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General Article

NATIONAL URBAN HEALTH MISSION: A MISSION FOR URBAN POOR IN INDIA

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ABSTRACT
India's population has crossed 121 crores as per census 2011, with the urban population at 37.7 cores which is 31.16% of the total population and the urban population is estimated to increase to 43.2 crores by year 2021. Urban growth has led to rapid increase in number of urban poor population, many of whom live in slums and other squatter settlements. Despite the supposed proximity of the urban poor to urban health facilities their access to them is severely restricted. The NUHM would have high focus on: Urban Poor Population living in listed and unlisted slums. All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, construction and brick and lime kiln workers, sex workers, and other temporary migrants. Public health thrust on sanitation, clean drinking water, vector control etc. Strengthening public health capacity of urban local bodies. The NUHM therefore aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. The NUHM would strive to put in place a sustainable urban health delivery system for addressing the health concerns of the urban poor. The NUHM proposes to measure results at different levels with a long term as well as intermediate term view.

INTRODUCTION
According to Census 2001, 28.6 crores people live in urban areas and by 2021, the urban population is estimated to increase to 35.7crores in 2011 and to 43.2 crores (Registrar General of India, 2006). Urban growth has led to rapid increase in number of urban poor population, many of whom live in slums and other squatter settlements. As per Census 2001, 4.26 crores people lived in slums spread over 640 towns/ cities having population of fifty or above. In the cities with population one lakh and above, the 3.73 crores slum population is expected to reach 6.25 crores by 2008, thus putting greater strain on the urban infrastructure which is already overstretched (Planning Commission, 2002-2007)

Despite the supposed proximity of the urban poor to urban health facilities their access to them is severely restricted. This is on account of their being "crowded out" because of the inadequacy of the urban public health delivery system. Ineffective outreach and weak referral system also limits the access of urban poor to health care services. The social exclusion and lack of information and assistance at the secondary and tertiary hospitals makes them unfamiliar to the modern environment of hospitals, thus restricting their access. The lack of economic resources inhibits/ restricts their access to the available private facilities. Further, the lack of standards and norms for the urban health delivery system, when contrasted with the rural network, makes the urban poor more vulnerable and worse off than their rural counterpart.

This situation is further worsened by the fact that a large number of urban poor are living in slums that have an "illegal status". The "illegal status" compromises the entitlement of the slum

dweller to basic services. Slum populations, obviously, 'face greater health hazards due to over crowding, poor sanitation, lack of access to safe drinking water and environmental pollution[7].

The above situation is reflected in the poor health indicators. As per the re-analysis of the NFHS III data, Under 5 Mortality Rate (U5MR) among the urban poor is at 72.7, significantly higher than the urban average of 51.9. About 47.1% of urban poor children under-three years are underweight as compared to the urban average of 32.8% and 45% among rural population. Among the urban poor, 71.4% of the children are anemic as against 62.9% in the case of urban average. Sixty percent of the urban poor children miss complete immunization as compared to the urban average of 42%. Only 18.5% of urban poor households have access to piped water supply at home as compared to the urban average of 50%. Among the urban poor, 46.8% women have received no education as compared to 19.3% in urban average statistics. Among the urban poor only 44 % of deliveries are institutional as compared to the urban average of 67.5%.[8]

Despite availability of government and private hospitals the urban poor prefer home deliveries. Expensive private healthcare facilities, perceived unfriendly treatment at government hospitals, emotionally securer environment at home, and non-availability of caretakers for other siblings in the event of hospitalization are some of the reasons for this preference. Poor environmental condition in the slums along with high population density makes the urban poor vulnerable to lung diseases like Asthma; Tuberculosis (TB) etc. Slums also have a high incidence of vector borne diseases (VBDs) and cases of malaria among the urban poor are twice as in the case of other urbanites. Open sewers, poorly built septic tanks, stagnant water both inside and outside the house serve as ideal breeding ground for insects. As per the forecasting data in National Commission on Macroeconomics and Health (NCMH) report, cases of coronary heart disease in the urban areas will continue to rise and will be higher as compared to rural areas, similarly the load of diabetes cases in India will rise from 2.6 crores in 2000 to 4.6 crores by 2015 particularly concentrated in urban areas.

