	20	1	1	20.00	One time renovation
Rent for NUHM office	1.5	1	6	9.00	Rent for NUHM office
Genset Purchase including installation and tax	6	1	1	6.00	One time cost
Air conditioners purchase	0.5	10	1	5.00	One time cost
Phone instruments for senior SPMU and Directorate FW Officers	0.1	11	1	1.10	One time cost
Phone instruments for State & District level NUHM staff	0.04	100	1	4.00	One time cost
Photocopy Machines on FSMA	3	2	1	6.00	One time cost
Desktops with laser printers	0.7	22	1	15.40	22 Desktop with laser printers
Laptops /Ipad with sim and peripheral	0.5	28	1	14.00	28 (SPMU officers and Div-PMs Laptops /I pad with sim and peripheral)
LCD Projector and screen	1	2	1	2.00	2 LCD projector (01 for SPMU and 01 for DG FW)
Telephone /Fax/Mobile phones/Other Communication Methods/maintenance	1.5	2	6	18.00	Operational expenses

Stationery/Photocopier Bills/AMC etc.	1	2	6	12.00	Operational expenses
Electricity Bills/AC maintenance/Genset	1	2	6	12.00	Operational expenses
Contingency / Management support/Imprest money / Office daily expenditure	1	2	6	12.00	Operational expenses
Office Maintenance/ Housekeeping/ Gardening	1	2	6	12.00	Operational expenses
Vehicle hire and POL	0.3	10	6	18.00	Vehicles for SPMU officers and pool
Vehicle for field visit	0.4	1	6	2.40	Spacious vehicle for field visit
Field visits/Meetings at GOI/for Officers as per norms	2	1	6	12.00	Mobility support and TA/DA
Cost of hiring Urban Health Coordinators	20	1	1	20.00	Urban Health Coordinators will be hired by external agency (NHSRC)
Study tours	10	1	1	10.00	Study tour to different State
Total				**210.90**	Operational expenses
Meetings					
State level Workshop and launch of NUHM	20	1	1	20.00	
Review meetings at State level	0.012	150	2	3.60	2 review meeting for district level officers
Multisectoral Stakeholders Meeting at State level	0.012	84	2	2.02	2 State level meetings for Stakeholders
Orientation Training of Urban Health Coordinators and SPMU staff	0.12	98	1	11.76	Rs1 2,000 per Urban Health Coordinator for induction training
Orientation training of DEOs	0.07	100	1	7.00	Rs 7,000 per Data Entry Operator for induction training(Computer based)
Accountant	0.12	78	1	9.36	Rs 12,000 per Accountant for induction training
Orientation Training of HMIS/MCTS Operators	0.07	638	1	44.66	Rs 7,000 per Accountant for induction training(Computer based)
Total				**98.40**	
Baseline survey				**3067.50**	
Total				**3067.50**	
Grand Total				**3520.26**	

21. Proposed District level budget for NUHM 2013-14 (6 months)

FMR Code	Budget Head	Unit cost* (Rs. In lakhs)	Physical Target (No.)	Budget (Rs. Lakhs)	Remarks
1	**Planning & Mapping**		0	270	
1.1	Metro cities	**15**	0	0	GIS mapping has been in 38 cities by Urban Development department and 14 cities by RSAC under NRHM (Total 41 cities) in the rest of the 90cities GIS mapping has been proposed in 2013-14 under NUHM, in that mapping of listed , unlisted slum and health facility mapping will be done .
1.1.1	Mapping	**0**	0	0	
1.1.2	Data gathering (secondary/primary)	**0**	0	0	
1.1.3	Any Other	**0**	0	0	
1.2	Million+ cities	**10**	0	0	
1.2.1	Mapping	**0**	0	0	
1.2.2	Data gathering (secondary/primary)	**0**	0	0	
1.2.3	Any Other	**0**	0	0	
1.3	Cities (1 lakh to 10 lakh population)	**5**	30	150	
1.3.1	Mapping	**0**	0	0	
1.3.2	Data gathering (secondary/primary)	**0**	0	0	
1.3.3	Any Other	**0**	0	0	
1.4	Towns (50,000 to 1 lakh population)	**2**	60	120	
1.4.1	Mapping	**0**	0	0	
1.4.2	Data gathering (secondary/primary)	**0**	0	0	
1.4.3	Any Other	**0**	0	0	
2	**Programme Management**	**0**	0	**1012.56**	
2.1	State PMU	**0**	0	0	
2.1.1	Human Resources	**0**	0	0	
2.1.2	Mobility support	**0**	0	0	
2.1.3	Office Expenses	**0**	0	0	
2.2	District PMU	**0**	0	1012.56	

