*Original Article*

# Reflections on Participation and Knowledge-Making as Part of India's National Urban Health Mission Technical Resource Group Recommendation Exercise

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**Abstract**

India's urbanization, though precipitous, is undirected, random, and opportunistic, shaped more by pressures than by policies. This has resulted in inequitable access to health services and adverse health outcomes for the urban poor. Late 2013 saw the launch of India's National Urban Health Mission, a broad scheme aimed at prioritizing urban health in the country with an emphasis on the poor. Acknowledging both the diversity and complexity of urban poverty across India's cities, a Technical Resource Group was convened by the Ministry of Health and Family Welfare to support the process. We describe the context surrounding this effort and the procedure followed, which entailed in-depth interactions with the urban poor themselves and with officials, health system actors, civil society, and other stakeholders. Even as

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recommendations were accepted, given the meager allocation for health in the country, only piecemeal implementation is underway. Thus, policy processes are often a dialectic involving shifts that a range of stakeholders may variably resist or embrace. The most important lesson, however, is that it is both feasible and desirable to engage directly with the community, implementers, and researchers and to negotiate and connect their knowledge in the crafting of public policy.

**Keywords**
urban health, policymaking, India, epistemology

India is urbanizing rapidly; an estimated half of the population shall be urban in the coming decade or so.[1] However, this urbanization is undirected, random, and opportunistic, shaped more by pressures than by policies. Urban living is often equated with advantage in economic opportunity, living standards, and access to services, including health. However, recent evidence points in fact to the "urbanization of poverty,"[2,3] whereby cities entrench inequalities by ghettoizing poverty and enclaving affluence in close and stark proximity. In fact, urban poverty is a burgeoning phenomenon in India: the number of urban poor increased by a third between 1973 and 2004.[4] Data from the latest National Family Health Survey suggests that the urban poor experience worse health outcomes in comparison to the urban non-poor and residents of rural areas.[5] In addition, the heterogeneity and varied needs of the urban poor, compounded by inequitable access to health services, result in adverse health outcomes.[3] Existing data suggests that the urban poor have higher under-five mortality, more underweight, and disproportionate vulnerability to respiratory and vector-borne diseases as well as non-communicable diseases such as diabetes, hypertension, and mental distress in comparison to rural populations. Further, they are highly susceptible to communicable and chronic epidemics due to the degraded nature of their living and working environment.[6] A recent spatio-temporal analysis of declines of immunization coverage in good-governance, high coverage states attributed the phenomenon to higher levels of urbanization in these states.[7]

Urbanization and its concomitant trends have easily outpaced policy making for urban health and services in India—by design. In its early post-independence years, India placed greater emphasis on rural health, as most of the available health services were concentrated in urban areas (erstwhile colonial capitals or hubs). Other research, has placed more emphasis on questions of urban burden and deprivation, rather than questions that may help the design and reform of health systems in cities.

In late 2013, the authors of this manuscript were closely involved in a policy recommendation exercise for India's National Urban Health Mission (NUHM), a broad plan aimed at prioritizing urban health in the country with an emphasis

on the poor. Here, we describe the context surrounding this effort, the process followed in this exercise, and our reflections carrying out an extensive exercise at the scale of the urban across a nation of the size, diversity and complexity of India. At this juncture, given a meager allocation for health in the country, only piecemeal implementation NUHM components and recommendations is underway in different Indian cities, something we also discuss. Thus, this article is an exercise in "referential reflexivity,"[8] a kind of self-awareness that results from the intersection of knowledge-making practices of different communities, an opportunity not only for formulating policy, but for building capacity, networks, and participation in health.

## The Background: Health-Related Policy Making in India

Various health and planning-related expert committees (Bhore Committee, 1946; Mudaliar Committee, 1959; Kartar Singh Committee, 1973; Shrivastava Committee, 1975) have focused on building and expanding India's rural health service delivery architecture.[9] India's National Health Policies of 1983 and 2002, respectively, also perpetuated this emphasis. A large thrust to rural health was given in the National Rural Health Mission, launched in 2005, which undertook architectural restructuring in health service delivery, governance, and financing in rural India. This idea, of "mission" mode, required that this effort be given exceptional priority within national and state health departments.