There are particular occupations such as rickshaw pullers, rag pickers, sex workers, and other urban poor categories like beggars and destitutes, construction workers, street children who are also a highly vulnerable group especially at greater risk to RTI/STI and HIV/AIDs. The National Urban Health Mission therefore seeks to address the health concerns of the urban poor by facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. The available gaps are planned to be filled by partnership with non government providers. This will be done in a manner so as to ensure well identified facilities are set up for each segment of target population which can be accessed as a matter of right.

The process of developing a health care delivery system in urban areas has not as yet received the desired attention. The Tenth Plan Document observes that 'unlike the rural health services there have been no efforts to provide well-planned and organized primary, secondary and tertiary care services in geographically delineated urban areas. As a result, in many areas primary health facilities are not available; some of the existing institutions are underutilized while there is overcrowding in most of the secondary and tertiary centers.

Goal and Core Strategies of NUHM

Goal

The National Urban Health Mission would aim to improve the health status of the urban poor particularly the slum dwellers and other disadvantaged sections, by facilitating equitable access

to quality health care through a revamped public health system, partnerships, community based risk pooling and insurance mechanism with the active involvement of the urban local bodies.

Core Strategies

The exigencies of the situation as detailed in the aforesaid chapters merit the consideration of the following strategies:

(i) Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing urban primary health structure: The situational analysis has clearly revealed that most of the existing primary health facilities, namely, the Urban Health Centres (UHCs) /Urban Family Welfare Centres (UFWC)/ Dispensaries are functioning sub-optimally due to problems of infrastructure, human resources, referrals, diagnostics, case load, spatial distribution, and inconvenient working hours. The NUHM therefore proposes to strengthen and revamp the existing facilities into a "Primary Urban Health Centre" with outreach and referral facilities, to be functional for every 50,000 population on an average.

However, depending on the spatial distribution of the slum population, the population covered by a PUHC may very from 5000 for cities with sparse slum population to 75,000 for highly concentrated slums. The PUHC may cater to a slum population between 20000-30000, with provision for evening OPD, providing preventive, promotive and non-domiciliary curative care (including consultation, basic lab diagnosis and dispensing). The NUHM would improve the efficiency of the existing system by making provision for a need based contractual human resource, equipments and drugs. Provision of Rogi Kalyan Samiti is also being made for promoting local action. The provision of health care delivery with the help of outreach sessions in the slums would also strengthen the delivery of health care services. On the basis of the GIS map the referrals would also be clearly defined and communicated to the community thus facilitating their easy access.

The eligibility criterion for resource support under the Mission however would be rationalization of the existing public health care facilities and human resources in addition to mapping of unlisted slums and clusters.

(ii) Partnership with non government providers for filling up of the health delivery gaps:

Analysis has also revealed that a large number of urban slum clusters do not have physical access to public health facilities whereas there are non government providers being accessed by the urban poor. It has also been observed that specialized care, diagnostics and referral transport is prominently available in the non government sector. It is therefore proposed to leverage the existing non government providers to improve access to curative care.

It was also observed that urban population living in slums lack health awareness and organizational capacity which the existing public health system is not able to deal with. However it was seen that in many cities non government agencies/ civil society groups are playing a significant role in community mobilization. It is thus proposed to forge partnership with this sector to promote active community participation and ownership.

(iii) Promotion of access to improved health care at household level through community based groups: Mahila Arogya Samittees (MAS)

The 'Mahila Bachat Gat' scheme in Maharashtra and urban health initiatives in Indore and Agra have demonstrated the efficacy of women led thrift/self help groups in meeting urgent cash needs in times of health emergency and also empowering them to demand improved health services. In view of the visible usefulness of such women led community/ self help groups; it is proposed to promote such community based groups for enhanced community participation and empowerment

in conjunction with the community structures created under the Swarna Jayanti Shahari Rojgar Yojana (SJSRY), a scheme of the Ministry of Urban Development which seeks to provide employment to the urban poor. Under the Urban Self Employment Programme (USEP) of the scheme there are provisions for Development of Women and Children in Urban Areas (DWCUA) groups of at least 10 urban poor women and Thrift Credit Groups (TCG) which may be set up by groups of women.