2.2.1	Human Resources	**0.48**	76 UHCs,76 Accountant, and 90 DEO	312.36	District total Town Population more than 20 lakhs -03 Urban Health Coordinators, 03 Accountants and 03 Data Entry Operators (DEO), 10lakh to 20lakhs- 02 Urban health Coordinators. 02 Accountants and 0 2 Data Entry Operators, Cities with 1lakh to 10 lakhs population 01 Urban Health Coordinator,01 Accountant and 01 Data Entry Operators. Cities population less than 1 lakh only 01 Data Entry Operator UHC Salary @ Rs. 30,000 pm, Accountant salary Rs 18000/- pm and DEO Salary @ Rs. 10,000 pm. Rs 8000 pm for Incentive to DPM for preparatory activity of NUHM(Rs 3.48 Lakhs in Lucknow for extra HR at DPMU)
2.2.2	Mobility support	**0.25**	77	117.9	One vehicle will be hired @ Rs 25,000 per month per Urban Health Coordinator and 01 Vehicle for Urban Nodal Officer for Lucknow (in Ghaziabad & G.B.Nagar 01 vehicle @ Rs 35000/-pm)
2.2.3	Office Expenses	**0.25**	75	162.3	Rs.25,000 pm for office expenses including rent ,stationary and internet to each DPMU and one time Rs.70,000 for one computer system, Data Card , Storage device , printer, table and chairs for each DEO of DPMU (Those Cites where UHC is not given, Rs.10,000 budget is proposed for office expenses) 61 District @ Rs 25000/-pm,14 Districts Rs 10000/-pm and Rs 70000per Computer printer set for 89 set
2.2.4	Strengthening Urban Health cell at District level	**5.5**	75	420	Rs.2.5 lakhs for Furniture, ACs, desktops, minor renovations etc. for the office of District level Nodal Officer & 2.5 lakhs for DPMU office for NUHM cell strengthening & 50,000 for DPM for laptop along with data card.(additional budget of Rs 6.00 Lakhs in Lucknow and Rs 1.5 in Farrukhabad)
2.3	City PMU	**0**	0	0	
2.3.1	Human Resources	**0**	0	0	
2.3.2	Mobility support	**0**	0	0	
2.3.3	Office Expenses	**0**	0	0	

3	**Training & Capacity Building**	**0**	0	**2825.30**	
3.1	Orientation of Urban Local Bodies (ULB)	**3**	130	114	Rs.5 lakhs for metros, Rs.3 lakhs for million+ cities, Rs.1 lakh for other cities above 1 lakh and Rs.0.5 lakhs for smaller towns below 1 lakh, One time activity
3.2	Training of ANM/paramedical staff	**0.05**	4466	223.3	Rs.5000 per ANM & Staff Nurses (for entire training package), 05 ANMs and 02Staff nurses from each UPHC will be trained.
3.3	Training of Medical Officers	**0.1**	1276	127.6	Rs.10,000 per MO (for entire training package), All MOs for UPHCs will be trained. 2 Mos per U-PHCs
3.4	Orientation of Specialists	**0**	0	0	Not planned this year
3.5	Orientation of MAS	**0.1**	14560	1456	Rs.10,000 per MAS (for entire training package)
3.6	Selection & Training of ASHA	**0.1**	7280	728	Rs.10,000 per ASHA (for entire training package)
3.7	Other Trainings/Orientations	**0**	0	176.4	
3.7.1	Stakeholders Workshop for launch of NUHM	**1**	130	80.6	Rs1,00,000 for 75 district headquarters and Rs.10,000 for 56 towns
3.7.2	Quarterly Multispectral convergence Meeting	**0.1**	132	20.8	Rs10,000 for 75 district headquarters and Rs.5,000 for 56 towns
3.7.2	Launch of NUHM	**1**	75	75	Rs1,00,000 for district headquarters in 75 DHQs
4	**Strengthening of Health Services**	**0**	**0**	**27172.11**	
4.a	**Human Resource**			**8658.46**	
4.b	**Infrastructure**			**3603.70**	
4.c	**Untied grants**			**1635.00**	
4.d	**Procurement (drugs and consumable)**			**8105.72**	
4.e	**Other services**			**5169.23**	
4.1	Outreach services/camps/UHNDs	**0**	0	3172.11	
4.1.1	UHNDs	**0**	15797	1421.73	01 UHND per AWC or per 1000 slum population per month @ Rs.015 per UHND for 15797 UHNDs per Month
4.1.2	Special outreach camps in slums/ vulnerable areas	**0.1**	3033	1750.38	One outreach camp per 10,000 population per month @ Rs.10,000 per outreach camp for 3033 outreach per month. In G.B. nagar (Greater Noida and Dadri) outreach camp will be conducted by mobile teams)