The result has been a kind of default policy (non)direction for urban health in India, manifest as a complex service delivery landscape comprising multiple systems of medicine (allopathy is dominant, but other codified systems of medicine—Ayurveda, Unani, Homeopathy, Siddha, Sowa Rigpa, Yoga, and Naturopathy—are recognized); a dominant, unregulated, and corporatized private sector; and fragmented jurisdictions (municipal, state, national, technical, and administrative). In broad terms, urban health services include primary health centers, industrial hospitals and dispensaries as part of the employees state insurance scheme (ESIS), municipal hospitals, and Urban Health and Family Welfare Centres (UHFWC).[10]

Constitutionally, health is the responsibility of state governments, although many health determinants, like pharmaceuticals and sanitation, are under the purview of both state and national governments. Further, Constitutional Amendments introduced in 1993 called for governance by Urban Local Bodies (ULBs, or municipal corporations) of all public services.[a] The result has been service delivery by all these stakeholders in various combinations, often varying based on the size and context of the state and city. By the mid-2000s, India had a major challenge in terms of integrating state-led health services and programs with local self-government and administration (each possessing distinct political mandates and identities)—what in 2010 was termed the "missing mission in health."[11]

## The Genesis of the National Urban Health Mission Technical Resource Group

On May 1, 2013, nearly six years after originally planned and after much political advocacy, the Indian cabinet approved the NUHM under its National Health Mission (NHM). Allocations and disbursals for NUHM have been modest, but this is among the first times there have been allocations for this purpose. The NUHM policy framework placed high focus on the urban poor and vulnerable, the social determinants of health and strengthening of institutional capacity of urban local governments. However, for states to achieve the mission, a need was felt for greater operational clarity on how the framework could be implemented and for which populations.

This is also a global concern. As Bosch-Capblanch and colleagues[12] have recently pointed out

> a World Health Assembly resolution [20] recently urged member states to use evidence-based approaches to assess "country's health and health systems challenges" and to develop "evidence-based responses to evolving challenges and opportunities, and to involve all relevant stakeholders." However, although well-established methods exist to develop clinical guidelines [21], there is little experience in developing health systems guidance and the process poses conceptual and methodological challenges related to the different types of evidence to be considered, the complexity of health systems, and the pre-eminence of contextual issues.

For more complex, intersectoral issue areas, such as social determinants of health, policy makers in fact hesitate to take policy action, particularly where that action would require upending or challenging biomedical dominance.[13] This piece of research is an exception; multiple systematic reviews on the use of evidence by policy makers also concludes that empirical data on policy processes or implementation of policy are rare.[14,15] Liverani and colleagues advocate for theories and approaches beyond the remit of public health or knowledge utilization to understand these processes.[15] In short, the NUHM needed a plan of action.

An important antecedent and precipitating factor in advancing NUHM was an expert group, led by S.R. Hashim, constituted for the development of criteria of "urban poverty." The expert group comprised a range of actors with experience in both state and civic action—individuals across the ideological spectrum involved with counting and representing the urban poor. Jointly, these members of the Hashim Expert Committee submitted that three categories of vulnerability characterize the urban poor: residential, occupational, and social.

Two years later, a member of this committee was given chairmanship of the Technical Resource Group (TRG) for NUHM. His efforts would be supported by the convenorship of the erstwhile Executive Director of the National Health

Systems Resource Centre, which is a technical support agency under the Ministry of Health and Family Welfare. In initial meetings, four working groups were created, corresponding to cross-cutting themes across the terms of reference. Two of the working groups—one concerned with identifying and highlighting the health burdens and needs of vulnerable groups, and the other tasked with laying out the institutional mechanisms for urban health service delivery—concluded that the existing secondary literature was incomplete for its purposes. The first group proposed to directly reach out to vulnerable groups themselves so they could directly speak to their experiences, burdens, and aspirations. Using Hashim Committee guidelines of residential, social, and occupational vulnerability, a free-listing activity was undertaken to identify target groups that would be visited (see Figure 1). In the second group, members felt that understanding the institutional architecture across a range of Indian cities would require direct interaction with its structures and agents. Thus, city visits were planned; cities were chosen that (1) reflected a range of sizes and (2) were the sites of prior work of working group members, (3) had either unique problems or solutions with respect to urban health, (4) were geographically dispersed, and (5) could feasibly be travelled to by small teams of TRG members to collect data.

The ambit of the remaining two groups was folded into the fieldwork proposed by the first two working groups, respectively, and tools for each kind of fieldwork were developed over a two-week period and rapidly piloted in Delhi (they are enclosed as an Annexure on Understanding Urban Health: A Guideline and Toolkit).[16] The tools were designed with standardized content so as to enable use by the multiple teams and included open-ended components to capture the widely differing realities and contexts of the cities selected. The tools underwent several iterations before and after field testing. Institutional Review Board clearance was neither sought nor required for this policy exercise, which was drawing on tools of research, but was decidedly not a pure research exercise.

