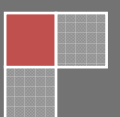


Final  
Report

# Report and Recommendations Of Technical Resource Group For National Urban Health Mission

Ministry of Health and Family Welfare  
February 2014



**Report and  
Recommendations  
*of the*  
Technical  
Resource Group  
*For the*  
National Urban  
Health Mission**

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## **Chapter 1:**

### **Mandate & Process of the Technical Resource Group for NUHM**

- 1.1 On 1st May 2013, the cabinet approved the National Urban Health Mission as a part of the National Health Mission (NUHM), thus bringing to conclusion a process which began, along with the National Rural Health Mission, as far back as 2006. The main objective of NUHM is “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”(NUHM Framework, 2013).
- 1.2 The National Urban Health Mission is proposed to be launched in all cities and towns with more than 50,000 populations as well as all district headquarters, towns and state capitals irrespective of their population. The active involvement of urban local bodies for the provision of convergent health services is part of the design.
- 1.3 The social and-political context for the launch of NUHM is the urgent need to address the health needs of the urban poor. As the economy of the country expands there is a trend towards urbanization. The urban population of the country increased from 27 crores in 2001 to 37.7 crores in the 2011 census and is expected to become 46 per cent of the entire population by 2030. Urban growth is largely fuelled by migration of the people from rural areas- partly due to increased opportunities and livelihoods available (the pull factor) and partly due to distress conditions in rural areas (the push factor). However, the expansion of the working and living conditions of the city and the access to basic services has not kept pace with such growth. This has led to major health issues in the urban centres, most of which predominantly affect the poorest and most marginalised populations in the slums. Poverty coupled with the lack of access to services emerges as a major issue for a poor and worsening health situation among the urban population. And this is poverty amongst plenty- for there is a surplus of doctors and hospitals in urban India- but for social and financial reasons, they are far out of the reach of a major part of the population. Indeed in key health outcome indicators like infant mortality and in major health service delivery indicators like immunization rates, though in absolute values, urban areas may do better. In terms of change, the rates of improvement in urban India are consistently lower than the rural areas. It is at this context that the National Urban Health Mission was proposed as a means for

the state to effectively address the health concerns of the urban population, especially the poor.

- 1.4 Once the NUHM was notified and its financial sanctions in place, on 25th July, 2013 the Government of India issued an order stating the formation of a Technical Resource Group (TRG) on National Urban Health Mission under the Chairpersonship of Mr Harsh Mander. The members of the TRG (Annexure 1) included Officers of the Ministry, representatives of the state governments and urban local bodies working on urban health issues, and members of the civil society and academics who had been engaged in urban health for long. NHSRC provided the TRG with its secretariat support. The terms of reference of the TRG were wide ranging and it called for the TRG to guide the NUHM on key issues of reaching to the vulnerable sections of the society. It also extended to examining the main strategies and institutional design of NUHM, formulating strategies to reach the vulnerable populations, and the better organization of health service delivery and its governance.
- 1.5 The first TRG meeting was held on 4th September, 2013. The NUHM leadership in the ministry presented its programme and plans, and various members expressed their priorities and concerns. On the basis of the discussions, to fulfil the objectives of the TRG as set out in its terms of reference, four working groups were formed namely Reaching Vulnerable Populations (WG I), Institutional arrangements (WG II), Community Processes and Convergence (WG III) and Urban Health Financing, Governance and Phasing (WH IV). Various resource persons were invited to contribute to these working groups. The Secretariat too was strengthened by recruiting five short-term consultants.
- 1.6 In the following month, all the working groups were convened and meetings of the groups were held on October 3rd, 4th, 5th and 10th respectively with the experts from across the country participating (Annexure 2). In the meetings it was decided to conduct visits and study urban health systems across 30 cities to understand the existing conditions. Members of the first working group also volunteered to carry out some primary research mainly in the form of focus group discussions with the vulnerable groups. Consultation meetings were also organised with public health organisations like PFI and PHFI which had been working on this theme and supporting MOHFW for the same. By the first week of November the secondary research was complete and the research tools (Annexure 6) were finalised and circulated among members of the working group.
- 1.7 During the months of November and December 31 identified cities and towns were visited by teams comprising of two to five members and over 40 focus group discussions with vulnerable groups were conducted. During the city visits to collect the data, the researchers interviewed various stakeholders like the officials of the

urban local body, state health department, representatives of the NGOs and of vulnerable communities. Also various primary health facilities were visited to understand the functioning of the primary health care facilities in the urban centres under the leadership of local bodies and state health department. The objective of consulting the officials of both local body and state health department was to understand the dynamics of health and related services in the urban centres. Vulnerable communities from the slums and streets of the city were identified to conduct the focus group discussions and understand: the extent of vulnerability; examine the availability of health care services and the accessibility of services to the vulnerable groups. To understand the prospect of engaging public private partnership in the health services, discussions were held with the NGO representatives who work closely with the local government in health care services.

1.8 All the city visit reports were collected and compiled by 30th December, 2013 and finalised and circulated by the first week of January, 2014. The list of the cities visited is given below.

**Table1.1: The Cities Visited**

Metro Cities	Million Plus cities	Cities ranging from 1 lakh to 10 lakhs
Delhi	Pimpri-Chinchwad	Raipur
Mumbai	Vishakapatnam	Bhubaneswar
Bangalore	Madurai	Guwahati
Chennai	Aligarh	Shimla
Ahmedabad	Pune	Jorhat
Kolkata	Tumkur	Ambala
	Patna	Muzzafarpur
	Indore	Bardhman
	Bhopal	Thrissur
	Kochi	Vizianagaram
		Dhamtari
		Villupuram
		Satara
		Valsad
		Gangtok

1.9 The second Technical Resource Group meeting for National Urban Health Mission was held on 17th December, 2013. The meeting was chaired by Mr. Harsh Mander, Chairman of the TRG and Mr. Keshav Desiraju secretary MOHFW and Ms. Anuradha Gupta AS & MD were special invitees. Dr. T Sundararaman, the member convenor, presented the progress of the NUHM TRG. Mr Harsh Mander then presented the emerging recommendations. He also presented and placed on record the review of secondary literature and the Urban Health Situation Analysis Tool that had been finalised by the working groups. Each working group of the TRG presented the

findings from the city reports and its review of secondary literature. The areas of focus in the discussion included mapping of vulnerabilities, budget constraints, special health facilities for vulnerable populations, physical constraints like land to build health facilities, inclusion of the private sector and creating referrals and nursing station and sub-health centres and many other issues of organization of urban health services.

1.10 Based on these inputs a draft report and recommendations was finalised and circulated- for comments by the members and the interested public. In researching for and the writing of this Report, a great number of experts have volunteered a great deal of time as a labour of love, and whatever worth the Report carries is because of their contributions. Those who contributed in undertaking field studies and writing for the Report include Rajib Dasgupta, Devaki Nambiar, Sulakshana Nandi, Anjali Chikersal, Arundhati Murlidharan, Tarique Mohd, M. Ganapathy, Nandita Bhan and members of the Secretariat- Pratibha Ganesan, Shikha Gupta, Richa Kandpal, Aastha Sharma and Ahonaa Roy. I am grateful to all the Members of the TRG who contributed greatly in all our deliberations, including a number of city health officers who were representing their commissioners and secretaries in the meetings and visits. I received valuable advice from Srinath Reddy of PHFI, Poonam Muttreja of PFI, Girinde Beeharry of BGF, Dr Srinivasa Murthy, and Dr Ritu Priya among many others.

1.11 The third meeting of the Technical Resource Group was held on 13<sup>th</sup> February 2014. The meeting was attended by TRG members or their representatives and by the convenors of the working groups. We collectively discussed each before finalising the same. I am happy to note that there was consensus on almost all findings and recommendations. The WHO representative, while welcoming and agreeing with the TRG report and recommendations, submitted a note on some broader perspective issues which was also taken note of.

1.12 I am very grateful to Secretary Health, Government of India Keshav Desiraju, Additional Secretary Anuradha Gupta, Joint Secretaries Manoj Jhalani and Nikunja Dhal for entrusting me with this important task, and extending valuable support and counsel throughout the process. And finally this Report owes a great debt to Dr T Sundararaman, Executive Director NHSRC, who both carried the enormous logistics of 31 city visits and a series of meetings in the short space of three months, but more importantly provided intellectual depth and rigour to the writing of the whole Report. The failings of the Report are all entirely mine.

**Harsh Mander**

Chairperson, TRG, NUHM

## Chapter 2

### Overview of Urban Poverty and its relevance to issues of urban health

#### 2.1 Urbanization in India:

- i. Urbanization is one of the most significant demographic trends of the 21<sup>st</sup> century, and is expected to significantly boost workforce participation, capital investment, and innovation<sup>1,2,3</sup>. India is slowly becoming more urban; the proportion of the urban population has increased from 10.8 per cent in 1901 to 31.2 per cent in 2011, and is expected to increase to 50 per cent over the next few decades.<sup>4</sup> Between 2001 and 2011, the urban population of India grew by 91 million to about 377 million, and is estimated to increase by more than 200 million by 2030<sup>5</sup>. For the first time in independent India, the growth of the urban population has been greater than that of the rural population; the proportion of the rural population has, in fact, declined over the past 10 years. There is considerable variation in urbanization rates across states, and Maharashtra, Uttar Pradesh, and Tamil Nadu are home to the largest number of urban residents in the country.
- ii. Urban population growth in India can be explained by three forces: natural population growth, net migration (from rural to urban areas), and transformation and reclassification of cities and peri-urban areas.<sup>6</sup> Urbanization in India is driven by some combination of these components, and evidence suggests that natural increase in population accounts for a larger proportion of urban growth as compared to net rural to urban migration and changes in municipal boundaries and reclassification of cities<sup>7,8,9</sup>. The 2001 Census found that rural to urban migration accounted for only about 22 per cent of all migration in the country. Additional analysis of census data offers more evidence

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<sup>1</sup>Grimond J. The world goes to town: A special report on cities. *Economist*. 2007: 3-5.

<sup>2</sup>Montgomery MR. Urban poverty and health in developing countries. *Popul Bull* 2009; 64 (2).

<sup>3</sup>United Nations. *World Urbanization Prospects: The 2011 Revision*. New York: United Nations; 2011.

<sup>4</sup>Chandramouli C. Urban rural distribution of population: Provisional population totals. *Census of India 2011*. 2011. Accessed on 30<sup>th</sup> May 2013. Available at: [http://censusindia.gov.in/2011-prov-results/paper2/data\\_files/india/Rural\\_Urban\\_2011.pdf](http://censusindia.gov.in/2011-prov-results/paper2/data_files/india/Rural_Urban_2011.pdf)

<sup>5</sup>McKinsey Global Institute. *India's urban awakening: Building inclusive cities, sustaining economic growth*. McKinsey & Company; 2010.

<sup>6</sup>Bhagat RB. Components of Urban Growth in India with Reference to Haryana: Findings from Recent Censuses. *Nagarlok* 1992; 25 (3): 10-14.

<sup>7</sup>Shindoa T. Morphology of India's Urbanization. *The Developing Economies* 1996; XXXIV-4.

<sup>8</sup>Datta P. Urbanization in India. Indian Statistical Institute, Kolkata. Submitted for the European Population Conference June 2006.

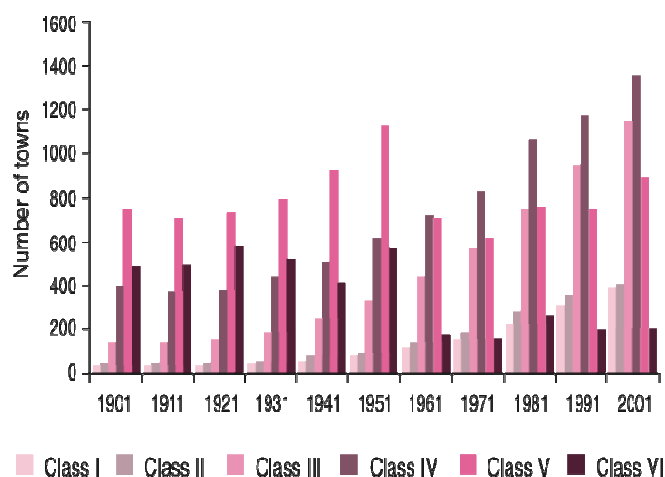
<sup>9</sup>Office of the Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India. *Census of India 2001. Data Highlights: Migration Tables*. Accessed on 19<sup>th</sup> December 2013. Available at: [http://censusindia.gov.in/Data\\_Products/Data\\_Highlights/Data\\_Highlights\\_link/data\\_highlights\\_D1D2D3.pdf](http://censusindia.gov.in/Data_Products/Data_Highlights/Data_Highlights_link/data_highlights_D1D2D3.pdf)



to support this - that the percentage of male intercensal migrants in urban areas has declined from 7.9 per cent in 1961 to 3.3 per cent in 1991.<sup>10</sup>

- iii. The 2011 Census reports that about 43 per cent of India’s urban population currently resides in 53 cities with a million plus population. In addition to this, there are 468 cities with a population of at least one lakh. By 2030, an estimated 590 million Indians will live in urban areas and the country will house 68 million plus cities. Mega-cities, like Mumbai, are large multi-nuclear urban agglomerations that boast of over 10 million residents, and mega-urban regions such as Delhi, are characterized by the “territorial expansion of urban settlements”.<sup>11</sup>
- iv. Perhaps most salient in India is that much of the urban growth is projected to occur in mid-sized and smaller cities, cities that currently lack the capacity to absorb and respond to this growth. Analysis of Census data from 1901 to 2001 also reveals that there has been an increase in the number of class I, class II, class III, class IV, and class V cities, but a decline in class VI (the smallest and possibly the most rural) during this period (see Table 2.1 for classification of cities according to population size and Figure 2.1 for a graphical representation of this growth).<sup>10</sup>

**Figure 2.1: Number of towns according to size classification**



Type of town	Population size
Class I	100,000+
Class II	50,000 – 99,999
Class III	20,000 – 49,999
Class IV	10,000 – 19,999
Class V	5000 – 9999
Class VI	< 5000

Source: Kundu 2006,<sup>10</sup> p 29

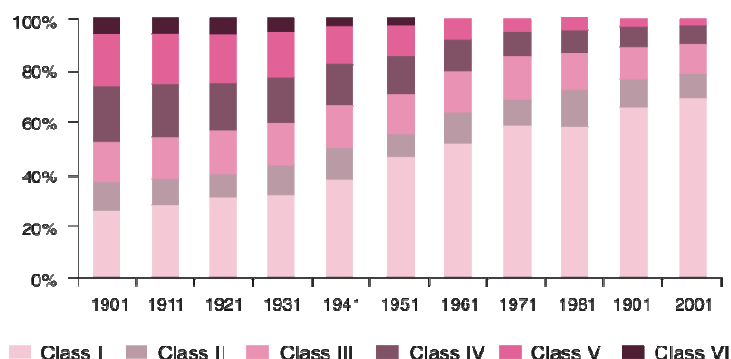
- v. The figure above clearly shows the steady growth in the number of class III and IV towns over the past five to six decades. At the same time, Class I towns have

<sup>10</sup>Kundu A. Trends and patterns of urbanization and their economic implications.2007. Accessed on 10<sup>th</sup> May 2013. Available at: [http://www.iitk.ac.in/3inetwork/html/reports/IIR2006/Trends per cent20& per cent20Patt.pdf](http://www.iitk.ac.in/3inetwork/html/reports/IIR2006/Trends%20per%20cent20&%20per%20cent20Patt.pdf)

<sup>11</sup>Hugo G. Urbanisation in Asia: An Overview.Conference on African Migration in Comparative Perspective; 4-7 June 2003; Johannesburg, South Africa.

significantly larger populations and account for a greater proportion of the total urban population as compared to the smaller towns (Figure 2.2).

**Figure 2.2: Proportion of urban population by town size**



Source: Kundu 2006,<sup>10</sup> p 29

- vi. Clearly, there is tremendous variation in urban India. The size, number, and variation between urban areas, and the changes over time have implications for urban services and infrastructure, including health care, water and sanitation, and housing.
- vii. Urbanization is often thought of as being beneficial for economic and social growth and gains. Migrants are drawn to urban areas for work opportunities and to establish a better life for themselves and their families. Rural to urban migration does not happen only because of “urban pull” but also because of “rural push” due to unemployment.<sup>12</sup> In this context, the growth of slums in urban areas may result from the disconnect between the processes of urbanization, industrialization and economic growth.<sup>12</sup> As pointed out by many scholars as well as some of vulnerable groups interviewed for this report, such as rickshaw pullers and construction workers, lack of landholdings in villages to support agriculture, and few other viable economic opportunities in rural areas often “push” the rural poor to urban areas in search of work opportunities. However, most Indian cities, from mega cities to small cities, lack the necessary infrastructure in terms of housing, water and sanitation, employment opportunities, and basic services such as health care and education to accommodate and meet the needs of migrants, having implications for their health, wellbeing and productivity.<sup>12,13,14,15,16</sup> Paradoxically therefore, cities can also serve as hubs of marginalization and poverty or “concentrated

<sup>12</sup>Davis M. Planet of Slums. New York: Verso; 2006.

<sup>13</sup>United Nations Human Settlements Programme. The Challenge of Slums: Global Report on Human Settlements 2003. London: Earthscan; 2003.

<sup>14</sup>United Nations Human Settlements Programme. Slums of the World: The Face of Urban Poverty in the New Millennium? London: Earthscan; 2003.

<sup>15</sup>Sclar E, Garau P, and Carolini G. The 21st century health challenge of slums and cities. Lancet 2005; 365:901–903.