There is also provision for informal association of women living in mohalla, slums etc to form Neighbourhood Groups (NHGs) under SJSRY who may later federate towards a more formal Neighbourhood Committee (NHC). Such existing structures under SJSRY may also federate into Mahila Arogya Samittee, (MAS) a community based federated group of around 20 to 100 households, depending upon the size and concentration of the slum population, with flexibility for state level adjustments, and be responsible for health and hygiene behavior change promotion and facilitating community risk pooling mechanism in their coverage area. The Urban Social Health Activist (USHA) an ASHA like activist, detailed in the following pages, may provide the leadership and promote the Mahila Aorgya Samitee. The USHA may be preferably co-located with the Anganwadi Centres located in the slums for optimisation of health outcomes. Each of the MAS may have 5-20 members with an elected Chairperson/ Secretary and other elected representative like Treasurer. The mobilization of the MAS may also be facilitated by a contracted agency/NGO, working along with the USHA responsible for the area.

(iv) Strengthening public health through preventive and promotive action

Urban Poor face greater environmental health risks due to poor sanitation, lack of safe drinking water, poor drainage, high density of population etc. There is a significant correlation between morbidity due to diarrhea, acute respiratory infections and household hygiene behavior, environmental sanitation, and safe water availability. Thus strengthening promotive action for improved health and nutrition and prevention of diseases will be a major focus of the Mission. The Mission would also provide a framework for pro active partnership with NGOs/civil society groups for strengthening the preventive and promotive actions at the community level. The USHA, in coordination with the members of the MAS would promote proactive community action in partnership with the urban local bodies for improved water and environmental sanitation, nutrition and other aspects having a bearing on health. Resources for public health action would be provided as per city specific need.

(v) Increased access to health care through risk pooling and community health insurance models

As substantiated by various studies (" Morbidity and Treatment of Ailments" NSS Report Number- 441(52/25.0/1) based on 52nd round) the urban poor incur high out-ofpocket expenditure often leading to indebtedness and impoverishment. To mitigate this risk, it is proposed to encourage Mahila Arogya Samitis to “save for a rainy day” for meeting urgent health needs. NUHM also proposes to promote Community based Health Insurance models to meet costs arising out of hospitalization and critical illnesses.

(vi) IT enabled services (ITES) and e- governance for improving access improved surveillance and monitoring

Various studies have shown that the informal status and migratory nature of majority of the urban poor, compromises their entitlement and access to health services.[4] It also poses a challenge in tracking and provisioning for their health care. Studies have also highlighted that the private providers, which the majority of the urban poor access for OPD services, remain outside

the public disease surveillance network. This leads to compromised reporting of diseases and outbreaks in urban slums thereby adversely affecting timely intervention by the public authorities. The availability of ITES in the urban areas makes it a useful tool for effective tracking, monitoring and timely intervention for the urban poor. The NUHM would provide software and hardware support for developing web based HMIS for quick transfer of data and required action. The States would also be encouraged to develop strategies for effecting an urban disease surveillance system and a plan for rapid response in times of disasters and outbreaks. It is envisioned that the GIS system envisioned would be integrated into a system of reporting alerts and incidence of diseases on a regular basis. This system would also be synchronized with the IDSP surveillance system. As per the current status, the IDSP is already at an advanced stage of implementing urban surveillance in 4 mega cities of the country by combining the existing Urban Health Posts with newly established epidemiology analysis units at intermediate and apex levels in these cities. There is a plan to upscale this model to include 23 more, million- plus cities, by the middle of calendar year 2008. Also a surveillance reporting network of 8 major infectious diseases hospitals located across the length and breadth of the country is being established that would act as state of the art surveillance centers for epidemics. It is envisioned that as the NUHM becomes operational there would natural synergies with the IDSP urban surveillance set up.

(vii) Capacity building of stakeholders

It was observed that except for a few, provisioning of primary health care was low on priority for most of the urban local bodies with many Counsellors showing a clear proclivity for development of tertiary facilities. This skewed prioritization appears to have clearly affected the primary health delivery system in the urban local bodies, also adversely affecting skill sets of the workforce and limiting technical and managerial capacities to manage health. NUHM thus proposes to build managerial, technical and public health competencies among the health care providers and the ULBs through capacity building, monetary and non monetary incentives, and managerial support.