Field visits to 31 cities (see Figure 1) were carried out by two or three people from across the working group membership. The main stakeholders who were met with during the field testing included government officials from the State Health Department and Urban Local Government, members of civil society organizations, and three or four vulnerable groups across the city. Two sets of officials were selected from each city/town, because unlike rural India, where the health system is completely under the stewardship of the state health department, in urban areas, both urban local governments and state health departments are charged with health services provision. To understand this variation, at least one or two primary, secondary. and tertiary health centers in the city, run by both the state health department and Urban Local Body, were visited.

Civil society organizations working with vulnerable groups were the key sources to reach the vulnerable sections in the city. All meetings with vulnerable groups were held at their place of work or residence so as to inconvenience them the least and to allow teams to observe the social determinants of health.

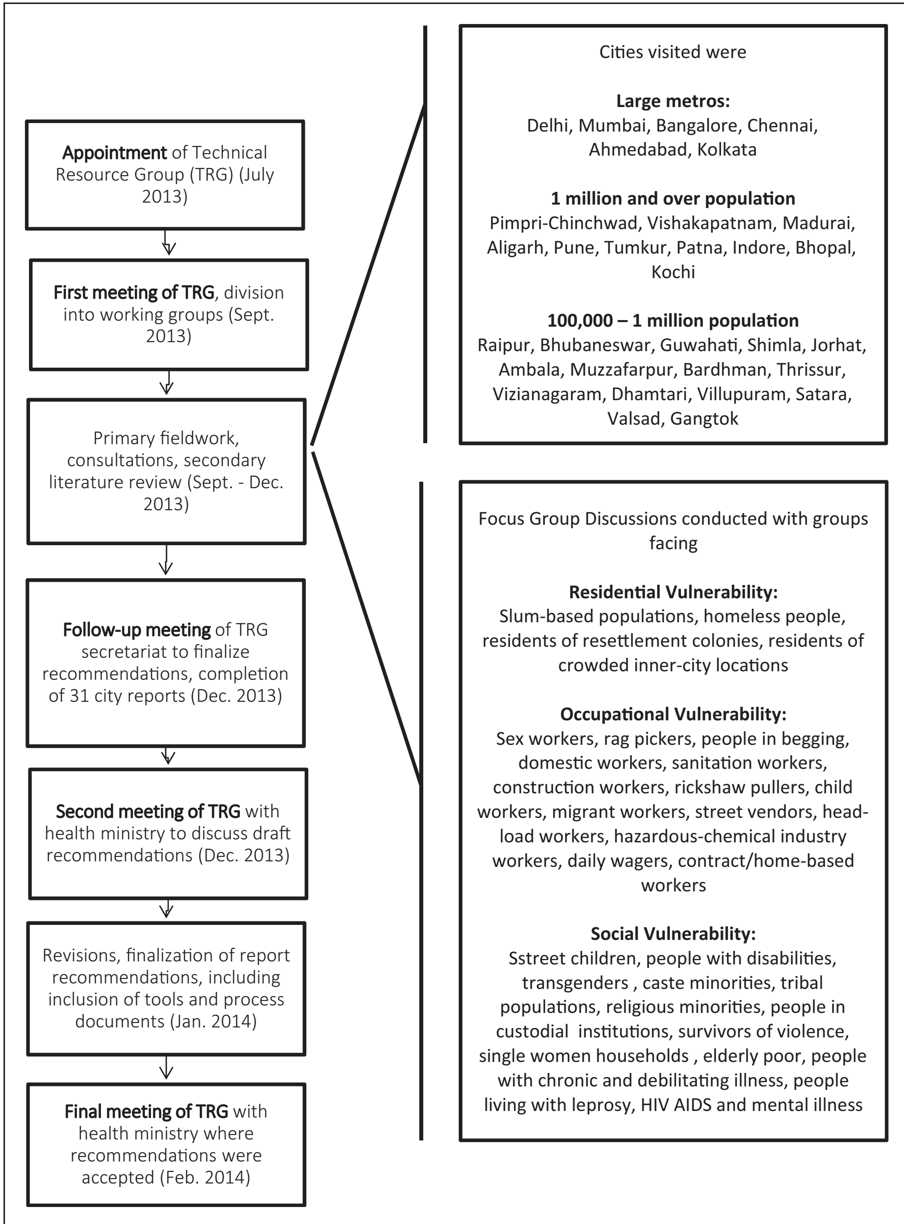


Figure 1. Summary of NUHM TRG process.