4.2	ANM/LHV	**0**	0	1907.31	
4.2.1	Salary support for ANM/LHV	**0.1**	3020	1812	Maximum Rs.10,000 pm for ANM as per approved norms in NRHM; 3020 new recruitment, 157 Govt.
4.2.2	Mobility support for ANM/LHV	**0.005**	3177	95.31	Rs. 500 pm for all ANMs contractual as well as on government payroll.
4.3	Urban PHC (UPHC)	**0**	0	20041.504	
4.3.1	Renovation/up-gradation of existing facility to UPHC	**0**	0	3550.6	
4.3.1.1	For Government owned buildings	**10**	119	1190	Rs.10 lakhs per UPHC, one time activity for renovation of building for 119 Govt. Building
4.3.1.2	For Equipments	**3**	638	2360.6	Rs.3.00 lakhs per UPHC, one time activity for UPHCs for purchase of equipments
4.3.2	Building of new UPHC	**0**	0	0	
4.3.3	Operating cost support for running UPHC (other than untied grants and medicines & consumables)	**20**	0	6920.90	Rs.20 lakhs per year per UPHC (For 1 UPHC)
4.3.3.1	Human Resource	**0**	0	6453.80	
4.3.3.1.1	MO salary	**0.36**	1203	2598.48	2 MOs per UPHC @36,000 pm. 1203 Mos will be hired and 73 Medical officer from state budget.
4.3.3.1.2	Salary of paramedical & nursing staff (Staff Nurse/ Lab Technician/ Pharmacist/ Other)	**0**	608	2324.12	2 Staff Nurses per UPHC @16,500 pm, 1 Pharmacist per UPHC @16500 pm; 1 Lab Technician @11,880 pm for 638 U-PHCs
4.3.3.1.3	Salary of support staff (non clinical staff)	**0.05**	1914	574.2	3 Support staff for 1 UPHC @5,000 pm for 638 U-PHCs
4.3.3.1.4	HMIS / MCTS operator	**0.1**	**638**	382.8	HMIS/MCTS data Entry operator 1 to each U-PHC
4.3.3.1.5	Office Expenses	**0.1**	638	574.2	Rs. 10,000 pm per UPHC
4.3.3.2	Others (e.g. hiring of premises/mobile PHC)	**0.15**	519	467.1	Rental for UPHCs running from rented buildings @15,000pm for 519 Hired buildings
4.3.4	Untied grants to UPHC	**2.5**	638	1595	Rs.2.50 lakhs per year per UPHC
4.3.5	Medicines & Consumables for UPHC	**12.5**	638	7975	Rs.12.50 lakhs per year per UPHC
4.3.5.1	Emergency drugs	**0**	0	0	
4.3.6					
4.4	Urban CHC (UCHC)			363.5	Strengthening of health facility has been done as U-CHC in Lucknow.
4.4.1	Capital cost support for new UCHC	**5**	8	53.1	8 BMCs existing & running by state budget (Computer with printer @Rs 70000 per BMC (Total 8 computer) + 5000 internet charges , operational charges + Operational and