(viii) Prioritizing the most vulnerable amongst the poor

It is seen that a fraction of the urban poor who normally do not reside in slum, but in temporary settlement or are homeless, comprise the most disadvantaged section. Under the NUHM special emphasis would be on improving the reach of health care services to these vulnerable among the urban poor, falling in the category of destitute, beggars, street children, construction workers, coolies, rickshaw pullers, sex workers, street vendors and other such migrant workers. Support would be through city specific strategy with a cap of 10% of the city budget.

(ix) Ensuring quality health care services

NUHM would aim to ensure quality health services by a) defining Indian Public Health Standards suitably modified for urban areas wherever required b) defining parameters for empanelment/regulation/accreditation of non-government providers, c) developing capacity of public and private providers for providing quality health care, d) encouraging the acceptance and enforcement of local public health acts d) ensuring citizen charters in facilities e) encouraging development of standard treatment protocols.

CONCLUSION

The NUHM would strive to put in place a sustainable urban health delivery system for addressing the health concerns of the urban poor. Since NUHM would complement the efforts of

NRHM, the expected health outcomes of the NRHM would also be applicable for NUHM. The NUHM would therefore be expected to achieve the following targets in urban areas:

- IMR reduced to 30/1000 live births by 2012.
- Maternal Mortality reduced to 100/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.
- Reduction in Malaria Mortality by 50% by 2015
- 25 % reduction in malaria morbidity and mortality up to 2010, additional 20% by 2012.
- Kala Azar Mortality Reduction Rate - 100% by 2010 and sustaining elimination until 2012.
- Filaria/Microfilaria Reduction Rate - 70% by 2010, 80% by 2012 and elimination by 2015.
- Filariasis: Coverage of more than 80% under MDA
- Reduction in case fatality rate and reduction in number of outbreaks of dengue
- Dengue Mortality Reduction Rate - 50% by 2010 and sustaining at that level.
- Chikungunya: Reduction in number of outbreaks and morbidity due to Chikungunya by prevention and control strategy
- Leprosy Prevalence Rate –reduced from 1.8 per 10,000 in 2005 to less than 1 per 10,000 thereafter.
- Tuberculosis DOTS series - maintain 85% cure rate through the entire Mission Period and also sustain planned case detection rate.
- Reduce the prevalence of deafness by 25% (from existing levels) by 2012

(d) Measurable Indicators of improved health of the urban poor at the City Level is also proposed to be assessed annually through e- enabled HMIS and surveys. Convergence would also be sought with the NRHM HMIS.

The NUHM would encourage the participation of the community in the planning and management of the health care services. It would promote an Urban Social Health Activist (USHA) in urban poor settlements (one USHA for 1000-2500 urban poor population covering about 200 to 500 households); ensure the participation by creation of community based institutions like Mahila Arogya Samiti (20-100HH) and Rogi Kalyan Samitis. It would proactively reach out to urban poor settlements by way of regular outreach sessions and monthly health and nutrition day. It mandates special attention for reaching out to other vulnerable sections like construction workers, rag pickers, sex workers, brick kiln workers, rickshaw pullers.

The NUHM would promote Community health risk pooling and health insurance as measures for protecting the poor from impoverishing effect of out of the pocket Public or empanelled Secondary/ Tertiary private Providers Urban Health Centre (One for about 50,000 population-25-30 thousand slum population). Strengthened existing Public Health Care Facility Empanelled Private Service providers Community Outreach Service (Outreach points in government/ public domain Empanelled private services provider) Urban Social Health Activist (200-500 HH) Mahila Arogya Samiitee (20-100HH) Referral Primary Level Health Care Facility Community Level. This may be adapted flexibly based on spatial situation of the city expenditure. To promote community risk pooling mechanism slum women would be organized into Mahila Arogya Samiti. The members of the MAS would be encouraged to save money on monthly basis for meeting the health emergencies. The group members themselves would decide the lending norms and rate of interest. The NUHM would provide seed money of Rs. 2500 to the MAS (@

Rs 25/- per household represented by the MAS). The NUHM also proposes incentives to the group on the basis of the targets achieved for strengthening the savings.

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