Focus Group Discussions (FGD) were carried out with each vulnerable group to understand population health care needs, issues of accessibility, and out-of-pocket expenditure (OOP). Concomitantly, consultations were held with think tanks and research and policy institutions with a reputation for work in urban health. Protocols were developed for secondary literature reviews on key topics.

Within three months, the secretariat had labored over the creation of 31 city reports and a number of vulnerability profiles (sometimes included in the city reports). These were carefully read by members of a skeleton drafting team, who elucidated the common features and patterns across the cities in terms of how different approaches played out in different contexts, to what extent these were successful, and what barriers they had faced. This meant that we could evolve a set of recommendations based on learnings from the field itself—not necessarily the best practices—but from the variability with which similar practices played out in different contexts. For example, Kolkata provided lessons on a viable public health response to dengue outbreaks and to abattoir management. Chennai provided learning of a different form, of organization of clinical services and interesting nongovernment organization experiences on reaching out to mentally ill persons from very poor households. Ahmedabad and a number of other city examples raised fundamental ethical and implementation issues with pay and use toilets for slum populations. Drawing upon this, the chairperson, based on consultations with the policy leadership, meetings with the secretariat, and an intuitive understanding based on his own experience, proposed an initial set of recommendations that could be used as a frame of reference for further consultations and inputs from various sources, including the fieldwork. Whereas there are well-established methodologies of studying a health systems or a health program, the process of generating recommendations that are "evidence based" yet "participatory" and "negotiated" is a challenge that the secretariat faced. Findings were presented within a month to the larger group and the Ministry and concerns and gaps were identified. Two months later, the final report with recommendations was presented and summarized to the Ministry. Almost all recommendations were accepted and the report submitted formally to the Ministry, after which it was also made freely and publicly available.

## Findings of the TRG[16]

Indeed, palpably, we found it to be the case that "among vulnerable groups, it was found that almost every hospitalization caused catastrophic health expenditure leading to lifetime indebtedness."[17] In addition, city visits led to the discovery of three archetypal institutional patterns for urban health service delivery: a) health care system completely under the control of the State Health Department (e.g., Shimla and Patna), b) health services provided by both the State Health Department and Urban Local Body (e.g., Kochi, Thrissur, and Bhopal, where for example maternity centers and dispensaries

were under the Urban Local Body while secondary and tertiary health care were completely under the State Health Department), and c) primary, secondary, and tertiary services provided by the Urban Local Body (e.g., Mumbai, Bangalore, Chennai). The patterns concorded more or less with the size of the city, that is, larger cities tended to have greater roles for Local Bodies. This helped us arrive at the need to carry out systematic, context-specific primary data collection from cities that focused on service delivery (from the perspective of system actors and implementers) and health seeking (from the perspective of communities and vulnerable groups).

A number of barriers to service delivery were also identified through interactions with implementers/service providers in cities. First, the inverse care law was found thriving in urban areas: There was a clear mismatch between the services available and the services needed in the primary and secondary health care facilities due to an exclusionary focus on maternal and child care.[b] A few cities had Community Health Worker (CHW) programs with narrow focus on maternal and child care (not even reproductive health more broadly), incommensurate with the needs of heterogeneous, aging populations. Further, although most health care needs could be managed at the primary health care level and indeed on paper that was the architecture, in practice the poor were in large numbers crowding public tertiary care facilities for most primary care needs. In cities with both Urban Local Bodies and state departments providing care, we found that Urban Local Bodies were retreating from their responsibilities in health care service delivery altogether, mainly due to financial constriction and lack of technical support. In peri urban centers, moreover, institutional arrangements were often ambiguous due to the transfer of responsibilities, further leading to vexed service delivery.

Focus group discussions with vulnerable groups substantiated the fact that social determinants were a serious factor in the health burdens of the poor. Historically, in the colonial era onwards, the management of services related to the social determinants of health, especially water supply, sanitation, and hygiene, was mainly carried out by corporation bodies, with support and monitoring functions played by the Municipal Health Officer. However, post-Independence, as state health departments began to take over health services in urban centers, this post would often be withdrawn officially or de facto, creating a vacuum in a very critical area of convergent intervention. In addition to the lack of services, existing, vulnerable groups often expected exclusion due to stigma, violence, discrimination, and fear of being victimized or criminalized. Migrant populations, especially in urban centers, were not visible to the health care system due to their mobility and lack of documentation, even as they faced unique disease burdens, including seasonal morbidities, and were highly vulnerable to injuries, traumas, and substance abuse. Public health was not a daily concern for the vulnerable groups mainly due to ill-timed consultation and waiting hours. Only during emergencies did the urban poor approach the public

health care system, typically favoring tertiary health facilities (hospitals) rather than primary health centers (dispensaries). The reasons given were mainly a) lack of services, b) lack of accessibility to services, and c) lack of services with respect to their special health care needs due to their specific forms of social and occupational vulnerability. The system therefore needed to be able to capture and act upon these realities and experiences.