<sup>16</sup> Kuiper M., and van der Ree, K. Growing out of poverty: Urban job creation and the millennium development goals. Global Urban Development (2006); 2(1).

disadvantage” for the urban poor.<sup>17</sup> Cities have dual identities, one that comprises “enclaves of prosperity and commerce” contributing to both the national and global economy, while in the other, cities intentionally and unintentionally foster social, economic, and political disadvantage and exclusion.<sup>17</sup> Urban low income settlements and vulnerable urban populations exemplify concentrated urban disadvantage and are “a reflection of the contradictory processes of the world economy and an expression of the retreat of the state in the wake of exogenous pressures and domestic inattention”.<sup>17</sup>

- viii. When thinking about how urbanization affects populations, we need to be cognizant of the residents of the city and the urban poor in the margins, and how this might impact their access to essential services. Certain types of migrants, particularly those who are seasonal migrants, are missed in population statistics. Slums are another contentious entity with differing definitions affecting whether certain areas are considered as slums or not, and consequently whether their residents receive basic civic amenities. Urban poverty is fairly widespread; the Planning Commission’s report on Urban Poverty, Slums, and Service Delivery Systems reports that close to one fourth of urban dwellers live below the poverty line, with a monthly consumption less than Rs.538.6. The number of urban poor has increased by about one-third between 1973 and 2004, whereas the number of rural poor has declined during this period.<sup>18</sup>

## 2.2 Urban Advantage or Penalty?

- i. Urban advantage refers to inequalities in health outcomes between rural and urban areas, where urban residents are believed to have more economic or income generation opportunities, better living standards, and greater access to a range health services, and are therefore perceived to have better health status than their rural counterparts. When comparing the health status of the average urban and rural resident, the urban advantage is indeed obvious, with the former faring better than the later on several key health indicators. Such conclusions are, however, misleading as they gloss over the heterogeneity in both urban and rural populations. As the vulnerable groups profile and city reports clearly highlight, urban populations and the urban poor are far from being homogenous and comprise several sub-groups that differ socially, economically, and geographically. The lens of *urban penalty* facilitates the examination of inequalities within urban spaces and populations to provide a more nuanced understanding of how urban and rural populations differ, and how various urban sub-groups have distinct characteristics and needs, having significant implications for the delivery of health care and other services.

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<sup>17</sup>Rice J and Rice JS. The concentration of disadvantage and the rise of an urban penalty” urban slum prevalence and the social production of health inequalities in the developing countries. *Int J Health Serv* 2009, 39(4): 749–770

<sup>18</sup>Steering Committee on Urbanization, Planning Commission (2011). Report of the Working Group on urban Poverty, Slums, and Service Delivery System. New Delhi: Planning Commission; 2011.

- ii. The Planning Commission's Ninth Five Year Plan highlights key features of urban poverty in the country, including the mushrooming of low-income settlements, rapid growth of the informal economy, growing informalization of labour, escalating demands on public services, increasing inequities in access to education and health services. These issues are compounded by insecure legal status, violence and crime.<sup>19</sup> Data on urban slums may provide some evidence to support the reality of urban penalty, countering claims of urban advantage. The existence of low-income urban settlements or slums "is the spatial and material outcome of urbanization processes enacted within a context of lack of employment, housing, and basic public services. And it is the unprecedented growth of urban slums that threatens to undercut the anticipated public health advantages of urban life in ways that many researchers have not yet fully understood."<sup>17</sup> The growth of informal low-income settlements and the sheer diversity of the urban poor and disadvantaged are stark manifestations of "urbanization of poverty" and possibly the "shifting of deprivation from rural to urban contexts."<sup>17</sup>
- iii. The few studies that explore inequalities in health within urban populations note that the urban poor and urban slum dwellers have poorer health outcomes than urban non-poor and non-slum dwellers. Some studies suggest that the health status of the urban poor and slum dwellers may even be comparable to that of rural populations for certain health outcomes.<sup>13,14,19,20</sup> The National Family and Health Survey 3 found that poor urban children were more malnourished, stunted and underweight, and were less likely to be immunized compared to children from non-poor urban families. Poor urban women also fared worse than their non-poor counterparts on a number of health indicators: they were more likely to marry and have children at a younger age and are less likely to use contraceptives, receive ante natal care, and deliver in health facilities.<sup>20</sup>
- iv. For more a sensitive understanding of urban penalty, data must be disaggregated to go beyond rural-urban residence to looking at residence within urban areas (e.g., slum, constructions sites, homeless, institutionalized), and socio-economic status of urban residents – i.e., looking more closely at social, spatial, and economics dimensions of urban poverty and marginalization. Currently in India, urban poverty is associated with slums, underscoring the gross neglect of other urban poor such as the homeless, daily wage labourers, construction workers, rag pickers, people who are institutionalized, male, and female and transgender sex workers and other groups who may not necessarily live in slums, but are socially, economically, and geographically marginalized in cities.

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<sup>19</sup>Hashim SR. Report of the expert group to recommend the detailed methodology for identification of families living below poverty line in the urban areas. New Delhi: Planning Commission, Perspective Planning Division, Government of India;2012.

<sup>20</sup>Gupta K, Arnold F, and Lhungdim H. Health and Living Conditions in Eight Indian Cities. National Family Health Survey (NFHS-3), India, 2005-06. Mumbai: International Institute for Population Sciences and Calverton, Maryland, USA: ICF Macro. 2009.

- v. The vulnerability of the diverse urban poor population derives from four interconnected factors: brutal physical and socio-economic environment, lack of social networks, social and economic isolation, monetization of basic needs, and the exclusionary attitude of the state towards the poor. Together, these forces undermine the capacities of various vulnerable groups in different ways to impact their physical and mental wellbeing. The lives and experiences of these vulnerable, marginalized groups contrast sharply with the lives of the urban non poor, bringing to light the urban penalty.

### **2.3 The harsh urban environment:**

- i. The urban penalty is obvious when examining the physical conditions in which the urban poor live. A slum dwelling is one that lacks one or more of the following: access to an improved water supply; access to improved sanitation; sufficient living area; durability of construction; and security of tenure.<sup>13</sup> Closer examination of this definition reveals that many of these characteristics apply not only to slum dwellings, but to shelters used by other poor urban residents as well, such as the homeless, street children, informal, daily-wage labourers, and pavement dwellers among others. These individuals often live in makeshift, temporary constructions fashioned out of plastic, brick, tin, and other waste materials (that may be unsafe and hazardous) or simply live on the road, under flyovers, railway platforms, and outside shops without shelter and in unsafe conditions. Most lack access to safe drinking water and sanitation facilities. Further, they may be driven out and their temporary homes demolished in efforts to '*clean up*' cities.
- ii. While urban residents, on average, had improved sanitation as compared to rural residents, the number of urban dwellers gaining access to improved sanitation is not able to keep pace with urban population growth.<sup>21</sup> Globally, the urban population has grown by 1089 million from 1990-2008, yet only 813 million people in these urban areas have access to improved sanitation. In contrast, the global rural population grew by 370 million, but 450 million rural residents had improved sanitation facilities during this time period.<sup>21</sup> India has the world's highest rates of open defecation with about half the population or 620.5 million Indians defecating in the open.<sup>21</sup> While urban residents may have more access to improved water and sanitation facilities, about 13 per cent continue to defecate in the open.<sup>21</sup> While this figure may seem low, especially compared to higher rates of open defecation in rural India, the health consequences in urban areas are significant given the congested nature of living spaces that increase risks of faecal contamination.

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<sup>21</sup>World Health Organization and UNICEF. Progress on Sanitation and Drinking Water: 2010 Update. Geneva: WHO; 2010.

- iii. Both the Census 2011 and NSS 69<sup>th</sup> Round furnish valuable (if at times conflicting) data on the status of notified and non-notified slums. According to the NSS 69<sup>th</sup> Round, about 44 per cent of slums (both notified and non-notified) were located on private land, which places them at risk for eviction with little or no notice.<sup>22</sup> Stark differences were noted between the housing construction in notified and non-notified slums. More than four-fifths of the houses in the former were made of *pucca* materials, in contrast with only about two-fifths of the homes in the later. Similarly, the survey findings revealed inequities in access to piped drinking water, toilet, and drainage facilities with notified slums having greater access to these amenities than non-notified settlements.<sup>23</sup> The NSS 69<sup>th</sup> Round and Census 2011 reports differed with respect to the number of urban households that have access to basic amenities. The Census 2011 found more urban households without access to toilets and electricity than NSS 69<sup>th</sup> Round findings.<sup>24</sup>
- iv. Each of the “slum” characteristics has differential deleterious implications for the health and wellbeing of the urban poor. Poor access to safe water and basic sanitation (a common problem for most urban poor) has considerable adverse effects on the physical and even cognitive development of children, results in a range of gastrointestinal disorders in adults, and makes it difficult for girls and women to maintain personal and menstrual hygiene.<sup>25,26</sup> Poor housing confers little or no physical protection against the heat, cold, pollution, traffic, crime, theft, accidents, and physical and sexual abuse. Children, adolescent girls, women living in such tenuous circumstances are particularly at risk for sexual violence, especially when they sleep in the open or in insecure dwellings, collect water, or defecate in the open.<sup>27</sup> Densely populated living conditions in slums places household members at risk for infectious diseases such as tuberculosis, acute respiratory infections, and various skin disorders.<sup>28</sup> Further many urban poor live in poor, disadvantaged parts of a city (e.g., city outskirts, low lying areas, near factories and construction sites) and are at risk for floods and outdoor air pollutants.<sup>29</sup> Lastly, the insecurity of tenure for most urban poor compounds the lack of access to basic amenities and opportunities, which other city dwellers do

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<sup>22</sup>Ministry of Statistics and Programme Implementation, Government of India. National Sample Survey 69<sup>th</sup> Round. Key indicators of slums in India. 2013.

<sup>23</sup>Ibid.

<sup>24</sup>India Sanitation Portal. Census, NSSO differ on slum population figures. Accessed on 5<sup>th</sup> January 2014. Available at: <http://indiasanitationportal.org/18551>

<sup>25</sup>Spears D. The nutritional value of toilets: How much international variation in child height can sanitation explain? Working Paper. June 2013. Accessed on 17<sup>th</sup> October 2013. Available at: <http://riceinstitute.org/wordpress/wp-content/uploads/downloads/2013/07/Sparks-height-and-sanitation-6-2013.pdf>

<sup>26</sup>House S. Gender based violence and sanitation, hygiene and water. Community-Led Total Sanitation 2013.

<sup>27</sup>Deshingkar P and Akter S. Migration and Human Development in India. 2009. United Nations Development Programme Research Paper 2009/13.

<sup>28</sup>Sclar E, Garau P, and Carolini G. The 21st century health challenge of slums and cities. *Lancet* 2005; 365:901–903.

<sup>29</sup>Satterthwaite D. The impact on health of urban environments. *Environ Urban* 1993; 5(2):87–111.

– especially in terms of education, health care, and employment. Additionally, insecure living conditions cause psycho-social stress.

- v. In addition to the harsh physical environment, the social environment of slums is also adverse: high rates of crime can cause physical and emotional trauma as well as financial loss for urban residents. The National Crime Records Bureau (2012) reported that the number of crimes in cities with million plus population was considerably higher than the domain state average and national average.<sup>30</sup> Major crimes (as per the Indian Penal Code) in cities include auto theft, theft, crimes against women, counterfeiting, cheating, and kidnapping and abduction.<sup>30</sup> Crimes against women are particularly alarming, and further, sexual crimes are often underreported. Poor urban women and girls who lack adequate physical shelter and access to toilets are especially vulnerable to gender based violence ranging from teasing and unwanted touching to brutal rape. There are also outcomes of psycho-social stresses and pathology resulting from the brutalised physical environment of slums.

## 2.4 Social exclusion

- i. The social environment includes the interactions, relationships, and social connections that urban residents share with their families, neighbourhoods or communities, and other institutions like place of work, schools, and even health care facilities.<sup>31</sup> The characteristics and structures of these relationships differ considerably from rural areas given the heterogeneous and transitory character of urban life. Consequently, the inclusionary and exclusionary nature of the urban social environment also varies from rural areas, having differential consequences for the physical and mental wellbeing of the urban poor.
- ii. The experience of social exclusion by the urban poor is multidimensional, relational, and dynamic.<sup>32</sup> Individuals, groups, and even communities may experience social exclusion due to caste, class, religion, occupational status, and residence. Further the experience of exclusion can take place at different levels – individual, family, community, societal, institutional, and policy levels. Rag pickers and sex workers for instance, face marginalization at a societal and policy level, but may experience greater social cohesion among their own community, even if they come from different regions of the country. There are also some groups such as the homeless and the mentally ill who may experience social isolation across all levels.

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<sup>30</sup>National Crime Records Bureau, Ministry of Home Affairs (2012).Crime in India Compendium. 2012.

<sup>31</sup>Harpham T. Urban health in developing countries: what do we know and where do we go? Health and Place 2009; 15: 107-116.

<sup>32</sup>Mathieson J, Popay J, Enoch E, et al. Social Exclusion: meaning, measurement and experience and links to health inequalities. A Review of Literature.WHO Social Exclusion Knowledge Network Background Paper 1; 2008.

- iii. Some urban dwellers are intentionally marginalized because they belong to or are associated with a particular group such as sex workers, rag pickers or waste workers, transgenders, homeless, mentally ill, etc. These groups may then be *excluded from* accessing and participating in various aspects of urban life including health care, education, employment, and even basic amenities such as housing, sanitation, and food.
- iv. Social exclusion is also a dynamic concept, with social relationships with both formal and informal institutions changing over time. For instance, the state's relationship with street vendors or hawkers has evolved from one of aloofness to brutal clamping down on their businesses, to more recently, some form of recognition and support. Social exclusion of any form and at any level results in inequitable access to opportunities, services, and basic human rights that affect their vulnerability to poor health and health seeking behaviours.
- v. Social networks and social capital play a critical role in urban residents' experience of social exclusion, and also shape individuals' health behaviours and health outcomes. Individuals with high social capital and adequate social networks have better health outcomes than those who do not.<sup>33,34,35</sup> The very presence of social networks can facilitate care seeking (from both informal sources such as family and community members, as well as formal sources such as public and private health facilities and NGOs), care giving, and physical, emotional, and financial support. The presence of social networks can promote an individual's emotional wellbeing, while the lack of such networks and support structures, strained social relationships and marginalization can place urban dwellers at greater risk for both common mental disorders as well as more severe psychiatric disorders such as depression, schizophrenia, substance abuse, alcoholism, and crime.<sup>36,37</sup>

## 2.5 Monetization of basic needs

- i. The "informal survivalism" that characterizes the urban poor is a reflection of the harsh and extremely competitive lives led by the urban poor due to poor urban infrastructure, services, and employment opportunities.<sup>12</sup> According to the Planning Commission poverty estimates (2011-2012), 13.7 per cent of the urban population lives below the poverty line; the monthly per capita expenditure for the poverty line being Rs. 1000 for urban areas.<sup>19</sup> While poverty estimates have declined in both urban and rural areas, the rate of decline is markedly slower in urban areas. Income and consumption related inequalities within urban areas

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<sup>33</sup>Kawachi I and Wamala S: Globalization and Health. New York: Oxford University Press; (2007)

<sup>34</sup>Lochner KA, Kawachi I, Brennan RT and Buka SL. Social capital and neighborhood mortality rates in Chicago. *SocSci Med*2003;56(8): 1797-1805.

<sup>35</sup>Sapag JC, Aracena M, Villarroel L, Poblete F, Berrocal C, Hoyos R, Martinez M and Kawachi I: Social capital and self-rated health in urban low income neighbourhoods in Chile. *J Epidemiol Community Health* 2008; 62: 790-792.

<sup>36</sup>Trivedi JK, Sareen H, Dhyani M. Rapid urbanization and its impact on mental health: A South Asian Perspective. *Indian Journal of Psychiatry* 2008; 50 (3): 161-165.

<sup>37</sup>Adli M. Urban stress and mental health. *Cities, Health, And Wellbeing*; 2011; Honk Kong.



are evident from the monthly per capita consumption and expenditure (MPCE) calculations. The MPCE of the top 10 per cent of the urban population was estimated to be more than 10 times that of the lowest 10 per cent of the population in 2009-10.<sup>19</sup>

- ii. The urban poor are vulnerable to economic shocks. They are often employed in the informal sector, may be seasonal or cyclical migrants who come to cities at certain times of the year for work, have tenuous residential status, live in insalubrious conditions, have financial responsibilities to their families in villages, and lack access to health care, education, financial services, and social capital. These factors individually and together impact their ability to respond to or fulfil basic needs of shelter and security, and food and water. Sivaramakrishnan and colleagues found that pavement dwellers and the homeless were more likely to prioritize saving money to send to their villages or to meet their daily needs than pay rent to ensure safe and stable shelter.<sup>38</sup>
- iii. Given their itinerant, illegal, unrecognized, and marginalized status, the urban poor may have to pay for basic amenities such as subsidized food, and water and toilets that may otherwise be widely available and affordable for the urban non-poor through public systems such as PDS. The costs (and quality) of basic food items may differ for the urban poor as they may not be able to access PDS. Further low incomes, and lack of disposable incomes, implies that they often have to make difficult choices between various pressing expenditures such as food, rent/shelter, commute for work, health care, and even bribes (that hawkers, sex workers pay to municipal authorities and the police). Unlike rural area, where families may have or share small plots of land to grow food for their own consumption, poor urban residents lack secure housing, let alone land to call their own. Additionally, rural areas are believed to have more dependable social networks or safety nets, which have deep roots in the community. However, urban social networks may be perceived as unreliable because of the lack of social supports (as may be the case with home and single migrant men), strained social relationships (e.g., in mixed slum communities), competitiveness, or even stigma (e.g., sex workers).
- iv. Housing may be basic for many urban poor, yet they incur several housing related expenses related to demolition, relocation, fines and bribes. The homeless and pavement dwellers forage for resources to construct shelters and may find and use unsafe or hazardous materials. Some families settle on perilous terrain such reclaimed land, river banks, industrial land to minimize living costs, but may face several environmental and health risks that increase health care costs. With the movement towards slum upgradation and relocation to the peripheries of mega cities, relocated residents may have longer and more expensive commutes to their places of work and education.

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<sup>38</sup>Sivaramakrishnan K C, Kundu A and Singh B N. Handbook of Urbanization in India. New Delhi: Oxford University Press; 2005.