					maintenance of ambulance Rs. 15000/ per month per ambulance for 8 ambulance.
4.4.2	Human Resource	**0.48**	40	115.2	1 Radiologist,1Pediatrician,1 Gynaecologist, 1-Physician & 1-Anaesthetist Rs.48000/- per month per BMC for 8 BMCs
4.4.2.1	Staff Nurse	**0.165**	24	23.76	3 staff nurses per each BMC Rs. Rs. 16,500 PM
4.4.2.2	Support Staff	**0.05**	8	31.44	6 support staff per each BMC Rs. 5000 PM,24 driver (3 driver per BMC) Rs. 8500 PM, & 8 Data assistant Rs. 10,000 PM)
4.4.3	Untied grants for UCHC	**5**	8	40	Rs 5 Lakhs per BMC
4.4.4	Medicines & Consumables for UCHC	**12.5**	8	100	Rs 12.5 Lakhs per BMC
4.5	School Health Program	**0**	0	349.58	
4.5.1	Human Resource	**0.5788**	64	222.26	One team consisting of 1 doctor Rs.36,000 pm; 1 ANM/GNM Rs.10,000 pm and 1 Ophthalmic Assistant Rs.11,880 pm
4.5.2	Other School Health services	**0.25**	64	96.6	Hired vehicle Rs.25,000pm, one per School Health team
4.5.3	Drugs, consumable & Operational expenses	**0.08**	64	30.72	Rs. 8000 pm per team for 6 Month
4.6	IEC/BCC	**0**	1	1338.1072	
4.6.1	ASHA Kit Flip Book, Slum HIR, Bag, ID, Pen, IEC material for ASHA on Maternal health, Child health and RI and handouts for community	**0.02**	7265	145.29	one time Rs. 2,000 per ASHA
4.6.2	UPHC Citizen's charter, ED List, Immunization Schedule, Signage	**0.2**	638	127.6	One time Rs.20,000 per UPHC
4.6.3	Safe Motherhood, Booklet, MCP Card and IEC material for U-PHC .	**0.00057**	641	546.65	1500 sets of MCP Card and Safe Motherhood booklet (total 960000 sets of Booklet and cards)to be printed per UPHC @ Rs.37/- per booklet and MCP card Rs 30,000/ for per U-PHC for printing of other IEC material @ Rs 3/- per household on communicable and non communicable diseases
4.6.4	Family Health Card	**0.0001**	2834818	283.48	Family Health Card to be printed for all slum households Rs10 per card
4.6.5	Communication material and wall painting at AWCs	**0.01**	15069	150.69	One time, Rs.1,000 per AWC
4.6.6	NUHM Hoarding	**0.2**	372	74.4	Rs 20000 per hoarding Including printing & installation.

5	**Regulation & Quality Assurance**	**0**	0	0	
6	**Community Processes**	**0**	0	**1165.90**	
6.1	MAS/community groups	**0.05**	14560	728	Rs.5000 per year per MAS
6.2	ASHA (urban)	**0.02**	7280	436.8	Approx. Rs.2000 pm per ASHA
6.3	NGO support for community processes	**0**	24	1.1	Quarterly community processes meeting
7	**Innovative Actions & PPP**	**As per need**	2	0	
8	**Monitoring & Evaluation**	**As per need**	0	0	
8.1	Baseline/end line surveys	**0**	0	0	
8.2	Research Studies in Urban Public Health	**0**	0	0	
8.3	IT based monitoring initiatives	**0**	0	0	
Total				**32445.87**	

Budget Summary & percentage of budget in different heads

FMR Code	Budget Head	State level budget (in Lakhs)	District level budget (in Lakhs)	Total budget (in Lakhs)	% of total budget
1	**Planning & Mapping**		270.00	270.00	0.8
2	**Programme Management**	354.36	1012.56	1366.92	3.8
3	**Training & Capacity Building**	98.4	2825.30	2923.70	8.1
4	**Strengthening of Health Services**		27172.11	27172.11	75.5
a	**Human resource**		8658.46	8658.46	24.1
b	**Infrastructure**		3603.70	3603.70	10.0
c	**Untied grants**		1635.00	1635.00	4.5
d	**Procurement (drugs and consumable)**		8105.72	8105.72	22.5
e	**Other services**		5169.23	5169.23	14.4
5	**Regulation & Quality Assurance**		0	0	0.0
6	**Community Processes**		1165.9	1165.9	3.2
7	**Innovative Actions & PPP**		0	0	0.0
8	**Monitoring & Evaluation (Base line Survey)**	3067.5	0	3067.5	8.5
	TOTAL	**3520.26**	**32445.87**	**35966.13**	**100.00**