## Recommendations of the TRG

Based on these findings, the TRG made a range of recommendations,[16] which are summarized as follows:

1. Map Vulnerability, Infrastructure, and Access

The TRG recommended 3-level spatial mapping of various elements that would help locate and understand (1) where socially vulnerable groups reside and work, (2) what facilities or health infrastructure are available, and (3) accessibility barriers and facilitators (e.g., provisions for persons with disabilities, the elderly). Based on this, city health plans could be drawn up to correct the discordances between levels of the map.

2. Organization of Services at the Community Level

A nursing station or nursing station cum health sub-center for every 10,000 people was proposed. Peopled by two female health workers, one male health worker, and five community health workers, nursing stations could provide all primary health care services that do not require the intervention of doctors. This comprises preventive and promotional health activities, health literacy and nutrition counseling, immunization, antenatal care, followup tests and counseling, and regular free medication for common urban ailments (e.g., tuberculosis, mental health issues, leprosy, hypertension, diabetes, epilepsy, asthma). The nursing stations could also be equipped with the capacity to provide counseling services for substance abuse, disability, geriatric, palliative, and domiciliary care. Finally, to make the nursing station most accessible to the people it is serving, it would have to consult directly with them to determine its timings for mornings, afternoons, and evenings.

3. Making Primary Health Centers Accessible to the Urban Poor: Issues of Location and Responsiveness

The NUHM framework suggests one Urban Primary Health Center (UPHC) for every 50,000 people. The TRG recommended that distribution of UPHCs maximize access to the urban poor, by ensuring, first, that at least 50% of the

UPHCs are located within or near the settlements and habitations of the urban poor and unorganized workers. Second, it was recommended that in a given city, some UPHCs have special additional services that cater to particularly vulnerable urban dwellers, like the homeless, street children, and temporary circular migrants. This would require mobile clinics and recovery shelters for patients post-discharge. Third, the TRG felt that at least 30% of all UPHCs should be in middle-class areas so as to serve those populations as well (where, quite often, the urban poor are also in employment). Finally, a pool of at least 5% of the UHM budget was recommended to be set aside so to cater to the demand-driven health care needs of the urban poor, especially those employed in the informal sector.

4. Measures to Ensure Inclusion

Drawing from the biggest barriers to access for the urban poor, the TRG proposed specific measures to ensure inclusion. First, the TRG recommended that it never be required for an individual seeking urban primary health care to produce proof of address or citizenship to have a caregiver. For intake/registration, all forms under the UHM should ask for the mother's name only, instead of father's or husband's name, as the latter can discourage or stigmatize children of single women or sex workers. Similarly, as is increasingly the practice, the option to register with one's transgender identity should also be permitted. The operating hours of the UPHCs should be revised so as not to exclude populations—for example, domestic workers, self-employed individuals, and sex workers. This typically means 3 to 9 p.m. daily would be a good time, with the exception of UPHCs in red-light areas, which could operate in the morning hours. The TRG also recommended the abolishment of user fees for primary and curative care services at public/government hospitals, essential medicines, and diagnostics, which create enormous barriers of access for individuals who are financially marginalized. It was also recommended that on a rotating basis, special clinics in medical college outpatient wings be set up for the aged and differently abled in existing facilities, specifically geared towards handling comorbid conditions that these two populations often have. UPHCs should all have a formalized help desk and counseling center that is run by trained, professional medical social workers, who could serve as the first point of contact for survivors of violence, children without adult guardianship, and old and disabled persons.

5. Effectiveness and Quality of UPHCs by Ensuring a Continuum of Care

Expanding the scope of primary health care to include more than just reproductive health services, the TRG recommended that vertical disease programs be integrated, at least one regular and part-time medical officer be present, basic

diagnostics and sample collection be provided, and a card-based referral system be employed.

6. Community Structures, Accountability, and Transparency

Drawing from the success of such processes in rural areas and in urban demonstration projects, the TRG recommended the creation of an empowered local health committee called Jan Arogya Samiti (JAS, People's Health Committee) and Mahila Arogya Samitis (MAS, Women's Health Committee) at the neighborhood level. While the objective of JAS is to help optimize the use of existing health services and suggest ways for improving them and addressing social determinants of health, MAS could provide support to community health workers

7. Intersectoral Convergence

Municipal health officers are responsible for continually monitoring the provision of public services relevant to health: disease surveillance, vector control, food safety, regulation of slaughterhouses, monitoring of air pollution, biomedical waste, rabies control, and linkages to plans of other departments (Women and Child, Education/School Health, Social Welfare, Urban Development, Food and Civil Supplies, Roads and Transport). Apart from encouraging and sustaining this role across Indian cities, the TRG called for active technical support to help urban areas learn from the best practices of collaboration across departments and for improved and sustaiined communication between the local government and the state health department in service of urban health service delivery.