- v. Another set of unnecessary expenses are sustained due to informal work. Rickshaw pullers, hawkers/street vendors, and even sex workers face constant threats not only from the police, but also Municipal authorities, both of who levy fines, confiscate and damage goods, and even take bribes.
- vi. Health care expenses are significant for the urban poor as they seek medical intervention either from private providers, or wait till the condition is critical, warranting tertiary level health care which is costly. The associated costs include missed work, travel costs, and costs of medicines, diagnostic and other medical procedures. The prevalence of private health care facilities in urban areas may place the urban poor at a further disadvantage. Studies have shown that women are more likely to consult private providers than public health care providers.<sup>39,40</sup> Lower socio-economic groups cannot afford expensive private care and may often consult unlicensed and untrained, yet more affordable private health care providers.<sup>40</sup>

## 2.6 Attitude of the state

- i. To meet the demands of an increasingly urban world, healthy urban environments call for supportive political structures, adequate and appropriate devolution of power, coordination among various stakeholders, adequate financial resources directed towards urban development, effective leadership, and underlying all of these – long term commitment from the state - forces that are tenuous in developing countries, including India.<sup>41,42</sup> Urbanization is typically beneficial for the health of urban residents in terms of better economic opportunities and availability of health and other social services. Yet these gains may be undermined by key challenges in terms of governance, urban development and infrastructure, and financing that typically excludes its poor and vulnerable citizens. The growth of slums in urban areas for instance exemplifies the “failure of housing policies, laws and delivery systems, as well as of national and urban policies”.<sup>14</sup> The state’s exclusionary attitude towards the urban poor can be understood through their definitions and estimations of the urban poor and slum dwellers, poor investments in and commitment to infrastructure and services that benefit these groups, and the promotion of citizen identification.
- ii. Defining the urban poor is critical to their inclusion in the city. Definitions that lack a more nuanced understanding of urban realities may lead to the exclusion of certain groups from being considered legitimate citizens of the city and

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<sup>39</sup>Shah More N, Bapat U, Das S, Barnett S, Costello A et al. Inequalities in maternity care and new born outcomes- one-year surveillance of births in vulnerable slum communities in Mumbai. *Int J Equity Health* 2009; 8: 21.

<sup>40</sup>Das J, and Hammer J. Money for nothing: the dire straits of medical practice in Delhi, India. *J Dev Econ* 2007; 83: 1-36.

<sup>41</sup>Galea S and Vlahov D. Urban Health: evidence, challenges and directions. *Ann Rev Publ Health* 2005; 26: 341-365.

<sup>42</sup>Burris S, Hancock T, Lin V, Herzog A. Emerging Strategies for Healthy urban Governance. *J Urban Health* 2007; 84 (1): 154-163

receiving essential services. Poverty estimations are calculated on the basis of the poverty line (drawing upon consumption expenditure). These estimates however reflect a limited understanding of who the urban poor are, as they often do not take into consideration the type of expenditures incurred by the poor, and overlook the challenging conditions in which they live, and their access to basic services. The identification of urban households under the poverty line is further complicated by the unavailability of standardized and sensitive methodology to do so.<sup>19</sup> Resultantly, states devise their own criteria to ascertain whether a poor family can avail of services and schemes or not, leading to grave inequities among the urban poor.<sup>19</sup> The poverty line estimates determined at the national level may not take into consideration the diverse and complex dimensions of urban poverty and the associated costs of the informal economy. Most recently, the differential estimates of slum statistics presented by Census 2011 and NSS 69<sup>th</sup> Round highlight how definitions shape the way data is collected and from whom. The state must be cognizant that the urban poor include not only slum dwellers, but many other vulnerable groups that live in cities. As aptly stated by Burris and colleagues (2012), “the legal and social factors resulting in the physical realities that increase health risks for urban residents, and in particular, the urban poor, require a governance structure that addresses, first and foremost, the unique urban issues of population size, density, and diversity, along with coordination across governmental agencies, disciplines, and sectors”.<sup>42</sup>

- iii. Increasing urbanization in developing countries is often unmatched by commensurate increases in investment in health and other social services. As a result, poor urban dwellers lack access to these basic services and amenities.<sup>43,44,20,45</sup> In India, most development schemes, including food assistance, income generation opportunities, and access to health, education and other social services in India have targeted the rural poor, not the urban poor. Providing services to the urban poor is complicated because they may live in areas that are not recognized by the government. Only about one fourth of slums across the country benefited from welfare schemes, including Jawaharlal Nehru National Urban Renewal Mission (JNNURM), Rajiv Awas Yojana (RAY), and other Central Government, State Government, local government schemes. The proportion benefiting from such schemes was 32 per cent among notified and 18 per cent among non-notified slums.<sup>22</sup> Additionally, even when the state institutes policies and schemes for the poor, they lack the commitment to implement them. The poorly realized night shelter scheme for the urban homeless (introduced in the late 1980s) illustrates this lack of political will.

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<sup>43</sup>Fotso JC, Ezeh A, Madise N, Ciera J. Progress towards the child mortality millennium development goal in urban sub-Saharan Africa: the dynamics of population growth, immunization, and access to clean water. *BMC Public Health* 2007; 7: 218.

<sup>44</sup>Montgomery MR. Urban poverty and health in developing countries. *Popul Bull* 2009; 64 (2).

<sup>45</sup>UN-HABITAT. State of the world's cities. London: Earthscan; 2006.

- iv. One of the pathways by which urban environments impact the health of its residents is through poor coordination between national, state and municipal structures.<sup>46</sup> This is exemplified in urban India where several schemes such as JNNURM and RAY are launched by different departments to benefit the urban poor, particularly slum dwellers, but with little or no collaboration. These schemes appear to be equitable in their approach, identifying slum dwellers (living in both notified and non-notified slums), as well as pavement dwellers and the homeless as vulnerable. Yet in their implementation, vulnerable groups are excluded from the process, with funds being diverted to other infrastructure related projects. A major criticism levied against JNNURM was the programme's focus on mega cities to the neglect of the rapidly growing small and mid-sized towns in the country.
- v. Another key concern relates to the capacities of Municipal bodies to address the needs of urban populations. But with limited devolution of powers and finances, and political pressures, their efforts are directed towards the more affluent urban settlements than the more disadvantaged. Further, there is simply no mention of decentralization of governance, with little effort to support its institutionalization through Municipal authorities financially and politically, and in an equitable manner in the country.
- vi. Compelling evidence exists highlighting that the urban poor experience worse health outcomes compared to the urban non-poor and comparable to the health of rural residents, and this, in part, is due to poor availability of and access to public health services.<sup>39,40,47</sup> Urban access to health services can take three patterns – 1) substantial urban exclusion category: where the urban poor and non-poor may both lack access to health services; 2) marginalization of the urban poor: where poor urban dwellers lack access to health care while the majority of the urban non-poor have access to care; 3) universal health care: where most of the population, irrespective of their socio-economic level, are able to obtain health care.<sup>48</sup> India clearly epitomizes the second scenario, where the urban poor face geographical, social, and economic constraints to accessing public health care. Resultantly, many seek health care from a range of licensed and unlicensed providers, or seek health care only when the health condition becomes severe (warranting tertiary level curative services), or do not seek health care at all. The out of pocket expenses are substantial when the poor seek tertiary level care or private health care, causing severe financial burden. The pattern of urban exclusion should therefore ideally inform the choice of strategies to improve availability of and access to health and other services. An

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<sup>46</sup>Vlahov D et al. Urban as a determinant of health. *J Urban Health, Bulletin of the New York Academy of Medicine* 2007; 84(1):i16-i26.

<sup>47</sup>Urban Health Resource Centre. State of urban health in Delhi. New Delhi: UHRC / Government of India Ministry of Health and Family Welfare; 2006

<sup>48</sup>Mathews Z, Brookes M, Stones RW, Hossain MB. Village in the city: autonomy and maternal health-seeking among slum populations of Mumbai. In: Moore S, editor. *A focus on gender: collected papers on gender*. Calverton, Maryland. ORC Macro; 2005.

increasing trend is to link services to the Aadhaar card or UIDAI card. For an urban resident to receive this unique identification number, he/she must furnish proof of residence in that city. For most urban poor who lack stable housing, this is a near impossibility. About 28 programmes are listed as Aadhaar enabled service delivery, and may enable citizens to receive the LPG subsidy, certain insurance schemes, PDS (especially kerosene), Janani Suraksha Yojana, social security pension for old age and widows etc. Aadhaar is not mandatory, yet its promotion is such that it is slowly taking over other forms of identification and validation, and further disadvantages the urban poor.

- vii. The urban poor are diverse, dynamic, and experience social, physical/spatial, occupational, and political marginalization to varying degrees. The health of the urban poor is therefore intimately tied to the availability of and access to private good and services (e.g., food, saving and credit), shelter, and health services, as well as the presence of social networks, participation in political processes, social exclusion, and freedom from violence, crime, and exploitation. Glossing over the heterogeneity of the urban population and their differential needs leads to inequitable access to health services and consequently adverse health outcomes.

## Chapter 3

### Reaching Vulnerable Sections

- 3.1. The National Urban Health Mission Framework Document places high focus on reaching urban primary health services to the most vulnerable amongst the poor:

*“Under the NUHM special emphasis would be on improving the reach of health care services to these vulnerable groups 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. Outreach services would target these segments consciously, irrespective of their formal status of resident ship etc.”<sup>49</sup>*

The recognition given here, to various forms of vulnerability holds great import, insofar as it expands our understanding of urban poverty as being multidimensional. Further, as NUHM notes, formal status – and by extension, ability to establish formal status - should not be a precondition for access to health. For services to therefore be provided to the population flexible, transparent and comprehensive process of identification, outreach, provisioning, quality assurance, supported by the engagement of vulnerable groups and organisations working with them will be necessary.

- 3.2 To this end, NUHM has indicated that city-specific models must be developed. Vulnerable groups have shared and distinct characteristics across cities; this chapter aims to shed light on this dimension in order to arrive at considerations that can shape city-level customisation and development of NUHM programme components. The non-negotiable principles of the institutional arrangements under NUHM include a) a seamless continuum of care; b) no requirements of any identity proof; c) multi-disciplinarity of services; and d) respectful and facilitatory services.

- 3.3 *The problems of definition* - While it is clear that each city has various vulnerable groups who may face disproportionate burdens of ill-health, as soon as we enter the field, the challenge emerges of identifying and demarcating such groups. Vulnerabilities are often intersecting, overlapping, and mutually constitutive. It must be appreciated that what the state defines as “vulnerable” may only partially reflect and overlap how communities and groups perceive themselves, each other, and the breadth of their life experiences. Most commonly, vulnerability is officially seen as coterminous with low incomes, not recognising the many other overlapping social vectors of vulnerability, such as quality of housing and public services, occupation, gender, disability, singleness, age, stigmatised and debilitating ailments, and many

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<sup>49</sup>Ministry of Health and Family Welfare, Government of India (2012). National Urban Health Mission: Framework for Implementation. New Delhi: Ministry of Health and Family Welfare, Government of India

others. The challenge, then, is to ensure that definitions of vulnerability accommodate these variable experiences and requirements. As indicated in the NUHM Framework document, the heterogeneity of urban populations is not captured in most published data, thereby masking the health conditions of urban poor sub-groups. It also recommends that the planning process “develop criteria for such identification on the basis of a wider understanding of poverty as not only income or nutritional poverty.”

3.4 To this end, we rely on the Hashim Committee (a Committee constituted by the Planning Commission to advise it about ways to identify the urban poor) recommendations for the vulnerability-based identification of the urban poor which is described as follows:

**Residential or habitat-based vulnerability** in urban areas would include urban persons/households that are houseless, living in kutchha/temporary houses, facing insecurity of tenure, unserved or under-served with basic public services like sanitation, clean drinking water and drainage. **Social vulnerabilities** point to gender-based vulnerabilities such as female-headed households, age-based vulnerabilities such as minor-headed households and the aged health vulnerabilities such as disability, absence [sic.] of basic civic services. **Occupational vulnerability** in urban areas would include urban persons/households without access to social security, susceptible to significant periods of unemployment, as well as those who by virtue of no access to skills training and/or formal education, are susceptible to a certain type/nature of occupation such as informal/casual occupations with uncertain wages/earnings and/or chronic illness, education vulnerabilities, employment subject to unsanitary, unhealthy and hazardous work conditions oftentimes bonded/semi-bonded in nature or undignified and oppressive conditions of labour and vulnerabilities based on social stratification including religion and caste.<sup>50</sup>

3.5 In many cases, these vulnerabilities enhance and moderate each other. In some cases, they point to distinct and unique life circumstances. We indicate this complexity as well as heterogeneity on the basis of over 40 focus group discussions with vulnerable groups.

3.6 *Residential or habitat-based vulnerability* - The most starkly visible form of vulnerability is associated with residence or lack thereof. Urban India has the distinction of a range of settlement typologies – over 3/4ths of Delhi’s population, for instance, resides in unplanned colonies, i.e. *jhuggijhopri* clusters, slum designated areas, unauthorised colonies, resettlement colonies, rural villages,

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<sup>50</sup>Steering Committee on Urbanisation (2011). Report of the Working Group on Urban Poverty, Slums and Service Delivery System.

regularised-unauthorised colonies, urban villages.<sup>51</sup> Most of these settlements are officially defined by the criterion of unsuitability for habitation and conditions which are “detrimental to safety and health.”<sup>52</sup>The National Sample Survey Organisation in its 69<sup>th</sup> round defines slums as “any compact settlement with a collection of poorly built tenements, mostly of temporary nature, crowded together, usually with inadequate sanitary and drinking water facilities in unhygienic conditions.”<sup>53</sup> The different dimensions of residential vulnerability are discussed below:

- i. In many if not all cities, the poor condition of sanitation, inadequate provision of drinking water, and lack of awareness or opportunity structures to practice good hygiene were visible for vulnerable groups, and not just those in slums identified, i.e. notified by Urban Local Bodies or Development Authorities. As evinced in the research literature as well, vulnerabilities are greater in non-notified slums as compared to notified ones,<sup>54</sup> where not only are slum-dwellers having to pay a higher percentage of household income for basic services, they also source these services through ad hoc, informal, illegal, exploitative, and sometimes more dangerous arrangements and practices (like bribery or open defecation). In Mumbai’s Rawli camp, community pay-per-use toilets built by the municipal corporation can cost upwards of 300 INR a month for an individual, who also has to train his/her digestive system to the crowds, the wait, and the rush. In Ahmedabad, the monthly cost of a single family member taking a daily bath is 10-25 per cent of a household’s earnings. Slum-dwellers in Patna had this to say: “The tube wells earlier constructed by the government went all dysfunctional, and they do not even visit the slum to see how the people are, no medical facilities, and no initiative for the city’s development. All we do now is to collect money, accumulate and develop infrastructural facilities by ourselves.”
- ii. The violence and relocation also presents health threats and leads to conditions of geographic vulnerability making communities more epidemiologically susceptible.<sup>55</sup> In Delhi, residents of a homeless shelter noted that they made their homes in a graveyard that was used for open defecation after being relocated from their earlier shelter area. Women recounted walking

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<sup>51</sup>Government of Delhi (2009). Delhi Economic Survey 2008-9. New Delhi: Planning Department, Government of Delhi. Available at: [http://delhi.gov.in/wps/wcm/connect/DolT\\_Planning/planning/economic+survey+of+delhi/economic+survey+of+delhi+2008+-+2009n](http://delhi.gov.in/wps/wcm/connect/DolT_Planning/planning/economic+survey+of+delhi/economic+survey+of+delhi+2008+-+2009n)

<sup>52</sup>Registrar General of India.(2012). Housing Stock, Amenities & Assets in Slums – Census 2011. [Internet] Accessed 2014 Jan 07. Available at: [censusindia.gov.in/2011-Documents/On\\_Slums-2011Final.ppt](http://censusindia.gov.in/2011-Documents/On_Slums-2011Final.ppt)

<sup>53</sup>National Sample Survey Organisation.(2013). Key Indicators of Urban Slums in India. [Internet] Accessed 2014 Jan 7. Available at: [http://mospi.nic.in/Mospi\\_New/upload/KI\\_SLUM\\_report69round\\_24dec13.pdf](http://mospi.nic.in/Mospi_New/upload/KI_SLUM_report69round_24dec13.pdf)

<sup>54</sup>Subbaraman R., O'brien J., Shitole T., Shitole S., Sawant K., Bloom DE, Patil-Deshmukh A. (2012). Off the map: the health and social implications of being a non-notified slum in India.Environment and urbanization, 24, 643-663.

<sup>55</sup>Mahadevia D. (2011).Tenure security and urban social protection in India. Centre for Social Protection Research Report, 5.



through sludge and solid waste up to their knees and lifting out the faeces with their bare hands to make space for their hutments.

- iii. There are also areas not included in these settlement typologies, where urban dwellers reside. For example, the Chapparbaand community that lives on the Pune railway tracks in a situation of such dire insecurity, those children of school-going age were found playing near sewer water in the company of pigs. It is no wonder that they said to us that their children were almost always ill. The high prevalence of infectious diseases is thus an accepted risk among those faced daily by these individuals, who eke out an income working in furniture shops, as domestic staff, painters, and cleaners. This area is not only clearly uninhabitable, but appears also to be un-visitable by health providers, so much so that an elderly man we met was found to be incapable of making his own way to the hospital, thus relegated to a fate of slow, humiliating and painful death from neglect, naked and covered with bed-sores and tended only by his older married daughters when they could escape their own domestic and work routines. We were told by residents that the government hospital is a great distance away and worse, will entail mammoth expenditure, not just for travel, but also for medical supplies like bandages, needles, gloves and medicine.
  
- iv. At least these individuals have a place they call home. In Chennai, the TRG study team met a group of mentally ill homeless women, for whom rather than a physical space to call home, shelter from violence –verbal, physical, sexual - was the main recourse sought. Estranged from their families, these women lacked access to water, food, sanitation and saw no relevance of primary health care centres, which in their experience were facilities only for pregnant women<sup>56</sup>. Homeless populations across the country have to make the sacrificial choice to live on the streets out of a desire to use their meagre incomes to support their families. Mander describes life on the streets, which “involves surviving continuously at the edge, in a physically brutalised and challenging environment, with denial of even elementary public services and assured healthy food; and illegalisation and even criminalisation by a hostile State of all self-help efforts for shelter and livelihoods by urban poor residents. There are both grave ruptures - but also continuities - of bonds with their families and communities. There may be somewhat better prospects of livelihoods and earnings than in the countryside, although for urban homeless people, work still tends to remain casual, exploited and without dignity and security.”<sup>57</sup> The pressures of such a life often drive homeless populations – including, tragically,

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<sup>56</sup>NGO partners noted that the continuous yet changing vulnerabilities of these groups were not on the radar of the public health system and required special attention. Chennai has a system in place of shelter homes in coordination with urban local bodies, 48 per cent of which are reserved for street children, the mentally ill and destitute. This may serve as a foundation to expand and further develop services.