Acronyms

ANC	-	Antenatal Care
ANM	-	Auxiliary Nurse Midwife
AYUSH	-	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
ACMO	-	Additional Chief Medical Officer
AWW	-	Anganwadi Worker
AWC	-	Anganwadi Center
ASHA	-	Accredited Social Health Activist
BPL	-	Below Poverty Line
BSUP	-	Basic Services for Urban Poor
CSO	-	Civil Society Organizations
CBO	-	Community Based Organizations
CDS	-	Community Development Society
LHV	-	Level Health Visitor
CMO	-	Chief Medical Officer
CDPO	-	Child Development Program Officer
CHC	-	Community Health Center
CGHS	-	Central Government Health Scheme
DOTS	-	Directly Observed Treatment – Short course
DUDA	-	District Urban Development Authority
DPO	-	District Program Officer
ENT	-	Ear, Nose & Throat
ESI	-	Employees State Insurance
EAG	-	Empowered Action Group
FOGSI	-	Federation of Obstetric and Gynaecological Societies of India
GIS	-	Geographic Information System
GoI	-	Government of India
HIV/AIDS	-	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPD	-	Health Post D-Type
ICDS	-	Integrated Child Development Services
IDSP	-	Integrated Disease Surveillance Programme
IEC/BCC-		Information Education Communication/ Behaviour Change Communication
IFA	-	Iron Folic Acid

IHSDP	-	Integrated Housing and Slum Development Program
IMA	-	Indian Medical Association
IPD	-	Inpatient Department
ICC	-	In charge Cum Computer
IPC	-	Inter Personal Communication
IAPSM	-	Indian Association of Preventive and Social Medicine
IPHS	-	Indian Public Health Standards
IUD	-	Intra-uterine Devices
JNNURM	-	Jawaharlal Nehru National Urban Renewal Mission
JNMC	-	Jawaharlal Nehru Medical College
JDA	-	Junior Doctors Association
LMO	-	Lady Medical Officer
MAS	-	Mahila Arogya Samiti
M&E	-	Monitoring & Evaluation
MCH	-	Maternal and Child Health
MTP	-	Medical Termination of Pregnancy
NPSP	-	National Polio Surveillance Program
NMCP	-	National Malaria Control Program
NVBDCP	-	National Vector Borne Disease Control Program
NFHS	-	National Family Health Survey
NRHM	-	National Rural Health Mission
NUHM	-	National Urban Health Mission
OPD	-	Out Patient Department
ORS	-	Oral Rehydration Solution
OCP	-	Oral Contraceptive Pills
PHN	-	Public Health Nurse
PMU	-	Program Management Unit
PO	-	Program Officer
PRO	-	Public Relation Officer
PPC	-	Post Partum Center
PHC	-	Primary Health Center
PIP	-	Programme Implementation Plan
PNC	-	Post Natal Check-up
PPP	-	Public Private Partnership

RCH II	-	Reproductive and Child Health
RNTCP	-	Revised National Tuberculosis Control Programme
RTI/STI	-	Reproductive/ Sexually Transmitted Infections
SJSRY	-	Swarna Jayanti Shahari Rojgar Yojana
SRTL	-	Sub Regional Team Leader
SACS	-	State Aids Control Society
SNC	-	Special Neonatal Care
SMO	-	Surveillance Medical Officer
SLI	-	Standard of Living Index
TB	-	Tuberculosis
TFR	-	Total Fertility Rate
TT	-	Tetanus Toxoid
UPHC	-	Urban Primary Health Center
UCHC	-	Urban Community Health Center
ULBs	-	Urban Local Bodies
U5MR	-	Under 5 Mortality Rate
U-ASHA	-	Urban Accredited Social Health Activist
VO	-	Voluntary Organization
WHO	-	World Health Organization