## Reflections on Process

The NUHM TRG digressed from typical processes of policy making in at least two key ways. First, this expert group had an expressed mandate of operationalization, of providing inputs for program design (rather than conceiving a program, a population [like the Hashim Committee], or a health reform agenda more broadly, as in the case of the High-Level Expert Group for Universal Health Coverage).[18] Second, it included as "evidence," or sources of knowledge, information from not just TRG members alone, but an expanded stakeholdership of working groups, from implementers across Indian cities providing public health services in the public and private sector, and from individuals and communities most concentrated at the fringes of outreach—the highly vulnerable.

At the outset, the chair and convenor of the TRG felt that it was important to have conceptual clarity on who constitute the "urban poor" for policy makers. The TRG was also mindful that "evidencing" recommendations for wider urban health system would require an altogether different process, both multi-method

and multi-vocal. Whereas there are many established ways to objectively describe the world as it is, or to explain it, the challenge is to be able to generate a unifying narrative of how, in a varied set of given contexts, change could happen. Since textbook theories had limited role to play, we undertook a sort of rapid theorization of what was seen across 31 cities, a theorization not by academics alone, but not without them, and done when in active engagement with those who have experiential knowledge, with the tacit (implicit made explicit) knowledge of the latter also contributing to building up a narrative of how change could occur. A framework was thus created to maximize participation of a range of stakeholders in the research and policy processes.

The framework for the NUHM, conceived nearly a decade ago, was intended to be the policy background for TRG members. Given its provenance, this mandate could not take into account lessons from the implementation of India's National Rural Health Mission (NRHM, 2005-2012). Analysis of existing research and data sources revealed the dearth of knowledge that actually exists on the diversity and range of populations and models of service delivery across cities. While there are multiple descriptions availability of vulnerability and service gaps, there is in particular an almost complete lack of work on what works and what are the lessons from past approaches to handling similar problems. An important element of this approach was the humility to acknowledge that we are not the first to either see the problems or to seek change, and we need to learn from the field to how seemingly obvious correctives that we would otherwise have recommended have worked when it was tried out earlier. Further, we shared the understanding that though poorly theorized, generalized, or disseminated, some of the apparently most intractable problems have been addressed relatively successfully before, albeit at local levels, and we have greater chance if we build on them rather than trying to pull out something "new" from our own heads. We also note that many past efforts at health sector reform construct interventions based on market based theories of public choice. Irrespective of the validity of such an approach, the importance lay in acknowledging that many such interventions have been made over the last two decades, and that the cumulative experience we have of most of them is either not yielding the desired results or leading to more exclusions and deprivation (e.g., user fees for public services that target the poorest). Failure to acknowledge past efforts and learnings is also to tragically or as a farce repeat those same errors.

This in turn reinforced the need for a process of primary data collection from cities that was subsequently undertaken—a primary data collection that also gave importance to what is being or has been attempted and the learnings from these, many of which are part of the experential understanding of the practitioners and the community. Secondary data was of particular use in examining financial and budgetary data; city visits validated various previous data and studies documenting impoverishment due to out-of-pocket expenditure.

The reports with their narratives, combined with the policy experience and implementation role of the team members, enabled the contextual link between specific narratives into general recommendations. Admittedly, these were more specific for some aspects of the report than others. This kind of hybridization, combining state governmentality "from above" with, at an unprecedented scale, what Appadurai calls "governmentality from below, in the world of the urban poor, is a kind of counter-governmentality, animated by the social relations of shared poverty, by the excitement of active participation in the politics of knowledge, and by its own openness to correction through other forms of intimate knowledge and spontaneous everyday politics. In short, this is governmentality turned against itself."[19] What we saw in the form of this "capillary reach" was a desire for "statistical visibility" on the part of not just the urban poor, but also those serving them, seeing this as a first step toward a governmentality aspiring to democratize and serve, rather than to control or exploit.