<sup>57</sup>Mander (2003). *The Ripped Chest: Public Policy and Poor People in India*. Books for Change.

the youngest - to substance abuse, rendering them ever more vulnerable to harassment, illness, and death.

- v. Indeed in many cities, those without secure tenure are migratory or “floating” populations. In Shimla, the “floating” population of the city is almost as large as the resident population, presenting challenges of identification, outreach, and follow-up. Even as migrants may contribute up to 10 percent of the state’s GDP,<sup>58</sup> they have no assurance of shelter, sanitation, security or public services.<sup>59</sup> Breman has described these workers as India’s “footloose workers” who travel from city to city for any kind of work to stay alive and keep their families alive, working in brick kilns, construction sites, pulling rickshaws, searching for waste, and somehow trying to survive with dignity.
- vi. Custodial populations –in orphanages or otherwise in the care of the state or charitable institutions - are often excluded from survey procedures and thus invisible. Conditions in these institutions are often shocking: a former resident in a Mumbai Beggars' Home described in trying detail how “food was prepared and served with indifference and in a very unhygienic manner. The vegetables are neither washed, nor peeled, and are straightaway chopped and used for cooking. The women who have been assigned the duty of cleaning toilets have also been assigned the duty of serving lunch. They serve lunch immediately after they have finished cleaning the toilets, without washing or sanitizing themselves.”
- vii. In a Kolkata mental health institution, high burden of tuberculosis was reported by patients, as well as waterborne intestinal ailments, particularly during the monsoons. Hospital staff was aware of these issues and attributed them to overcrowding and use of facilities far beyond their originally designed capacity. They also reported a lack of sanitation staff and of specialist doctors to address skin, intestinal and dental issues. Attention to design features of health facilities, and crucially, their maintenance, may help create a better atmosphere for patients and citizens.
- viii. *Occupational vulnerability*- Research has shown that among the urban poor, employment can sometimes contribute more to inviting pathogenesis than it can to averting it – through hazardous and or exploitative work conditions, lack of job security, entrenched stigmas and the apathy and antipathy of law enforcement, employers, and municipal authorities.

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<sup>58</sup>Deshingkar P, Akter S. (2009). Migration and Human Development in India, United Nations Development Programme Research Paper 2009/13, April

<sup>59</sup>Mander (2003). The Ripped Chest: Public Policy and Poor People in India. Books for Change.

- ix. Migrant labourers in Mumbai and Aligarh talked about their income insecurity, where after having travelled from far-away states like Odisha and Bihar, they remained vulnerable to penury, hunger, respiratory health hazards, and worse, violence. They noted that they are often denied wages by employers and middle-men in construction companies, who are rarely crossed given their underworld connections. In rare cases where complaints to the police were made, they were met with physical and verbal abuse. Migrant labour is largely invisible to the state in large cities like this, ineligible for ration and BPL benefits and subsisting with insecure, exploitative conditions of tenureship. In Ambala, a community of *kabaadiwalaahs* (recycled waste sellers) told us that the insecurity of labour conditions has resulted in vulnerability to musculoskeletal disorders, respiratory diseases, as well as lung and liver disorders, given the widespread use of tobacco and alcohol. Similar complaints - wheezing, shoulder-pain and chronic fatigue - are common as is alcoholism among Madurai sanitation workers. Further, only permanent workers are entitled to protective gear, leaving out large segments of the workforce. The Hamaal Panchayat, a trade union of head-loaders in Pune spoke of severe spinal and back problems because of their vocation of carrying heavy loads.
- x. Time is another constraint for the working poor. Fisher folk in Chennai noted that their lean period, 3-4 months in a year of the off-peak season, is a time of greater vulnerability for them because of their almost complete reliance on government assistance. The areas in which they reside had no ICDS centre, no drinking water, nor any toilet facilities. Insurance cards had been issued to them, but they were unaware of their use or meaning as it had never been explained to them. Domestic workers in Kolkata and Pune said that they cater to others' convenience and therefore have less control over hours of work and consequently, constrained access to health-seeking. The unpredictability in conditions of work among *kabaadiwalahs* (recycled waste sellers) in Ambala also means that labourers are not available at the times that outreach services may be offered, something noted by an ANM in Ambala.
- xi. Survivors of the methyl isocyanate leak in Bhopal 30 years ago comprised large numbers of factory workers, as well as home-based workers in the vicinity of the disaster who continue to suffer from reproductive, respiratory and other morbidities – a price they pay for being in the wrong place at the wrong time.
- xii. We found in our visits that sex workers – both male and female – may have greater risk of exposure to sexual and reproductive health problems, but are also vulnerably to other morbidities like respiratory or digestive infections, diabetes and heart problems. They have to make their own arrangements for any health concern other than HIV or STI related - their area NGOs are bound to vertical targets and struggle or refuse to meet other needs. Compounding

this inattention is the unwanted, inordinate attention and threats of violence for sex workers and sexual minorities, which was observed in a number of cities, including Pune, Mumbai and Madurai.

- xiii. Safety is another issue of concern across ages, genders, and occupations, although more so for children in labour. Rag pickers in Patna reported that adolescent girls work in groups to assure their own safety. Street children in Mumbai engage in a variety of unsafe and frequently humiliating occupations from rag-picking, to begging, to helping in shops and stalls, rendering them at times subject to physical and sexual abuse.

*3.7 Social vulnerability* – A number of vulnerabilities are related to social identities of gender, caste, religious, sexual orientation, or also to prior morbidity. Women face the threat of violence and attacks upon their safety in urban contexts. These dangers are steeper at urban peripheries, due to lack of services, and basic infrastructure.<sup>60</sup> This creates dependencies on other members of the family or community or indeed the state such that women’s needs run the risk of being accorded lower priority—especially when not related to pregnancy. In an FGD with elderly women in a Delhi *raenbasera*, the women knew they were all entitled to widow pension, but neither they nor their community leader knew how to get it. Until they could bring it onto the local NGOs’ radar, they would be waiting. Categories and features of such social vulnerability are presented below:

- i. Leprosy patients we interacted with in Madurai had access to family counselling and reconstructive surgery through an NGO that had been working there for over four decades. The group still felt uncomfortable accessing public health services outside the ambit of this NGO for fear of stigma – it appears that while access is assured by Tamil Nadu’s pioneering effort to integrate leprosy eradication activities in primary health care, acceptability and comfort with these services requires some attention.
- ii. People with disabilities are another group whose isolation from society obviates access to care for even common health problems. Children and persons with disabilities are at special risk for certain health issues, which must be reflected in the provisioning of health services and the training of those staffing them. Among people with disabilities, secondary conditions occur in addition to (and are related to) a primary health condition. By virtue of being predictable they are preventable. Examples include pressure sores, urinary tract infections, osteoporosis and pain. For instance - children with cerebral palsy are at high risk for osteoporosis and fractures due to the fact that they are often on anticonvulsants, rarely go outdoors, and poor nutritional

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<sup>60</sup>Khosla, Rena (2009) Addressing Gender Concerns in India’s Urban Renewal Mission. New Delhi: UNDP. [Internet] Accessed 2013 3 Jan. Available at: <http://data.undp.org.in/dg/pub/AddressingGenderConcerns.pdf>.

intake (all leading to Vitamin D deficiency). Persons with spinal cord injury are likely to develop pressure sores if care is not taken.” Children and persons with disabilities will have significant and often multiple health care needs. For example, a child with cerebral palsy may need the services of an orthopaedic surgeon and or occupational/physiotherapist, a neurologist for epilepsy and an ophthalmologist for eye related issues among others. Thus, the requirements of care-giving and health-seeking for persons with disabilities are complex, typically lifelong, and usually both human and financial resource-intensive insofar as the system –even with projects and policies in place- has largely ignored disability in the provisioning of public services, including health. This is starkly manifest in the lack of accessibility facilities in most Urban Primary Health Centres.

- iii. Mental health conditions have enormous co-morbidity/ co occurrence with developmental disability. For example, the prevalence of diabetes in people with schizophrenia is around 15% compared to a rate of 2-3% for the general population.<sup>61</sup> Individuals with Down syndrome have a 30% risk of hypothyroidism, congenital heart disease. They are also likely to have vision impairment and hearing loss. Persons with Spina Bifida are at risk of urinary tract related complications. Further, individuals with autism very often have anxiety and depression as do 25 to 30% of individuals with Attention Deficit Hyperactivity Disorder (ADHD). Persons with Down syndrome are known to be prone to anxiety, obsessive compulsive behaviours, sleep disorders and depression.<sup>62</sup> If we do not look specifically for these, they will not be addressed.
- iv. Then there is the condition of children who are abandoned or who run away from violent and abusive homes, who tend to be exposed to a number of risks such as extreme climate<sup>63</sup> as they lack “protection, supervision and care from concerned adults.”<sup>64</sup> Common vulnerabilities of children living on urban streets include substance abuse (generally of drugs, tobacco, *pan masala* and alcohol), hazardous working conditions, abuse, and inadequate access to nutrition, clean water, sanitation and health care. Further, most street children have to pay to access basic amenities, such as drinking water and using toilets, and are at risk of exploitation and harassment by law enforcement, criminal organisations, and other homeless persons.

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<sup>61</sup>World Health Organisation. (2013). Disability and health: WHO fact sheet. Geneva: WHO. [Internet] Accessed 2013 17 Feb. Available at: <http://www.who.int/mediacentre/factsheets/fs352/en/index.html>

<sup>62</sup>Kundu I. (ND) Health Concerns of People with Down Syndrome. Presentation for Human Rights Law Network. Available upon request from radhika.alkazi59@gmail.com

<sup>63</sup>Bhaskaran R, Mehta B. (2011). Surviving the streets: A census of street children in Delhi. New Delhi: Institute for Human Development/Save the Children.

<sup>64</sup>Kumar A, Schofield T. (2008). Orphan and vulnerable children: Health policy interventions in India. Journal of Health and Development, 4: 1-4.

- v. In speaking to slum-dwellers in Bhubhaneshwar, Pune, Kochi and Jaipur, children, women and the elderly are said to be especially vulnerable. Also, monsoon season is the time of year that brings various health crises.
- vi. There is also the phenomenon of ghettoized minority populations in inner cities. The literature points to a history of deliberate marginalisation of Muslims by the state, notably in the reach and provisions of the educational system, of employment opportunities.<sup>65</sup> While it has been noted that Muslims have lower infant mortality as compared to Hindus and national averages (attributed by some to urbanisation and others to maternal height, diet and son preference), there is no further disaggregation of poor Muslims as compared middle and upper class Muslims in cities that would help account for class and educational confounding.

3.8 *The heterogeneity, complexity, and intersectionality of vulnerability* - As must be evident even from the trifurcated descriptions above. Vulnerabilities intercalate in the syndemicity of illness -reproductive, infectious, chronic through a complex and shifting matrix of attributions - occupational, environmental, seasonal, cultural. For example, brick kiln workers we met in Jorhat, Assam are not only seasonal migrants; they are also Muslim minorities, who for traditions have been locked into this vocation. They work for in the city during the months October-March, also reliant on their employers for temporary housing during their stay in town, earning 400 INR for every 1000 bricks made, which is shared by three workers. Moving from rural to urban areas, across occupations, dealing with different sets of employers and working conditions, shifting and changing contexts - and vulnerabilities - are a constant in their lives.

- i. A poor, single slum woman we spoke to in Guwahati blamed alcoholism for her husband's abandoning and leaving her and her four children. Heading her family as a single woman, she is not eligible for most public sector schemes. Women like her mentioned the attention they would get from men, some unwanted, and sometimes sought because of the support - financial, emotional, and physical - it could bring to the household. The inherent contradictions in being both abandoned and sought after - all in an environment that undermines and sometimes ridicules the strength of an independent woman introduces grave insecurities for women on whose shoulders many other lives depend.
- ii. In this and other groups, it is the lack of basic amenities - which actually define these groups as a category - that causes much of ill-health - lack of water, sanitation, shelter, economic opportunity, social security. It may thus be useful

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<sup>65</sup> Gayer L, Jaffrelot C, Eds. (2012) Muslims in Indian Cities: Trajectories of Marginalisation. New Delhi: HarperCollins.

to think of vulnerability as a process rather than a state or static characteristic. Services must be designed to address these complexities and shifts.

- iii. These intersections are difficult for us to fully understand, and more difficult to convey in bureaucratic processes to prove or establish one's identity. For example, we learned of the Sikhligadde notified tribal community residing in Pune, that their continued association with their ancestral occupation of making weaponry renders them vulnerable to criminal allegations on a routine basis. Routine stigmas affect their eligibility for BPL and ration cards. In Ambala, as in many other cities, we learned from an FGD with slum dwellers that because they lack identity proof, they are unable to benefit from PDS, food security. The case is similar for Gangtok's slum dwellers, some of whom had even applied for ration cards and neither received them, nor any reason for non-issuance.

**3.9 Health burdens:** The health burdens of the urban poor are well known; most are the same as those that affect other urbanites, but more pronounced and more often, co-occurring. The NUHM framework document points many of these out: high prevalence of under-five mortality, underweight, lung disease, and vector-borne diseases like malaria. Immunization rates in these populations are also low. The literature corroborates and expands upon this: infant mortality rates are higher by 1.8 times in slums as compared to non-slum areas. Diarrhoea deaths account for 28 per cent of all mortality, while acute respiratory infections account for 22 per cent. Nearly 50 per cent of urban child mortality is the result of poor sanitation and lack of access to clean drinking water in the urban slums. Disease epidemics are strongly correlated to site location and cramped space; vector-borne and respiratory diseases are easily spread, especially under conditions of poor sanitation and the inhalation of fumes. Mental health problems are also high, because of the stressful, lonely, alienating environment, cut off from traditional, emotional and social security support systems.<sup>66</sup>

**3.10** From our fieldwork in slums and even less secure habitations, we were told there can be no expectation of normal development and health from birth through to adolescence, reproductive, middle and old age. Instead, the urban poor expect stigma, violence and discrimination, living in constant fear of being criminalised, victimised, or both. In addition, there is routine, seasonal vulnerability to infectious disease; a continuous and growing risk of chronic disease, compounded by mental health impacts of a life lived with many indignities. In a 2012 study on the Health of the Urban Poor, malaria, dengue and diarrheal diseases were reported as being among the most commonly suffered infections in most Indian cities.<sup>67</sup> Diabetes,

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<sup>66</sup>Mander H. (2004). The State and Urban Poor People in India: No Time to Cry. In *The Ripped Chest: Public Policy and Poor People in India*. New Delhi: Books for Change.

<sup>67</sup>Population Foundation of India (2012). Burden of Disease. Unpublished Draft.

hypertension and to a lesser extent, asthma, are reported as among the most commonly suffered chronic diseases. These common and unique burdens were reported, as the following sections indicate.

3.11 *Common burdens of Vulnerable Groups.* For the urban poor, public health is not a daily concern like food, shelter, recognition or recompense. It is the concern of emergencies – when, as some told us, there are injuries caused by violence, or work, or infections brought on by the profusion of vectors – mosquitoes chiefly, but also viruses, helminths, and dogs - that thrive in the insecurity of their living conditions. In Patna, for example, Kamla Nehru Slum is bifurcated by a drainage channel carrying untreated sewage; solid, liquid and gaseous effluents are attributable for the death of children due to diarrhoea and pneumonia, and of adults from tuberculosis. In a city where the Sulabh system of public convenience toilets was devised, it is a sad reality that only 20 per cent of urban households have underground sewage.

- i. There are problems of sugar or hypertension, meted out by a lifestyle over which one hasn't much control. These vulnerabilities were found among transgender in Villupuram, who had the benefit of housing provided by the municipality and state government support for surgery and reproductive health check-ups. In Chennai, slum-dwellers noted that the PHCs in their zone did not have services to accommodate the growing incidence of diabetes and hypertension. Instead, they would have to go to a tertiary care hospital, spending up to 100 INR on travel just for a check-up. Diabetes and hypertension were reported as common ailments in cities across the country, from Bhubhaneshwar to Villupuram, Gangtok to Raipur.
- ii. Deliveries too were described to us as emergencies, as they are hugely impoverishing. In Indore, JSY compensation is not being claimed because checks are crossed and women don't have bank accounts, something borne out in the literature as a major failing of demand-side reforms.<sup>68</sup> There are even occasional reports of middle-women taking between a Rs. 500 to 700 cut of the mother's 1000 INR compensation to just open her bank account.
- iii. In no city did we find any homeless persons without physical health problems. The burdens faced by these groups included under-nutrition, injury, skin conditions, infections, metabolic disorders, cardio-vascular problems and extremely high burden of schizophrenia, psychosis, bipolar affective disorders and substance abuse. As was observed in Chennai, dire life circumstances often lead homeless persons to substance abuse early in life, a condition that has to then be managed chronically, often in the absence of family support. In very few cities are NGOs equipped to provide the environment to address the multiplicity of challenges they

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<sup>68</sup>Hunter BM, Bisht R, Chakravarthi I, Murray SF. (2014). Demand-side Financing and Promotion of Maternal Health. What Has India Learnt? Economic and Political Weekly, XLIX(2): 66-73.



face – a place to recover and heal, a place far from psychotropic substances, and the violence of the streets, a place with caregivers, a place to call home.

- iv. Across occupations, sites and social circumstances, the toll alcoholism and substance abuse were taking on the health of the people was noted. From Shimla to Trissur, and Pune to Jorhat, alcoholism was broached as “a major issue,” participants choosing not to provide more detail, reflecting the stigma associated with alcohol use, and deflecting the violence so commonly associated with its abuse. A major initiative for de-addiction and treatment, sensitive to the social and contextual circumstances that shape substance use and abuse, appears to be an urgent psychosocial and physical health need of urban poor people across cities.
- v. It is well known that ill-health can lead to catastrophic expenditure and push people into poverty in India.<sup>69</sup> This economic consequence of ill-health is amplified among the urban poor and in particular the urban poor and homeless. A recent study has found that untreated injuries among homeless persons in Delhi have resulted in lifelong disabilities that have in turn, cost them their livelihood, and in the case of some, been the root cause of homelessness.<sup>70</sup>

3.12 *Unique burdens.* Vulnerable groups have particular health burdens, shaped by histories and contexts of urban areas. At a meeting of gas disaster survivors in Bhopal, one elderly lady went into extensive detail talking about how she was not affected by the gas disaster three decades ago, but had nonetheless joined the ranks of those served by Sambhavna clinic. Sambhavna Trust officers had included in their vulnerability mapping various environmental sequelae of the gas disaster in the old part of the city – now toxic effluents have leached into the water table, resulting in another kind of vulnerability. For urban poor across cities, vulnerabilities multiply and reinforce, but for certain populations, the way in which these vulnerabilities affect bodies and lives is specific.

- i. Certain burdens faced by vulnerable groups are tied to the institutions and evolutions of the health system in cities, over the past decade. In Dhamtari, where the Rashtriya Swasthya Bima Yojana (RSBY) and Mukhyamantri Swasthya Bima Yojana (MSBY) have been operational for a few years, there are still out of pocket payments that have to be made – community members we spoke to put it quite simply, “*kharcha toh hona hee hai.*” Apart from the inevitability of spending out of pocket even with a government subsidy, there have been major concerns raised about irrational treatment and unethical

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<sup>69</sup> Berman P, Ahuja R, Bhandari L. (2010). The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings. *Economic and Political Weekly*, XLV(16): 65-71.

<sup>70</sup> Prasad V. (2011). *A Study to Understand the Barriers and Facilitating Factors for Accessing Health Care amongst Adult Street Dwellers in New Delhi, India.* Unpublished Dissertation. Masters in Public Health in the School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape.

practices, particularly with reference to arbitrary hysterectomies being performed in both government and private facilities.

- ii. Muslim minorities living in Beganwadi slum in Mumbai noted that the lack of outreach of family planning services. The predominance of slaughterhouses in their area, and the absence of sewage and waste management, makes all residents more vulnerable to infectious diseases and zoonoses.
- iii. Other burdens reflect the alienation of vulnerable groups from care and support. In heart-rending detail, child labourers in Jorhat, most of them employed as domestic servants spoke to us about working with stomach-aches. The cause of these aches is well known – hunger. Severe malnutrition is a continuous and acute challenge for such groups of the urban poor, and represents an especially banal kind of injustice given that, so often, in so many ways, the livelihood and lives of young children are subject to employer whim. As we heard from a 17 year old working in a zari and zardozi factory in Mumbai: “If Chacha is angry, I and the other boys do not get food.”
- iv. A major burden for homeless persons is trauma, from accidents, attacks, and protracted neglect, for want of spaces for recovery and rehabilitation.
- v. Given the pathogenic living and working environments, it is not surprising that vulnerable groups are perpetually vulnerable to infections – skin, urinary tract, ear/nose/throat, and others. These were reported in almost every city, from Ambala to Vizianagaram. Some of these infections, as in the case of rag-pickers in Guwahati, are directly linked to the unhygienic conditions of life and work: “My clothes and kambal (blanket) are burned by the police. I sleep on the side of the rail track and often is the case that the insects cut my body. I have rashes and inflammations on my face that have become serious.”

**3.13 Health-seeking.** The NUHM framework document indicates the following barriers faced by the vulnerable: crowding out due to ineffective outreach and weak referral, social exclusion, lack of information, dearth of economic resources – all of which delay, divert, or otherwise dilute health-seeking in the public sector. Our fieldwork exposed us to these and a number of other experiences in health-seeking that have to be accommodated in the design of the mission.

**3.14 *Being visible and eligible in the system*** Vulnerable groups accessing health services have to confront the esoteric and excluding bureaucratic rituals and requirements of proving one’s existence to the system<sup>71</sup> – as though without an identity proof with your father’s (not mother’s) name, a homestead, and a date of

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<sup>71</sup>Mahamallik, M. and Sahu, GB. (2011). Identification of the Poor: Errors of Exclusion and Inclusion. *Economic and Political Weekly*. XLVI (9): 71-77

birth, you don't exist. In some cases, vulnerable groups have been sought out and given that recognition, at others, they are caught in the crosshairs of one identity defining or declining another, particularly among migrants. Migrants residing in Aligarh for close to two decades recounted how when seeking help from officials to get identity or voter cards, they were dismissed because they are "Biharis."

3.15 *Ill-timed consultation and waiting hours.* Vulnerable groups reported the need for service that is better timed. This pertains to daily timings for check-ups. We found in our city visits that there was a wide range in timings that UPHCs were open. A UPHC in Bhubaneswar reportedly was open from 9-noon and then 3 – 5pm while in Delhi and Pimpri-Chichwad, dispensary timings are 8am to 2pm. This excludes all domestic workers and daily wage workers, even self-employed impoverished workers, indeed most of the populations. In every city, they explained that a visit to a morning OPD at a UPHC would cost them a day's wages. If they visit a private practitioner instead in the evening, it actually works out cheaper from the perspective of opportunity cost. In Kochi, slum-dwellers employed in waste collection reported not being able to access public health services because by the time they finish work and come to dispensaries, outpatient coupons are sold out.

3.16 *Location, distance, and accessibility of appropriate services.* In a Kochi slum, residents reported the routine visits of the Junior Public Health Nurse. They noted, however, that they were unable to get away from work and be around when she visited. In many cities, including Kolkata, Bhubhaneshwar, Guwahati, and Ahmedabad among others, vulnerable groups mentioned that public health facilities were simply too far away. In Muzaffarpur, it was reported that people were often referred to the Medical College a distance away, and make additional trips to get results from a private provider who had a separate collection centre.

- i. In the focus groups discussions held with blind women and those held with persons with disabilities and families it came out clearly that even as adults, a large number of persons with disabilities only access health facilities when they are accompanied by someone from the family or a friend. Without support, they find it impossible to navigate the health system on their own. Women with vision impairment felt that they would be totally lost if they went to a hospital on their own. They would not know where to go and how to go through all the procedures of registration etc unless there was someone to guide them. Again and again families spoke of their inability to take the child or person with disability to the healthcare facility because of illness, loss of occupation, among the main bread earners and major care givers in the family. A mother of a young adult with mobility impairment living in a Delhi slum shared that she has to put her son on her back to get out of the slum area. She then has to put him onto a bus to reach the health facility. Once in the facility, the mother must go looking for a wheelchair which will only be given to her if she can produce some

documents of identity. No one comes to her support: she and she and her son have to wait in the long lines. Today, the mother herself has a heart problem; the boy's father has always kept unwell. The physical strain is now too much for them to handle, therefore it is now well-nigh impossible to take their son to the hospital. As parents and caregivers grow older and face their own health issues, accessing healthcare becomes increasingly difficult for persons with disability.

3.17 *Disrespectful behaviour.* This was noted in the majority of our interactions with vulnerable groups and really stood out. Manual scavengers in Tumkur have been turned away when seeking care for their various occupational ailments including skin allergies, wheezing, joint pains and injuries. NGOs working with these populations put it quite frankly: the practice of un-touchability still exists in the health sector. Polio control efforts seem to have reached out, in many cities, though even this may not be uniformly the case. The nature of polio immunization is unique, however – requiring less follow-up and continuous interface with the health system, Many people we spoke to – from gas *peedhit* to rag pickers talked about the hostility of the public system –a domestic worker in Bangalore mentioned that when women scream with pain during childbirth, they are taunted by the PHC nurses saying “*Why are you screaming now, did you not know this when you were enjoying with your husband?*”.

- i. This issue of respect is major. Vulnerable groups want to be recognised and reached through services more sensitive to their lives – either services offered through outreach. In a Delhi slum, women report that the government hospitals are a waste of their time and energy, ‘*sarkari aspatal mein to garib ki koi sunwai nahin*’ (there is no hearing for the poor in government hospitals). The doctors seldom give them medicine and when they do they give them medicines without a check up.
- ii. This may be especially the case for stigmatised populations like those of *hijras* and *kothis*, whom our team met with in Pune. Confined by the binary of male/female identity markers in health-seeking, such groups are highly reliant on NGOs to access basic health care. This does not, however, protect them from extractive rent-seeking practices of private practitioners. Unique burdens faced by this community, including violence at the hand of partners, clients, or law enforcement, require constant negotiation on the part of such advocates. Very often, there is an almost isolated emphasis on certain health issues, which is not linked to comprehensive care– in our FGD, participants knew the CD4 count which qualifies them for ART treatment, but also recounted having to lay in toilets rather than hospital beds for in-patient care:

*“Humey haspatal mein mutari ke paas sulata hain, doctor haat na lagata humhe, humari bimari ko dekh ta bhi nahi hain, haaspatal mein humarey saath saab*

*bura vyavhaar karte hain –kutton ki tarah”* (We are given beds in front of toilets in the hospital during the time when we are admitted. Doctors do not even touch our body and diagnose. All behave very badly in the hospital, like people treat dogs.)

- iii. Neglect in treatment and devaluation of the life of children and persons with disabilities is another major challenge. For one, it is very common for health providers to deny treatment to children and adults with disabilities based on the perception that it is not worth diagnosing or treating them. In Delhi, a six year old child with cerebral palsy was flatly denied immunisation at the PHC. We also heard of a ten year old girl losing her life because she was repeatedly denied treatment for pressure sores at various hospitals. Apart from this, when admitted, persons with disabilities face denial of food, water, and medication. In in-patient care, too often, violent crimes or violent responses towards persons with disabilities are tolerated in circumstances they would not otherwise be. Physical, chemical and environmental restraints would be considered as an assault if carried out on persons without a disability. Over medication of children and persons to keep them quiet and docile. This is particularly true for children with Autism, hyperactivity and children who behave differently from others.

3.18. *High, Hidden costs.* The vulnerable specifically try to seek out service that is affordable - many are in favour of free medicines – NGO clinics offer select diagnostics free, which is highly appreciated, Across cities, there appear to be major variations in the application and magnitude of user fees for health-seeking, even as the evidence against their use is now conclusive.<sup>72</sup> Uniformly, vulnerable populations felt that the toll of these costs was excessive for them, and in many cases, a deterrent to health-seeking.

- i. In Bardhaman township in West Bengal, user fees are charged for diagnostics and secondary care. After paying a 2 INR per family member, those with BPL cards still have to pay 75 INR for an abdomen ultrasound, unless they go to Barddhaman’s Medical College hospital, where this procedure is free. Bed charges are 40 INR per day. Speaking of their experience in a Bhubaneswar public hospital, rural migrant slum-dwellers who had lived in the city for some 20 years reported having to incur up to 2,000 INR of costs on medicines and tests during pregnancy. Further, access to care was only assured through payment of bribes between 200 and 400 INR to nurses or class IV hospital employees. A homeless person in Mumbai told us about the arbitrary amount of 155 INR she had to deposit with the admit form in a government hospital when she sought maternity care. There were many such frustrated stories

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<sup>72</sup>Lagarde M, Palmer N. (2011). The impact of user fees on access to health services in low and middle income countries. Cochrane Database of Systematic Reviews. (4)

recounted to us. A 40 year old rickshaw puller in Guwahati described his experience with catastrophic health expenditure in painful detail: “I had to sell my house in the village to get my ligament and bone surgery done. It took me nearly 4 lakh rupees to do the surgery, and the neighbours also contributed.”

- ii. In some cities like Muzaffarpur, beneficiaries had no protection against catastrophic expenditure. In some cities, groups we spoke to did have [RSBY] cards but noted that the scheme pays for hospital expenses, but not for all family members in the case of Bhopal, and not for tests, as noted by people in Delhi. This is in contrast to Kochi slum dwellers and members of the *Narikkuravar* community we spoke to in Madurai who possessed government insurance scheme cards and were aware of their purpose and usage. In Kochi, however, cards had not yet been used by those we spoke with.
- iii. *Rent-seeking, corruption, and malpractice.* The variability of health-seeking was not an idiosyncrasy of groups themselves. It issued, we noted, from the unpredictability of any one pathway of health-seeking among the vulnerable. Even among members of a self-help group in Vizianagaram, who were relatively organised, there was no typical tendency of health-seeking at a government or private hospital. They reported that at government hospitals, doctors would tell them to return to evening private clinics. This was also noted by women in a self-help group in Gulbarga: “Here government doctors also have private service. When we go to the government hospital, they anyway call us again to their private service. Why two times of running around? Therefore we directly go to the private hospital the first time itself.” This was a recurring complaint in almost all cities we visited, including Bangalore, Patna, Delhi and Pune. In fact, in Patna, slum dwellers reported that they were asked for bribes even for birth certificates and institutional deliveries, and if they were unable to pay these, they were told that the delivery could not be undertaken because the woman was too anaemic.
- iv. For conditions like TB, vulnerable groups are fearful and sometimes untrusting of medicines provided in the public sector because of their side effects. A recent study in Delhi found that after getting a qualifying letter as an individual from the ‘Economically Weaker Section,’ a homeless person with a fracture – with heavy NGO facilitation- was granted a free bed, and then promptly asked by a private hospital to make a deposit of 10,000 INR. This was ultimately negotiated down to 5,000 INR.<sup>70</sup>
- v. In Thrissur, elderly people reported that government hospitals do not admit patients without attendants – this results in their automatic exclusion as these individuals do not have family or other caregivers who can accompany them. In Delhi, slum dwellers said that “*haspatal mein jaan-pehchaan lagana bahut*

*jaruri elaj karne keye liyee*”(in the hospital, you have to make good contacts to get treatment). This can be extremely disheartening, as one elderly woman pointed out: “I have no one to take care of me and if government hospitals don’t accept me, who will? I am without hope.” For individuals such as this woman, who must endure chronic health conditions, hopelessness only hastens morbidity.

- vi. A great burden faced by children and persons with disabilities is their involvement –without permission – in research, clinical trials, and biomedical interventions. Little attention has been given, for instance, to the continued use of non-therapeutic chemical and surgical sterilisation, hysterectomies and abortions of women and girls with disabilities.

3.19. *Latent care needs and lack of follow-up.* We noted the importance of timing in access to care – that is, primary and secondary prevention – like screenings and so on– which can be cost saving. A case of gas in Indore after 8,000 INR and months of tests, was diagnosed as late stage cancer. Primary health-seeking is weak in most cities and so there is a tertiarisation of health-seeking and, in tandem, shaping of expectation and demand (for injections, antibiotics). In Gulbarga, slum women noted that “some diseases can get cured with the treatment in Government hospital like diarrhoea and some diseases do not get cured and therefore for those we need to go to the private hospital such as fevers, boils& blisters”. Ironically, as we saw in Vizianagaram, maternal care hospitals are not equipped to address ubiquitous health concerns like anaemia – highly common among the urban poor, especially tribal and migrant subpopulations. In the public sector, women in Indore noted instances where pregnant women were given appointments for sonographies dated after their deliveries!

3.20. *Consequences* The aforementioned problems have in many cases led to health-seeking in the private sector, even in the most unexpected of circumstances. For example, sanitary workers employed permanently in the Satara Nagar Pallika chose to visit a private practitioner for family health needs because the time needed and distance travelled. They happened to live in non-notified slums along with their contractually employed peers; gastrointestinal and respiratory infections were common complaints.

3.21. In many cases, there is no automatic preference for public or private – as long as care is there and offered with respect. As of now, respect has to be demanded not expected by the poor – and this requires knowledge and organisation – this is the lesson of self-employed women in Ahmedabad. In some cities, however, like Kolkata and Indore, care is sought in the private sector in order to stave off the

economic costs of missing a day's work due to long waiting periods, and in most cases, not having to pay middle-men to be admitted.

- 3.22. Women domestic workers in Kolkata, living and working too far from government hospitals, relied on the advice of their employers with regard to medicines and providers. Many workers are apprehensive about seeking care from government doctors, as "you have to know how to deal with them." Others pay 20-50 rupees for a shahi or Bengali doctor to help address smaller problems so they can get quick remedies. In some cases, this has hastened and worsened morbidity.
- 3.23. For many, the first choice is to not seek care: to self-medicate and to avoid even having to approach the public health system. For example, residents of a government-run beggar home (none of whom were actually beggars) noted that Medical Store remained the first preference for getting assistance in form of pain killers and generic medicines like Paracetamol, Disprin etc. Most of the participants did not discuss "small" diseases with the doctor nor did they follow up the treatment once they took the medicine and felt better. Indeed for many slum residents we met, the pharmacy was the first and only port of call in all smaller and even some graver illnesses, whereas for the poorest among them and for many of the homeless there is no health-seeking at all, only to soicallly live and sometimes become permanently disabled or die with their illnesses.
- 3.24. The team learned from its fieldwork that for no-one is there a generic pathway of health-seeking. There are local variations shaped by concatenations of vulnerability which are in turn shaped by the history, governance, and circumstances of each city. In Indore, USAID funded the EHP a decade ago, allowing for the creation of a cadre of slum federated outreach workers who are now wondering where they fit in the system. The strategy for health-seeking here is different. In central Delhi, rickshaw pullers who work near the *raen basera* described a strong relationship with the police (partly because their employer is a police-wallah) and how this helps them in accidents and emergencies. Vulnerable groups themselves have networks, strategies for care and exercise agency – but they are very context-driven.
- 3.25. All vulnerable groups are hopeful of improvements in their living and working conditions, i.e. stable and if at all possible legal tenure; access to clean drinking water; use of well-maintained toilets with routine waste management; well-lit streets; accessible and affordable transportation; child-care and educational facilities for young children; respect and recognition as citizens, workers, and beneficiaries of public services.