Such a methodology of generating evidence for recommendations from multiple sources signifies a departure from hitherto practiced traditional mechanisms of establishing TRGs that are composed of experts who provide weighty, lofty, and thus disconnected recommendations. While we do not dispute this method, the participation of a group of practitioners, technical experts, nongovernment organizations that work on equity aspects, and finally those with an in-depth knowledge of survival techniques of the poor and marginalized in urban areas created a group that brought varying perspectives and the possibility of deeper, closer, and more pragmatic observation, validated by city reports and then crafted into recommendations.

This could be seen as a process of coproduction, or "the process through which inputs used to produce a good or service is contributed by individuals who are not 'in' the same organization."[20] In co-production (for an extensive treatment of co-production, see Albrechts[21]), the users or beneficiaries of services interact with policy makers and their expert advisers not merely in a consultative role, but in a manner that makes use of their skills to deliver services, policies, plan,s or projects. Further, "coproduction plans and delivers in mutually beneficial ways and acknowledges and rewards local 'lay' experience while continuing to value professional expertise."[22] Of co-production, Albrecht points out that citizens are actively involved in the agenda setting; problem formulation; the shaping of the content of policies, plans, and projects; and the delivery as well.[21] He adds: "For planners working in the system (government planners), an equity type of planning is open to local knowledge and where citizens and the disadvantaged become an equal part of the action seems suited ... [and] 'hard distinctions between expert and lay, scientific and political order, and facts and values are rejected' (Bovaird, 2007: 423) and in order to bear on the implementation of actual projects, programmes, and policies."[21]

Importantly, they also represented different epistemologies—of lived experience from the perspective of citizens, of operational lessons from the perspective

of implementers, and of academic research and synthesis with theory building—largely but not necessarily following a grounded theory approach from the perspective of researchers (see Table 1). The efforts of the TRG were centered on not privileging or ordering, but rather accommodating and negotiating all these forms of knowledge, contribution, and participation.

In most decision making, there is usually a "hierarchy of opinion formers"[23] such that targets or beneficiaries of policies are often the least valued or visible in recommendation processes. Elsewhere is noted that there is "increasing reliance on the notion of evidence-based knowledge rather than value-commitment" creating a situation where since "'participation is undertaken on what are seen as stigmatizing terms' it may reinforce exclusion rather than promote inclusion."[24] Further, the literature is critical of instrumental or "consumerist/managerialist" approaches to participation in which agendas are set from above.[25] Even where attempts are made at the local level to create genuinely participatory spaces, these can be circumscribed by government priorities and targets.[26]

As we view our own efforts, we are mindful that "community participation is often used by governments as a means of legitimizing the political system and as a form of social control. The level of commitment by many governments to community participation has often been dubious or extremely limited. Formal channels of community participation have not always generated major benefits

**Table 1.** Types of Knowledge Sought, Methods Employed, and Lessons Learned in the NUHM TRG Process.

| Type of knowledge | Method employed | Lessons learned |
|---|---|---|
| Epistemic/Academic | Secondary literature review: Integrating information from observations and interviews with recognition of patterns and learnings into forms of theory building | Impoverishment due to out-of-pocket expenditure<br>Adoption of context-specific qualitative research methodologies for systematic collection of primary data<br>Path dependence of systems, understanding and negotiating stakeholder positions on recommendations |
| Implementer | In-depth interviews, team visits, and observations | Ubiquity of private sector, multiplicity of governance structures |
| Community | Focus group discussions, in-depth interviews, team visits, and observations | Experiences of discrimination, invisibility of heterogeneity in categories (slumdwellers, homeless) |

for local communities".[27] How, then, to think about a different kind of participation in this context?

Conceptually, it may be useful to think about the principle of "participatory parity" enunciated by Nancy Fraser: the ability of all (adult) members of society to interact with one another as peers."[28] According to Fraser, participatory parity is comprised of three concepts: redistribution, recognition, and representation. Redistribution refers to equality of *what* (in terms of "rights, resources, primary goods, opportunities, real freedoms, and capabilities;"[29] and recognition is preoccupied with equality among whom (i.e., "who is entitled to consideration in a given case").[29] More recently, taking note of an increasingly globalized neoliberalized/ing context, Fraser has added the "how" of equality in the notion of representation, to mean "the question of who is included, and who excluded, from the circle of those entitled to participate."[29]