### 3.26. Recommendations:

- i. It is recommended that NUHM adopt and adapt the Hashim committee guidelines to identify vulnerable groups across residential/habitational, occupational, and social axes. As indicated in the NUHM framework document, there is a problem of targeting the poor on the basis of the BPL card. Other approaches to identifying the vulnerable have been used -with some success -in the past and most these are often loosely called mapping.<sup>73</sup>
- ii. The process of mapping must essentially be a process of making the vulnerable visible to the health care system, and capture their problems in access and their health care needs. Thus it is not only the geo-spatial distribution of populations that is the object of such mapping, but also the social relationships and issues of access to health care. Mapping therefore requires inputs from social scientists and activists/non-government organisations who have experience and empathy in working with these populations.
- iii. The process of mapping must also identify vulnerability with respect to access to piped water supply, sanitation facilities, food security entitlements, legal status of occupation of the land and rents and the recognition of their identity by governments. Mapping must carefully identify and bring to visibility slums which have not been notified and illegal settlements where peoples live, and relate it to the services they provide the city.
- iv. The process of mapping must include an access audit, where it considers whether the location of PHCs or any other social barriers exclude access to vulnerable groups and suggest in consultation with the community which location would be most useful. Given past experience, in most urban contexts if at least 50 per cent of PHCs and nursing station sub health centres are not located within slums, there are likely to be barriers to their access. Of course there would be problems of finding the space, and getting the sanctions, but assuring access requires such an effort.
- v. The periodicity of this mapping will have to take into account the temporality of vulnerability: it may be useful to think about 1) times of life, 2) times of day, and 3) times of year more carefully in providing services. The lives of vulnerable groups can be quite heavily time ordered, and not in ways that they can control. This is why children, women beginning their reproductive years or pregnant, and elderly are identified even by vulnerable groups as the most vulnerable among them. As aforementioned, seeing vulnerability as a process rather than a state requires a kind of continuous vigilance to the

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<sup>73</sup>Public Health Foundation of India and World Health Organisation. (2013). PHFI/WHO Consultative Workshop on an Indian 'Health Equity Watch': A Report of Proceedings. New Delhi: Public Health Foundation of India.

various ways the urban population encounter vulnerability, in relation to space, place, organizations, community, neighbours, family, and so on. This requires that mapping processes will have to be resourced enough to function adaptively, iteratively, and routinely if not continuously updated, lest exclusions remain.<sup>74</sup>

- vi. Inasmuch as mapping is a key component of NUHM's planning process, the state will have the information (perhaps not at the individual level but at the group level so as to not require extensive proof of eligibility from the vulnerable during health-seeking. It is therefore recommended that establishing eligibility is the duty of the state, not the urban citizen or resident, and that health services and providers focus on more comprehensively understanding processes of pathogenesis, as well as pathways and prognoses of the urban poor.
- vii. Vulnerable groups are ill-informed about their public health vulnerabilities, exposures, rights, and responsibilities. In part this is due to the tertiarisation of care, but partly this is because attention to the specific burdens of vulnerable groups is only now increasingly being paid. Far greater, concerted, and predictable forms of outreach, dissemination of health promotion information and primary prevention (screening, spraying, immunisation, health fairs, etc.) should be made available to vulnerable groups, preferably with their active engagement and participation. They are eager to learn how to avoid ill-health, as the toll it takes on their lives is highly catastrophic.
- viii. NUHM has to accommodate in its design provisions to address the determinants of health (living and working conditions), as well as health seeking behaviours from both demand and supply side, including reach, range, quality, connectivity, accountability, and flexibility of services. Conceivably, NUHM could monitor its progress against indicators of expenditure, health-seeking in the private sector among these populations, as well as lack of care-seeking.
- ix. Based on the inputs of vulnerable groups, as well as the information available from research, services provided under NUHM should be appropriately timed, respectful, cash and corruption-free, and facilitated. Some specifically feel the need for an advocate on their side – a community member or an NGO outreach worker who can serve as alibi and guide to their health-seeking.

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<sup>74</sup>Rajshankar M. (2013). Low funding hurts Delhi's welfare programme. The Economic Times. Sep 9, 2013. Available at: [http://articles.economictimes.indiatimes.com/2013-09-09/news/41903510\\_1\\_gender-resource-centres-welfare-programme-grcs](http://articles.economictimes.indiatimes.com/2013-09-09/news/41903510_1_gender-resource-centres-welfare-programme-grcs)

- x. As far as practically possible community health workers, facilitators and interlocutors must be drawn directly from or connected to vulnerable groups themselves. Communities feel most comfortable with family members, co-workers, community members or NGO workers supporting them in their health-seeking. In many cases, these networks already exist – through work, because of former NGO presence or prior projects or schemes. These must be understood in local context and worked with. For example, in the *raen basera* in Delhi, the FGD we were conducting was joined by an elderly lady who was speech impaired – she communicated through gestures that others seated around me attempted to explain. Their community leader had interlocuted between her, the NGO, and the ambulance when she was stabbed one evening while walking on the periphery of their settlement.
- xi. Good practices should be extended, supported, and scaled up. A number of interventions and programmes to reach vulnerable sections exists that offer great potential in the NUHM framework. These are listed in subsequent sections.
- xii. Efforts to restore faith in, accountability and use of these services requires advocates who can work in teams, show results, and maintain commitment over time – and this requires a collaborative, transparent, and mutually respectful relationship. A strategy of advocacy and change management would thus need to be put in place.
- xiii. There is a need to improve responsiveness of services with specific respect to the vulnerable groups. Responsiveness may be understood as consisting of following seven elements, which refer to non-medical elements of the health system that may be legitimately expected by users.<sup>75</sup> These seven elements are: 1) dignity, 2) autonomy, 3) confidentiality (of information), 4) prompt attention, 5) provision of social needs, 6) basic amenities, and 7) choice of provider or facility.<sup>76</sup> We found that vulnerable groups across the 21 cities raised most of these issues (although confidentiality was less of an issue than sensitive handling of stigmatising conditions, which is an issue of dignity).
- xiv. Finally, a carefully justified menu of options may be most appropriate to address the diversity across vulnerable groups in various cities and states, mindful of history, governance structures and the articulated as well as observable needs of vulnerable groups. These menus may be developed in each city, by consortia comprising policymakers, technical and research

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<sup>75</sup> De Silva A. (1999). A framework for measuring responsiveness. Geneva: World Health Organisation, unpublished document. Available at: [www.who.int/healthinfo/paper32.pdf](http://www.who.int/healthinfo/paper32.pdf)

<sup>76</sup> Darby C, Valentine N, Murray CJL, De Silva A. (ND). World Health Organisation (WHO): Strategy on Measuring Responsiveness. GEP Discussion Paper Series: No 23, (EIP/GPE/FAR) unpublished document. Available at: [www.who.int/healthinfo/paper23.pdf](http://www.who.int/healthinfo/paper23.pdf)

institutions, as well as institutionalised formations or non-governmental organisations serving vulnerable populations may be required to support this process. In many cases, State Health Resource Centres may serve as the convening body for this effort, with the guidance and stewardship of health department and the ULB leaderships. In some cases, regional formations may support the needs of peri-urban areas and migrant workers. Thus a nested network model of technical capacity may be required.

**In conclusion:**

Vulnerable groups struggle with a number of antipathic social conditions – from lack of housing, to lack of sanitation, to lack of employment or compensation and the problems of access to health care are only a part of this spectrum. Health care systems that are respectful, physically and economically accessible, and responsive – that makes an effort to reach them, and does not reinforce the burdens of stigma and discrimination vulnerable groups already face, can help ameliorate their suffering and empower them to contribute to change. Building strong primary health care service delivery systems that could reach out and address their primary health care needs and reduce the unnecessary tertiarisation of care would be the central challenge of design and implementation under NUHM. For this we have to understand how institutions of health care delivery are structured and how they function, and how one could improve their design and functionality so that they are more responsive and effective.

## Chapter 4

### Institutional Arrangements for Urban Health Care Delivery- Focus on Medical Services

- 4.1. The earlier sections have elaborated on the gaps in public health service delivery in urban areas and the consequences the poor face on this count. An in-depth institutional analysis is essential to understand these gaps and their determinants both inside and outside the health system. But this institutional analysis would need to be preceded by an extensive institutional mapping of what public health services actually exist in various cities especially for primary health care, and how do these function in general and especially for the poor and vulnerable populations in these cities and towns. This institutional analysis would help us understand how constitutional principles and the policy mandates for providing healthcare have translated into the health infrastructure and services, their distribution by socioeconomic and geographic sections, the special emphasis on vulnerable groups and scope for action, existing and needed governance mechanisms, and finally the challenges or barriers in service delivery. A critical reflection and appraisal of the institutional systems for health will also assess issues around distribution of services across different facilities and human resources,<sup>77</sup> the choice of technology and programme design and aspects related to health financing. In the process of deliberations, this group made developed a guideline sand tool kit for understanding urban health (Annexure 6) and made an attempt to assess these through its in-depth primary interactions with both general and special vulnerable sections, along with actors and stakeholders engaged in health at multiple levels. These included urban local bodies and health service providers at primary, secondary and tertiary levels.
- 4.2. There seems to be, at first appearance, a wide and bewildering diversity of institutional arrangements for the attainment of better health outcomes and the delivery of health care services in urban India.<sup>78,79</sup> But for ease of analysis we have categorised the observations from the case studies into three broad institutional patterns from the perspective of which layer of government takes primary responsibility for organising health care in the city.

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<sup>77</sup>Rao, Mohan, et al. "Human resources for health in India." *The Lancet* 377.9765 (2011): 587-598.

<sup>78</sup>PHRN. (2010). *Public Health Resource Network: Issues in Public Health, Book 16*. Delhi: Capital Printers.

<sup>79</sup>Raha, S. (2010, December). Institutional Arrangements in providing Urban Health Services: Current Context and the possible way forward. *India Health Beat: Supporting Evidence-based Policies and Implementation*, 4(3).

- 4.3. In the first pattern, health care facilities are entirely provided by the state departments of health, with no involvement of the urban local body (ULB). There is usually a municipal health officer who is in charge of a number of non-medical services relating to public health; but even this post is often vacant or sub-critical in functioning, lacking the necessary support staff and importance. This is the pattern in *all* urban areas of states like Himachal Pradesh and Bihar, and the pattern in small towns typically below 2 lakhs in almost all states. There is an effort in some states to correct this situation though; West Bengal has initiated the process of appointing health officers in smaller towns that previously had none.
- 4.4. In the second pattern a minority of care provision is by health care facilities under the urban local body and this role is usually receding. Typically it is usually a maternity hospital and a few urban health dispensaries or health posts and sometimes a cadre of health volunteers who are under the urban local body (ULB). For the main part it is the district hospital or medical college hospital that provides the health care services- and there may be some UHCs under the state government as well. Bhubaneswar is a typical example
- 4.5. In the third pattern the majority of health care facilities are under the urban local body which looks after medical and non-medical public health functions in an integrated manner. The state government may have a few facilities, usually medical college hospitals; but the rest of the functions are delivered effectively by the ULB. This is the pattern in all the metropolis visited- Mumbai, Kolkata, Chennai, Bangalore, Ahmedabad, and Delhi, though in the last the state govt has also a number of facilities under it. Among non-metros Pimpri, Visakapatnam, Bardhaman and Madurai show this pattern.
- 4.6. One important observation is that – as noted in Chapter 2 - urban areas have growing population size not only due to births and in-migration, but also through notification of previously considered peri-urban areas into urban settlements. Even as area jurisdictions may vary, cities and urban areas have been expanded in many cases for reasons related to residential or industrial purposes. The incorporated area may already be fairly urbanised, with notification being a long overdue rationalization of an existing reality, as in Tamil Nadu.<sup>80</sup> At other times these are well-populated villages with on-going agricultural activity, taken in as part of a long term strategy of expanding the urban-scape as in Bangalore and Surat,<sup>81,82</sup> or to construct a new capital as in Raipur/New Raipur.

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<sup>80</sup>Das Gupta, M., Desikachari, B. R., Shukla, R., Somanathan, T. V., Padmanaban, T., & Datta, K. K. (2010, March 6th). How might India's Public Health Systems be strengthened:Lessons from Tamilnadu. *Economic and Political Weekly*, XLV(10), pp. 46-60.

<sup>81</sup>Dasgupta, R. (2010). Ahmedabad and Surat:Urban Health Services. New Delhi: Unpublished work.

4.7. The implications for health care in this incorporated population also fall into three patterns. In some places, typically the highly urbanized peri-urban areas, services were weak before and they continue to be weak later, but is a fertile ground for private practitioners and nursing homes.<sup>83</sup> In a second pattern, typically where a rural area is being incorporated the available services are withdrawn usually because the human resources (HR) are re-deployed and the urban area is unable to take over (in both the second and third type of institutional patterns). And in the third pattern the handing over is relatively smoother and this is usually when both the new and old leadership is within the state department of health itself.

4.8. **Recommendation 1:** *The NUHM design leaves these above decisions to the state government, respecting the needs, capacity and will of the states for implementation of health services. At the same time, it establishes that certain core principles and parameters need to be exercised:*

- i. There should be no withdrawal or reduction in the current services being offered, even in a transient or temporary sense, from the people it serves.
- ii. Mechanisms for convergence with health related non-medical services (water, sanitation, waste disposal) centred round the municipal health officer should be retained and strengthened.
- iii. Where the population is over a million and a municipal corporation is in place, the preferred option be integration of health services under the urban local body- with coordination mechanisms for ensuring care in peri-urban areas and for handing over of rural services along with the human resources and the finances needed for the same. However if the state government chooses to take over- the following para applies.
- iv. That where the population is less than a million and the ULB is not effectively in charge (pattern 1 and pattern 2) then the state government takes over the health care provision- while the ULB retains the position of the municipal health officer for non-medical dimensions of public health. (One divergent view expressed in the

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<sup>82</sup>Dasgupta, R. (2010, December). Public Health in Urban India:Lessons from Surat. *India Health Beat:Supporting Evidence-based Policies and Implementation*, 4(5).

<sup>83</sup>Chatterjee, M. (2010, December). Urban Health:Policy and Polity. *India Health Beat:Supporting Evidence-based Policies and Implementation*.

discussions is that the cut off should be 2 lakhs – and not as high as a million).

- v. Where the state health departments are the main governance institution for health, they must ensure effective coordination with the ULBs and the continuation of all preventive and secondary care services..State government must formulate a timeline for a plan for '*legacy management*' on the absorption of existing health workforce - link workers, health posts, dispensaries and MMUs and secondary hospitals into a formal framework, with no redundancy or duplication or loss of role clarity. On the positive side legacy management requires re-allocation of job descriptions with appropriate training and supervisory and support changes. Legacy management shall also apply to a plethora of urban health projects (mostly externally funded) in a number of states that have varying patterns of existing delivery models as well as their cadres healthcare workers.

**4.9. Current Patterns of Primary Care Provision: The Health Care Pyramid:** The ideal organization of health care services could be described as a health care pyramid. At the bottom of the pyramid are community and outreach processes where community health workers and frontline health workers like ANMs provide services. At the next level are the primary health centres that together with the frontline health workers, and community and outreach processes constitute the primary care team. This is where the major part of preventive and promotive action takes place, as well as in numbers the largest proportion of curative clinical encounters as well. Over 70 % of health services occur at this level. At the next level are secondary hospitals, which act as the first referral site, offering hospitalisation and a larger range of diagnostics? This is an integral and essential part of the primary health care. The district hospital is at the apex is the medical college hospital providing tertiary health care. Only 5 per cent of care and illness requires tertiary levels of care, with a majority of this being for complex illnesses requiring medical professionals, who have specialised skill sets or who are needed to make informed judgements, or where high levels of technology support are required. As viewed by the NUHM framework, most primary care should be delivered by the lowest levels of care, only complex cases requiring specialist care need to go to tertiary care site.

4.10. Observations in the urban areas visited by working group members show that primary care is being accessed at all five levels- medical college hospital, secondary care hospitals of two levels, , primary care facilities and the outreach services. In terms of frequency of use- there is an *inverse pyramid* phenomenon. The major proportion of curative primary care provision may be occurring at the medical college and the district hospitals, with the UHC and maternity



homes catering to a much smaller proportion and almost no care occurring at the outreach of community level for a major part of the population. This cannot happen to this degree in a rural setting, because of distances. But in urban areas, geographical distance is not a major barrier- and since services are more assured at the higher site, the poor prefer to go there.

4.11. Reasons for this inverse pyramid in urban areas have been attributed to different reasons across stakeholders. Some providers have insisted that it is inherent health seeking behaviour- that everyone prefers the bigger hospital and the specialist in these times. Others would attribute it to poor quality of care in the periphery. Yet others perceive the cause as a lack of service provision: either providers not being in place or not delivering services as expected of them. Our own impression drawn from the focal group discussions- is that it is primarily a mismatch between the services available and the services needed- and that service packages at each level are not responsive to needs. In the periphery, the urban health centres (where in place) or the urban family welfare centres (UFWC) along with maternity homes provide a minimal range of services in primary care , with a focus on family planning and a limited menu of reproductive and child health services. In most cases, these may be limited to immunization and antenatal care and to institutional deliveries in the maternity homes and some level of symptomatic minimalist curative care.

4.12. In contrast to divergent views on causes, there is considerable unanimity on the consequences of these aspects on the health needs and experiences of urban populations, particularly the poor who may rely on public systems. Over-crowding, long waiting times, very cursory examination, peremptory and often discourteous communications by the doctor with the patient, hasty referrals and rushed disposal of cases leading to misdiagnosis, patient disillusionment with the health system or building of any meaningful doctor patient relationship- are all direct consequences. Add to this the inconvenient timings of the peripheral facility (facilities in several cities operate between 9am and 2pm) and insensitivities of the provider leads to (a) poor trying to access the tertiary system for primary care needs, (b) poor paying for private sector even as it remains unaffordable, pushing them into poverty, while also having its own set of quality of care issues (c) poor not being able to access health at all. These choices are faced by the urban poor, not just as patients, but also as care-givers to the patient in the household. Only those who can forgo a day's wage are able to access primary health from public primary health care institutions.- and forgoing the wage has adverse consequences for all family members- even those who are not sick.

4.13. Accessing primary care through private providers or even through public tertiary systems drives the cost of care up considerably, including both direct

costs of treatment and indirect costs of transport or other expenditures. In addition, urban poor face difficulty in accessing health, due to their reduced knowledge and information, low social capital, poor ability to negotiate and power relationships in the big public hospital setting.

- 4.14. **Population Based Services:** The other big issue in the organization of primary care services is that primary health care in the urban setting has not been population based.<sup>84</sup> The urban dispensary- from which the urban health centres evolved in many cities were not designed keeping in view the distribution of population. Typically the urban peripheral facility- be it health post or health centre, treats those coming to it- and does not feel responsible for the health of the entire population in a defined catchment area. This has not been so in the urban space. Population-based ANMs and link workers were introduced during different phases of the India Population Project (IPP) and under urban RCH schemes; their activities were limited to antenatal care and immunization-, even this was very weak across states.<sup>85</sup>
- 4.15. This lack of definition of a catchment area and the connection between the health centre to a given population base has a direct adverse consequence for reaching the vulnerable. In a rural area- even 80 per cent coverage reminds us that the last 20 per cent- may be the neediest. But even in the best showcased UHC programmes, the notion of population-based calculations to estimate coverage has been missing.
- 4.16. Another consequence is that availability of outreach services is limited. Since the urban centres have not been defined as per a population base, health workers have little basis or even a formal requirement to conduct any outreach activities for their catchment population and therefore limit activities to providing services for those who come in. This implies that those with latent illness or with inadequate health seeking behaviour get altogether missed.
- 4.17. There have been a number of efforts to improve access to healthcare for the poor through coverage in publicly financed insurance schemes such as the RSBY, where a smart card empowers them to seek free in-patient care in private hospitals. However, observations and experiences from the states have shown that this is not necessarily meeting this objective with respect to the poor.. The card is an entitlement for the private provider to seek reimbursement from government, but as it is practiced currently, it neither entitles the service user to

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<sup>84</sup> Singh, Ranvir (2012a), Health Care in Delhi: A Spatial Analysis of Disparities in Utilization, unpublished PhD Thesis, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

<sup>85</sup>More, N. S., Das, S., Bapat, U., Choredkar, L., Alcock, G., Joshi, W., & Osrin, D. (2010, December). Maternal and Newborn Health: Dynamics of seeking healthcare within Mumbai slums. *India Health Beat: Supporting Evidence based Policies and Implementation*, 4(7).

free services, nor even to physical access to care (Case Studies: Raipur, Villupuram). As experiences recorded in FGDs have shown, individuals have been denied care despite having an RSBY card and reaching an empanelled hospital.

4.18. There is also considerable instances of denial of care that is based on the lack of ability to “prove identity” with some stipulation as to what is an acceptable identity documentation. Further, the creation of these documents and their use has been subject to several issues including provider idiosyncrasies, corruption, ad hoc treatment and even exclusion. Identity documentation must have no relevance in primary care settings and no documentation must be required for those seeking care. There is also the larger non-negotiable that proof of sickness should be enough proof of identity- and public services to the sick cannot be made dependent on the production of identity. The RNTCP/DOTS institutionalises this and mandates the providers to deny DOTS and put patients on conventional regimes.

4.19. An example of good practice in this area is Chennai city- where for RCH services every household is mapped and linked to a health post staffed by an ANM. Even households without door numbers are designated as migrant families and mapped. Interestingly, in some places there is a separate headquarters building for the provider in the health post- but in more situations, this health post is co-located with a secondary or tertiary care facility- the principle being universal population-based outreach to every household- even if the house is in the door step of a medical college hospital. They note that there are slums around many secondary and tertiary care facilities which also require house to house coverage by a community/outreach provider.

4.20. **Recommendation 2:** *The establishment of a primary health care infrastructure would be based on population distribution, with particular emphasis both on settlements of the urban poor including slum and slum-like colonies, and on clusters and areas with high density of homeless and moving populations such as bus and railway stations, and where sizeable numbers of vulnerable groups may be located (e.g. street children, homeless, disabled, elderly). Population basing is non-negotiable- but the approach to achieving this could be locally decided.* Such a standard would have in the least the following attributes or measurable criteria:

- i. That every primary care facility should have a well-defined catchment area that it must reach out to in its prevention and outreach programmes, along with national health programme drives irrespective of whether they reach it or not.

- ii. Primary care facilities having well defined catchment areas would include the following – all community health volunteers, ANMs providing outreach services, existing health posts or proposed nursing stations cum health subcenters, all outreach services like health camps and mobile medical units, and all urban health centres.
- iii. Certain dimensions of primary health care would also be available at the Anganwadi Centre (AWC), the primary and secondary schools.
- iv. That those not residing in the catchment area will also remain eligible for services, with only the obligation of health providers being required to visit them in their houses to check on latent health needs is not imposed. However, all homeless or vulnerable, ordinarily or with periodicity, resident in this area should be mandatorily included, and mobile clinics may be deployed to regularly reach dispersed populations.
- v. That the mechanism of identifying those who have to make it to the list and who are in danger of getting left out (because of the inherent invisibility of these sections) is loosely referred to as mapping. Earlier efforts at such mapping could help. Though there are many schemes that have undertaken such a mapping exercise earlier, the most successful and accessible of these in our cross-city observations has been the pulse polio programme, including the health facility analysis: ‘who accesses what’.
- vi. That creating an enduring patient-provider relationship shall be a mandate of each health centre so that residents and households in urban areas are able to name their nearest health centre and establish relationships with their ASHA (CHW), her health post/ANM. This would be monitored through on-going patient surveys to assess both the outreach of the centres and extent of patient-provider relationships. As a measure of achievement, 100 per cent of the poorest 40 per cent should be able to so name the above three providers to which they have preferential access and a home care entitlement.
- vii. That there should be a point of access to essential drugs<sup>86</sup> and first contact care- of at least a nursing station sub health centre or health

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<sup>86</sup>Selvaraj S, et al. (2012). Pharmaceutical Pricing Policy:A critique. Economic & Political Weekly, January 28.

post, so that no resident of the poor habitation has to use a bus or motorised transport to reach there.

- viii. The architecture of each PHC will link it to the nearest homeless shelter, nutrition rehabilitation centre, drug de-addiction facility, recovery shelter, mental health rehabilitation centre and an in-patient secondary health facility.
- ix. The staffing of the UPHC should include a social worker who will be trained and equipped to deal with secondary referrals which are not to secondary hospital health facilities, but to psycho-social rehabilitation centres. The social workers must be aware of the rights of children and persons with disabilities and be trained to communicate with them and also be responsible for ensuring that others working at the UPHC are appropriately aware and responsive.
- x. That there should be explicitly a bar on any kind of document being a mandatory requirement for treating any patient who voluntarily comes to a public health facility, and explicit instructions that no human being who seeks care can be turned away on any ground.

4.21. **The Mix and Match of Needs, Services and Facilities:** There is a serious mismatch between service needs of the poor and the package of services for which different facilities are currently designed. For this reason even where we have the UHC, health post/ANM and link worker in place- as seen in many cities and in effective PPPs with good NGO partners, we find the FGDs report almost the same dismal picture- of high out of pocket expenditure, inappropriate care in unqualified private providers, high waiting times and cursory care or even denial in overcrowded tertiary care facilities.<sup>87</sup>

4.22. Part of this reason is the path dependence of institutions. Urban outreach and clinics expanded under IPP and later under RCH -1 and II programmes, where the focus was on immunization and ante-natal care. For all the rest, the primary care package had only what was/is referred to as 'general OPD' services. This seems in practice, as per observations across all cities and contexts, to be confined to the provision of medical care of acute minor medical illnesses, most of which are anyway self-limiting, but where some symptomatic relief would help. Whenever anything more is encountered, it is referred away, and in the absence of a secondary system, the next point of care is usually the district hospital or the medical college hospital, or, where affordable, a private provider. Thus typically a city visit to an urban health centre would report a 100

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<sup>87</sup>Prashanth NS. (2011). Public private partnerships and health policies. Economic & Political Weekly, October 15, 2011.

to 300 patients being seen in the space of a few morning hours and the FGD from neighbourhood slum would show a larger access from private providers or from tertiary care centres. In such a context, chronic conditions which may be prevented early- like hypertension and diabetes -get missed.

4.23. For RCH care there seem to be functional maternity homes and secondary care provision available, but not all maternity homes provide services, either reliably or of good quality. And as NRHM/NUHM proceeds, there is a trend to cut back on dedicated maternity homes in the expectation that the district hospital would take care of this. In practice, this is not as easily accessible as the former was. As a result of this, cases and deliveries that can easily be handled at the primary facility also end up in tertiary care overloading an already loaded health system. At the same time, RSBY and similar (state government led) schemes has the potential to somewhat decongest (though unlikely to be in any large measure) some of these institutions. The introduction of these schemes however, with components of private participation in service delivery, must be viewed with caution, since social insurance can potentially increase unnecessary surgeries, driving up the cost of care.<sup>88</sup>

4.24. A considerable part of the overcrowding at the higher level is for routine follow up services, like a hypertensive or diabetic collecting free drugs, or a woman with an injury going for daily dressings. These should be done at the local centre- but there is no feedback for follow up established and no mechanisms for delivery of these in the general OP approach of the primary provider.

4.25. **Recommendation 3:** *There is a need to re-think the exact package of services that should be available at: (a) community level (from ASHA/MAS); (b) outreach level- what could be named a nursing station and health sub- centre, with some similarities to the earlier health post (with services provided by ANM/MPW or Nurse provider), and (c) the urban primary care facility (UPHC). We give in the Annexure 3 specific templates for each of these facilities. The UPHC that is being proposed is not a one doctor PHC, but a health care team that would provide a comprehensive package of primary care services with investigative and referral support. Though this is again a context-specific choice, it is useful to put in place the following principles of design or to describe a set of standards which primary care provision should attain for it to be meaningful- and for re-inverting the inverse health care pyramid back to its base. These principles of design could be enumerated as follows:*

- i. All the care that could be potentially provided in the primary care levels – in that it does not require a doctor’s examination- should

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<sup>88</sup>Selvaraj, Sakthivel, and Anup K. Karan. "Why publicly-financed health insurance schemes are ineffective in providing financial risk protection." *Economic & Political Weekly* 47.11 (2012): 61-68.

be made available at this level. This would be provided by primary health providers including health workers and posts. This would include: a) immunization; b) care in pregnancy- especially ante-natal and post natal care; c) access to family planning counselling and contraception; d) treatment of acute non-complicated medical illness; and e) basic diagnostic and monitoring procedures including: blood slide for malaria, strip based measurement of blood glucose (Kolkata MC has initiated this at Dengue Detection Centres) and blood pressure measurement.

- ii. Ability to correctly diagnose and treat a certain level of complicated medical illness- especially fevers – with necessary investigative support. This requires a doctor available at the UPHC- but more important it needs a higher level of equipment and diagnostic support than currently available at the health facilities.
- iii. Ability to screen for all non-communicable diseases, where screening is technically feasible and desirable and useful to identify latent illnesses that require secondary prevention and where timely and appropriate care provision could be lifesaving.
- iv. Ability to provide follow-up care for specialist/ medical officer consultations for non-communicable diseases: repeat drugs, periodic monitoring of parameters such as Hb1c, counselling and supportive care between specialist consultations (made necessary as infrequently as possible).
- v. Ability to treat minor injuries and more important follow appropriate follow up at the primary care level for injury management in the form of dressing, plaster cast maintenance, identification of complications etc.

4.26. The above services would be delivered through the following institutional mechanisms-

- i. The ASHA worker – role and services to be described in next section
- ii. The MAS and other community based organisations (role and services to be described in next section)

- iii. Outreach sessions organised at the community level on an intermittent basis- similar to the village health and nutrition day.
- iv. Nursing station (and/or health sub-centres)- converting the earlier health posts (template provided in annexures)
- v. Urban Primary Health Centres- whether managed by ULB, state department or contracted in through PPPs
- vi. Mobile Medical Units- Limited role- described later in section 4.35
- vii. In addition to the above there is a set of vulnerable- specific special services that many UHCs will need to be linked to. (As an example of this a template for homeless shelters is provided in the Annexure 4)

4.27. **Nursing Stations cum Health Sub-Centres in Urban Primary Care:** Of the above, the new concept being introduced is the nursing station. In a sense it re-affirms the faith in Health Posts, envisioned by the Krishnan Committee, but with an expanded set of services that shall include follow up care for NCDs, health and nutrition counselling, preventive and promotive health activities, vaccination and ANC, and access to the essential drug list (EDL) as mandated by law and prescribed by a specialist or doctor based on their diagnosis and dispensed in linked pharmacies and dispensed here after some follow up check-ups as may be required. This would include drugs for TB, leprosy, mental illness, NCDs and dressing for wounds. Along with drugs, availability at low-cost of drug ancillaries like IVs, cotton and needles will be mandated. Nurses and pharmacists in dispensaries are allowed to prescribe most of these drugs under standing orders of a doctor. We feel that the legal issues and the ability to change mindsets would be easier if these facilities are named as nursing stations- but alternative names like calling them health sub-centers ( as in rural areas) or health kiosks as proposed by Karnataka are also acceptable, provided the package of services is expanded to cover these health priorities. This would reduce the need for intermittent outreach sessions, though it would not eliminate it altogether. To deal with male patients, especially single male patients, male nursing personnel are desirable. This should be initially introduced in those nursing stations catering to specific areas and vulnerable groups. We therefore propose that the staffing pattern be of two female health workers/nurses and one male health worker/nurse. One nursing station cum health sub-centre would cover a population of 10,000 persons, and given the fact that a rural sub-center for a population of 5000 has this level of HR- there is



a clear case for increasing it to the same level in the urban context also. With such a complement of staff, a morning clinic, an evening clinic and home visits and outreach sessions can all be managed.

4.28. **Secondary and Tertiary Care Issues:** Several vulnerable sections have specific sets of health concerns (see Chapter 3). Since primary health centres have delivered mostly reproductive health services, most of these specialized services are available only in advanced tertiary care settings. Examples observed across the states include the following: Head-load workers requiring orthopaedic consultation for disabling neck and back pains, frequent trauma care need in head load workers, street children, homeless street dwellers, construction workers, gender violence victims requiring both gynaecological and psychiatric assistance, de-addiction related drugs and other requirements among high alcohol and substance abusing groups, specific infections among sanitation workers, street children, rag-pickers etc, sexually transmitted diseases in specific sub-groups with unusual levels of exposure to unsafe sex, chronic lung infections subsequent to unusual levels of dust or other air pollution, infectious disease exposure in rag-pickers and sanitation workers- especially hepatitis and HIV, etc.

4.29. The earlier chapter and sections have described the barriers to access for secondary and tertiary care services that the poor face. In cities that have medical colleges, most secondary care has been provided by them. Where there are no medical colleges, secondary care is largely provided by tertiary care hospitals under the state government, usually the district or sub-divisional hospitals. In a large number of towns district hospitals are being converted into medical college hospitals. Sometimes the consequence of this for secondary and tertiary care access for the poor is positive- with a larger range of services being available. (case study: Jorhat, Malda etc.). In other contexts the start up of a medical college takes away staff and even services from the district hospital, - when the district hospital is separated from the district health system, and/or a new district hospital is started up (case study - Villupuram). In a district headquarters setting, even old existing medical colleges have this problem of lack of referral or programme connectivity with the district hospital- as the medical college becomes the main site of all secondary and tertiary care.

4.30. In large cities and urban centres where colonial municipalities existed, municipal architecture for secondary care provision has seen different patterns from other areas. In general, mother and child hospitals provided all RCH care. Fever hospitals, later renamed as infectious or communicable disease hospitals or TB hospitals provided care for general or specific infectious diseases. Finally, general hospitals attend to all other health care. In large cities all three are seen to survive, with only maternity hospitals being expanded but not in scale with

the underlying health needs. Further expansions in secondary and tertiary care at medical colleges and speciality hospitals (especially cancer) have mainly been conducted under the state governments, or as in the case of Delhi, under the central government. (case study- Chennai, Delhi, Raipur, Visakapatnam, etc). The reasons for this lack of scale failure in adding to historically acquired capacities by ULBs would need to be discussed separately.

- 4.31. Negotiating the waiting times, large numbers and physical access to facilities continue to be concerns in the secondary and tertiary care systems. Almost all city reports showed that follow up for drugs, dressings or periodic examinations/investigations is yet another barrier (case study- almost all city case studies). Patients without attendees are often marginalized more than others, and often turned away completely, especially affecting populations like single migrants, single women, abandoned aged persons and single migrants.
- 4.32. Amongst aspects related to healthcare other barriers to access reported in the primary research, financial barriers are the main one. For this reason alone, despite all the problems, and all the problems of quality, the public hospitals remains overcrowded. There is of course considerable spilling over into private sector even at the cost of impoverishment. It is difficult to state whether if care was equally free and accessible in public and private sites- which would be preferred. But when both sites have considerable out of pocket expenditure despite insurance coverage, and when overcrowding limits access in the public sector- and denial of care or the inability to enforce an entitlement flowing from insurance coverage- limits access in the private sector, it is difficult to conclude on this question.
- 4.33. The lack of referral and follow up mechanisms to ensure continuity of care is another major constraint. For example, if a specialist diagnoses diabetes and prescribes on a certain set of drugs and follow up tests, there are no arrangements in place for the UPHC to take it forward from there- providing easy access to drugs and diagnostics and ensuring medication adherence. The drugs prescribed may not even be available at the UPHC and the specialist may have little knowledge of what is available. There is no way the PHC could contact the specialist if there is a consultation required by the primary care provider.
- 4.34. **Recommendation 4:** There is a need to plan for an expanded notion of referral and continuum of (secondary) care as part of the mandate for universalization of primary health care, drawing on a considerable set of services which are currently in tertiary care into the secondary or even primary care setting. Such a plan should include the following minimum components:

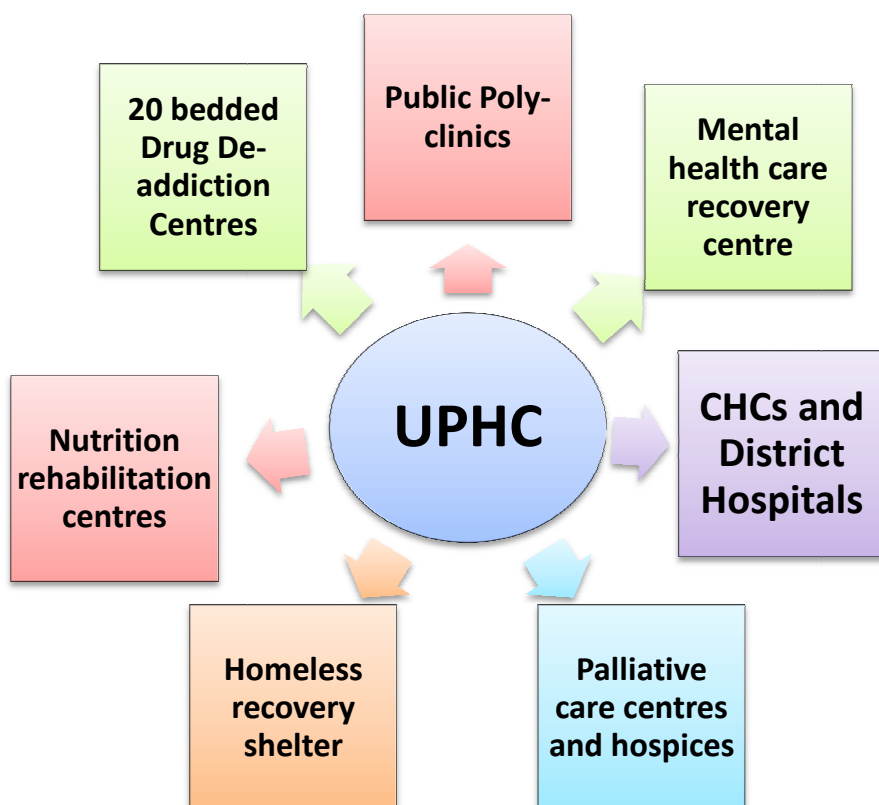
- a. Ensuring that there is better segmentation and availability of public services for secondary and tertiary care that the poor can understand and access.
- b. Shifting some primary care services, currently available only at the tertiary site, to primary and secondary care. This would include all those instances where patients are visiting the tertiary site merely to collect their next week's drugs or getting dressing done, or where regular diagnostic monitoring is needed.
- c. Special empowered help-desks staffed by a social worker who helps the poor from primary health services navigate referral through the tertiary care facility and access care in a timely and dignified fashion. Though these are essential at secondary and tertiary care centres, they would make a valuable contribution even in UPHCs for access to vulnerable groups.
- d. Engage medical colleges in the running of specialist poly-clinics in the evenings for referral consultations for acute complicated medical illness not requiring in-patient care- but often requiring specialist consultation and investigations. Such services shall also include ophthalmology, ENT and dental consultations and minor procedures. They shall also have specialist services required for the elderly and disabled, at least on some special timing or on Sundays. These could be located in out-patient blocks of medical colleges or district hospitals as well as in the UPHCs with infrastructure- most of which lies un-used in the evenings and on weekends. Payments for overtime for doctors contributing time or hiring additional staff may be needed, along with developing referral systems from primary care. Local youth volunteers could help in weekend clinics for special services to some of the vulnerable groups. This enables efficient use of available infrastructure even as planning for human resources need greater political will. Involvement of local volunteers may also help in building systems for participation.
- e. Developing special services at secondary clinic sites or even at UPHCs for special needs – including half-way rest homes or dharamshalas for recovering homeless, street children, residential de-addiction centres to assist alcoholism and substance abuse patients, mental health care recuperation centres for poor patients, and resource centres offering support services (medical, legal, and social) for survivors of violence, among others.<sup>89</sup>

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<sup>89</sup>BMFG Resource Material 7.1: Case Study: Project Orchid: NGO based opioid substitution therapy for deaddiction in Manipur and Nagaland.