Our fieldwork was prefaced in many cases by a government mandate involving requests "from above" to see facilities, to speak with officers, etc. In the case of implementers and health system actors, access was afforded by municipal corporation representatives, administrative service bureaucrats, or state health department technocrats. In academic institutions, senior researchers or organizational heads referred the TRG to individual researchers and pieces of research. Similarly hierarchical, if somewhat more diagonal, relations characterized access to knowledge from nongovernment interlocuters and beneficiaries or networks of the "vulnerable." We are sensitive to the degree to which this may not meet the criterion of *representation*, even as it attempts to *redistribute* (the right to influence policy through very open-ended consultations and primary appraisal) and *recognize* (epistemic, operational, and experiential knowledges). The TRG may have addressed issues of redistribution and recognition somewhat, but had only made limited gestures toward recognition in expanding its working groups. While the acknowledgement of and attentiveness to the vulnerable urban poor was foregrounded in this policy making process, the actual, direct participation of vulnerable groups in final deliberations and decision making was not undertaken in this exercise. However, the frame and scope of urban health reform may have been widened enough through the TRG exercise to entertain this possibility in certain cities or contexts—perhaps not immediately, but eventually. This remains to be seen.

It is important to underline that the task of representation to favor the urban vulnerable would require negotiating the existing power structures wherein decision making takes place. Time as always was a challenge, and one casualty was an insufficient analysis of the city reports. Time constraints meant that the TRG as a complete group was unable to meet together more often, resulting in a small core group who were actually entrusted with the review and analysis of reports and writing the final recommendations. Only about two months were spent developing and analyzing the reports respectively, placing acute pressure and strain on this small group of people. On one hand, this resulted in a kind of

emergent, immersive analysis. On the other hand, the clarity that could have come with some distance and time away from analysis was missed, as was the clarity that could have come from the time it would take to directly involve the urban poor in the making of final decisions and recommendations.

A related challenge was that the report was written *pari passu* with the states developing project implementation plans (PIP), the planning and financial proposal submission mechanism for the NUHM. In some sections, the report complemented the framework that formed the basis for plans; in others it was contradictory, and on some issues, it was silent. The challenge for states was on reconciliation of these three possibilities in each urban context, particularly when the PIP was the financing instrument.

## Impact of the TRG Recommendations on Urban Health Reforms

While drafting the recommendations, we anticipated both policy reactions and implementation to be variegated and episodic. We were mindful that "programs demanding conformity are likely to meet with superficial compliance efforts from local implementers. In addition, demanding uniformity when processes are poorly understood robs us of vital information and limits the street-level bureaucrats' use of their knowledge as a resource."[30] The recommendations were therefore open-ended, allowing customization and the use of local agency and knowledge in application.

Even with these considerations, we had been overly optimistic in our prognosis. Two months after the recommendations came out, India had elections. A new government came to power, which in the first two years of its five-year tenure has signaled a lack of interest in strengthening public health.[31–33] Funding for health has declined over the past two years, with a shrinking share of federal contributions.[33] This has translated into an attenuation of neglect of urban health, as even with the launch of this (and other plans) and the refinement of program design through TRG recommendations, there has been no tandem allocation of funds for implementation. Thus, the implementation of TRG recommendations has been forestalled by the larger belt-tightening of the health sector over the past four years.[34]

This is not to suggest that there have not been small-scale efforts to adopt reforms. In many cities, urban primary health centers operate in evening hours so as to accommodate the working poor. *Mohalla* or neighborhood clinics (customizations of the sub-center concept) are being opened in areas where the urban poor reside in larger proportions—in cities across a range of sizes—large metros like Delhi, smaller cities like Pune, and even smaller ones like Mysuru.[35–37] From these efforts,we are learning that the process of implementing the changes proposed by the TRG will will be poly-vocal and heterogeneous. The hope is that

they will also be sustainable, notwithstanding the trend of fiscal consolidation in the country.

## Conclusion

In the face of the ongoing challenges of prioritizing health in India, the NUHM TRG recommendation exercise has been a unique experiment with co-production in policy making. We have learned that policy processes are often a dialectic that may suggest or involve shifts that a range of stakeholders may variably resist or embrace,[38] and indeed that even in a larger context of neglect, such processes may be modestly advanced. The most important lesson, however, is for national policy makers: It is both feasible and desirable to engage directly with the community, implementers, and researchers and to negotiate and connect their knowledge(s) in the crafting of public policy.

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### Notes

a. Globally, around the same time, in 1991, World Health Assembly Resolution 44.27 noted the need for development, reorientation, and strengthening of urban health services and decentralization of responsibilities. The Healthy Cities and Municipalities Movement approach placed premium on principles of the Health for All strategy and Local Agenda 21 emphasized equity, participatory governance, and inter-sectoral collaboration to address the social determinants of health.
b. To address this in particular, the TRG recommended that at least 50% of the primary health centers should be in the immediate vicinity of slums areas, offering a range of services (sexual and reproductive, occupational, infection control, for chronic diseases) commensurate with the identified needs of vulnerable groups concentrated in the area.

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