- f. Here it is important that critical areas like mental health are not ignored. There is a need for both training in mental health issue for all UPHC doctors and nurses and enough stocking of mental health medicines in nursing centres and UPHCs.
- g. The term referrals from UPHCs to CHCs and others has usually implied a one way referral to secondary and tertiary health facilities. The meaning of referral should be expanded to include all the following: a) designated Secondary Health Centres (i.e. CHCs); b) designated Public Poly-clinics; c) Free residential and out-patient 20 bedded Drug De-addiction Centres (at least one for clusters of 5 UPHCs); d) Free residential 20 bedded mental health care recovery centre (at least one for clusters of 5 UPHCs); e) Nutrition rehabilitation centre 20 bedded (at least one for clusters of 5 UPHCs); f) Recovery shelters for those without homes or care-givers; g) palliative care centres and hospices; and h) centres offering specialised rehabilitative, legal, and social services to survivors of violence.

**Fig. 1 Comprehensive Referral Alternatives from UPHCs'**



- h. To decongest tertiary care hospitals and incentivise the use of UPHCs, there would be an active facilitation of patients coming with referrals from UPHCs or secondary hospitals. For example referred patients could have a green card, that ensures that a help desk attends to them, helping them navigate the complex hospital terrain for meeting the right doctor and getting diagnostics done on a fast track basis. Those coming directly would go through a primary clinic screening process and possibly face longer queues.
- i. Withdrawal of all user fees and planned reductions in out of pocket expenditures on health, especially for the urban poor, through provision of free drugs and consumables, diagnostics, diet in the public hospitals.
- j. Better gate-keeping and community/public accountability of insurance coverage- through involvement of communities.<sup>90</sup>

4.35. **Mobile Medical Units** are currently operational in many cities; however in most contexts their utility has been questioned. Typically a MMU reaches a fixed point in a slum on one or two days a week or one or two days in a month. It carries supply of medicines and staff roughly equivalent to an urban PHC. MMUs have been rationalised by the argument that they are potentially more efficient than having a regular stationary unit (with designated space and staff). However, in practice this limited transient interaction leads to lack of a regular connection between the patient and provider, with the latter being unfamiliar with the patient and her/his context. This has implications for treatment as well. (Case Studies: Raipur, Dhamtari). MMUs were seen to be considered token measures, easing public dissatisfaction with the government, without really contributing much to the health service needs.

4.36. There are, however, unique examples of MMUs which have performed well. For example, a mobile medical unit for mental health in Delhi, or the distribution of drugs for chronic illnesses through fixed day MMU services in Andhra Pradesh.

4.37. **Recommendation 5:** *In an urban context, the MMU as a service may provide relief for the health burden in several areas, but it may not be able to address fundamental health service issues. While good practices exist for several states, where possible, creating a UPHC is essential to establish patient-provider relationships for expected improvement in outcomes. The basic principle for MMUs is that for any settled population, including those living in slums, MMUs cannot*

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<sup>90</sup>Ellis, Randall P., Moneer Alam, and Indrani Gupta. "Health insurance in India: prognosis and prospectus." *Economic and Political Weekly* (2000): 207-217.

*replace the obligation to provide on-going services like Nursing stations and UPHCs. MMUs are applicable only for mobile or highly dispersed populations with very special health needs, such as scattered homeless populations. (A parallel from Education is that informal classes for vulnerable children should not be seen as substituting the duty of the state to provide high-quality regular schooling to these children). This is elaborated upon in an annexure.*

4.38. **Ambulance and Patient Transport Services:** An increasing number of states have cashless ambulatory services, available as per need. Despite this, there have been 'last mile' access issues, for instance, the inability of ambulatory services to reach households located within dense slums, door-to-door service in several areas, and these issues affect the vulnerable the most. (Case Studies: Tamil Nadu, Assam, Chattisgarh, Shimla, Odisha)

4.39. **Recommendation 6:** *The dial 108 services are an example of a step forward in ambulatory care and emergency transport. There is a need to link this to better planned patient transport systems in all urban areas. In some states, patient transport systems offer services for shifting a mother home along with her new-born after delivery. This service should be extended for transportation of disabled or sick patients between hospitals or from primary care to tertiary care settings and vice versa. It is envisioned that once a patient has entered a secondary care hospital for health care, especially if it comprises emergency services, that it be the responsibility of that facility to shift the patient to a suitable referral site- as needed -where treatment can be continued. This may include both transport to a higher level of care or to a half way shelter or home for supportive care. Similarly some categories of illness when they present in a primary care setting and are found to be needing in-patient care could be shifted to the appropriate site to save time and costs to the patient.*

4.40. **RCH** – Despite the predominant focus on RCH (particularly family planning) services, the urban context is characterised by significant lack of coverage of the same in a number of slums and peri-urban areas. A number of health centres and health posts need to be established to meet this un-met demand. In many cities, this lack of facility density is being addressed by recruiting NGOs for providing a basic RCH package, consisting largely of ante natal care and immunization, along with family planning counselling. Despite this, a large number of slums do not get these services (with the exception of pulse polio that has been well covered in cities).

4.41. Even in places with access to RCH preventive services, the providers are unable to account for all deliveries and pregnant women in the area. Typically a single ANM covers close to 10,000 to 30,000 population, not being able to reach this entire catchment area. Even in places where the entire population remains

reasonably covered, provision of postnatal care and abortion services has been inadequate. Active support for institutional deliveries also remains weak. This aspect seems to be the focus of PIPs, with most PIPs generating funds for hiring of ANMs for basic RCH services.

4.42. Medical College Hospitals, where the poorest access healthcare, account for a major part of all deliveries. But these facilities have remained outside the purview of the JSY and JSSK. Municipal Health Centres and large hospitals have also been excluded from JSSK, even as JSY has reasonably good coverage. Organisation of FRU services has also been an issue. We believe that the small number of facilities in place must not be dismantled. However, developing and building over existing facilities is essential. Maternity homes, often under ULBs, need to be strengthened where existing. Where overcrowded, they may be expanded with infrastructure and staff for improving quality of services already being provided. The utilization of these services also needs to be assessed, and where being overused, space, services, infrastructure and human resources need to be added.<sup>91</sup>

4.43. **Recommendation 7:** *For strengthening urban RCH services, the following measures are recommended:*

- i. *Increasing the number of ANMs so as to provide at least 1 ANM per 10,000 populations. A case has been made for bringing in a metric similar to the recommendations in rural areas – 1 ANM per 5,000 populations. Initially, ANMs may function from hospitals and UPHCs- but over time, there must be a demarcation of ANMs to specified nursing stations from where they deliver health services.*
- ii. *Improving the coverage of services utilizing the ASHAs to reach and mobilise the marginalised and develop the UPHC as the hub of all activity.*
- iii. *Upgrading overcrowded facilities, and expanding the under-utilized ones to include other services along the lines of CHCs.*
- iv. *Ensure JSY and JSSK programmes in all public hospitals irrespective of ownership.*

4.44. **RNTCP:** In most cities, the RNTCP has a well-organized quasi-vertical structure for delivering services.<sup>92</sup> In some states, chest clinics offer specialist services, and are co-located in PHCs (Case Study: Kolkata), and possess the

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<sup>91</sup>Rao, Mohan, et al. "Human resources for health in India." *The Lancet* 377.9765 (2011): 587-598.

<sup>92</sup>BMGF Resource Document 3.1: Perspectives on the integration of the TB programme into the National Urban Health Mission.

additional technical capacity to detect and treat patients. This has been organized in some cases through the involvement of NGOs. In Chennai, nutritional support (breakfasts) have been offered to patients who come for DOTS in the urban health centre. Partnerships with private sector hospitals for TB case management have also been reported.<sup>86</sup>

4.45. The areas where the programme has been lacking remains case detection and subsequent management among the urban poor.<sup>93</sup>A combination of factors may be at play here. Lack of coverage of services across urban populations has led to issues in case detection and for mechanisms of follow up of persons with tuberculosis. Other factors such as physical exertion, poverty and malnutrition and high exposure to dusts, co-infection with HIV, alcoholism and substance abuse – have impacted the disease risks, especially among vulnerable sections, leading to greater severity and drug resistance.<sup>94</sup>Migrant populations either get excluded from services altogether or face interruptions in treatment. Additionally, vulnerable groups face enormous difficulties in accessing secondary and tertiary care facilities for drugs and follow up. Even a ‘well-functioning’ urban PPP for primary care services in Bhubaneswar does not have RNTCP and DOTS provision integrated within it. Missed doses (as distinct from defaulting on treatment), particularly in the intensive phase of treatment are fairly common and contribute to drug resistance. Multi-Drug Resistant (MDR) TB is therefore becoming an increasing public health concern. Systematic efforts to link private providers in partnership arrangements are needed, but do not exist in practice. Even systems for notification of TB cases by the private providers are yet to be established on the ground.

It must be recognised that TB among single person households – like single male migrants, single and abandoned women and old people, and street children and youth etc- cannot be cured in the absence of rest, nutrition and recuperation spaces; this is why recovery shelters for the homeless are an essential part of the urban primary health infrastructure.

4.46. **Recommendation 8: The strengthening of the Revised National Tuberculosis Control Programme (RNTCP)** in urban areas needs focus and the following measures are recommended:

- i. *Continuity of care should be ensured for persons who are not able to report to the same DOTS centre (being relocated residences in the same town/city) during the course of treatment.*

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<sup>93</sup>BMFG Resource Document 3.2: Case Study: Mumbai Mission for TB Control

<sup>94</sup>Agarwal SP & Chauhan LS.2005. TB Control in India. DGHS, MOS 2005



- ii. *Effective mechanisms need to be devised for migrants who are away from their towns/cities of residence for a few weeks/months. It is likely that no single mechanism is adequate. Ensuring a TB patient card, communication links between facilities in different geographical regions, special help-desks for migrants with TB, building awareness and some degree of mandatory obligations on employers of such labour (work-site inspections in hazardous tasks)- are measures that urban RNTCP must consider.*
- iii. *The programme shall need to take special care in mapping the vulnerable and marginalised areas and populations and link them to designated providers.*
- iv. *Where a patient is registered within an urban care delivery system, the process indicators and protocols should record and have an approach for missed doses. The DOTS provider and/or STS should follow up within 24 hours and the action/s taken should be part of the process indicators.*
- v. *For the most vulnerable sections, DOTS must be available in convenient settings, along with supportive services for nutrition (as in Chennai).*
- vi. *MDR testing facility could be offered to private sector in PPP mode, where the public sector manages the drug testing laboratory and offers free diagnostic services for any patient referred to it, even by the private sector.*
- vii. *Treatment provisioning may be undertaken through private/NGO providers; Greater efforts at private sector participation including revision of current rates which are reported as being unaffordable. Notification, already mandated by law, needs to be strengthened.*
- viii. *For TB among single person households – like single male migrants, single and abandoned women and old people, and street children and youth etc- which cannot be cured in the absence of rest, nutrition and recuperation spaces, recovery shelters in the ratio of at least one 20 bedded recovery shelter for a cluster of 5 UPHCs to start with should be seen as an essential part of the urban primary health infrastructure. (Design provided in the annexure)*

**4.47. Recommendation 9:** It is important for health based rehabilitation to take place alongside health facilities rather than separate from it. A sub-set of secondary centers or UPHCs should have a multi-disciplinary team of therapists (physio-occupational therapists, speech therapists, and others visiting at least once a week to train and advise families and or persons with disabilities. The convergence with schemes like the ADIP scheme (scheme for supply of aids and appliances) of the Ministry of Social Justice and Empowerment would be extremely useful for children and persons with disabilities.

- i. There is a need to specify the level of rehabilitation services that can be provided at the primary, secondary and tertiary levels. The principle would be to make services available at the peripheral level where it is most

practical to do so – which in the current context, would mean the secondary center or a sub-set of UPHCs. However all others levels below need to be sensitised to detect early, to refer appropriately and

- ii. The specific support requirements of people with disabilities must be thought of in each program that will converge at the UPHC. – For example there are children may have special difficulties in feeding, or to be still for long periods of time. The requirements of women with disabilities must be woven into RCH and family planning programs in a rights based manner. Maternal health is as important for a mother who has intellectual disability or hearing impairment and the program needs to be designed in a way to include all.
- iii. As more and more children with disabilities enter schools, there is an urgent need to look at the school health program from a disability lens and review what it can include for the children with disabilities.
- iv. For children and persons with multiple healthcare needs, a single window approach will be immensely helpful. The NUHM can think of special clinics with multidisciplinary personnel available on a regular basis and located in a sub-set of secondary care facilities or UPHCs. This would include a social worker who can look at special needs such as Families of children/ persons with disabilities or single parent families
- v. Community Based Rehabilitation Programs-. India has a wealth of understanding and experience of community based rehabilitation and this experience and understanding should be used by the NUHM. Community based workers have been trained to detect disability, provide training in daily activities, provide basic therapy, positioning, stimulation and information to children and persons with disabilities and their families. Wherever community based programs for children and persons with disabilities are available and being implemented, the NUHM will do well to collaborate with them
- vi. **The Inclusion of Persons with Disabilities and their Families in the all Community based groups and Committees.** The official inclusion of women with disabilities and men with disabilities as well as family members of children with disabilities is a must in all groups and committees set up at the community level. Otherwise their concerns are likely to get left out in planning and other community processes. Even then, the capacity building of such groups must include cross disability concerns and understanding.

- 4.48. **Vector Borne Disease Control Programme** - Malaria, Dengue and Chikunguniya today are major health problems, with consequences for morbidity in urban areas. Kala Azar and Urban Leptospirosis occur significantly in some states (Bihar). Municipalities where Urban Malaria Scheme was implemented have a good Vector Borne Disease Control Programme in some cities, but gaps remain.
- 4.49. The vector control programme has been very human resource intensive which remains a critical area. Most of the control functions are performed by hired/contractual workers. Clearly the vector control has been more effective where dedicated vector control workers have been active (Delhi). Reasonable success has been seen in other areas where sanitary workers have been mobilized by the municipal health officers. But in places with inadequate workforce under the city health officer, or because the sanitation force is not under the medical officer, and coordination with them is poor, or because the post itself is defunct and headed by a sanitary inspector who has no access or alertness to the relationship of a specific disease outbreak and the preventive response needed, the NVBDCP has no institutional mechanism to get this task done.
- 4.50. Notification and targeted action can be used effectively to achieve source reduction. This also finds scope in the office of the City Health Officer and health laws as well as for building bye-laws (construction sites and faulty drainage systems are responsible for a significant proportion of breeding in and around houses). The main and emerging problem in most urban areas currently is dengue. For this disease and its vector, bed nets, spraying and fogging are not very effective, and the emphasis has to go back to source reduction. The SMS system in Kolkata has been a good practice in demonstrating how to organize such action. Every detected dengue case sets off alarm bells in 5 concerned departments plus triggers off action by a field team, to do site specific vector control measures. This has brought down the incidence considerably. Tamil Nadu too benefits from such an active triggered-off field response in all its municipalities.<sup>80</sup> Where ASHA or local community based organizations have been involved, the response seems promising. Lessons from urban Malaria should be utilized in this respect.
- 4.51. **Recommendation 9:***The following measures are proposed for strengthening the National Vector-Borne Disease Control Programme (NVBDCP) in urban areas:*
- a. *The UPHC should emerge as a hub of vector control measures, with involvement of the Medical Officer and field staff- and clear zoning standard*

*operating procedures so that all areas are linked and connected to a UPHC and no zones are left out.*

- b. Identification/notification of outbreaks and cases from across all health care providers- private or public must be incorporated as a feedback system loop and Task Forces/ field response teams must have procedures to systematically take action to achieve source reduction(Case studies: Chennai, Kolkata). Protocols must be established across all municipalities-with the city/municipal health officer coordinating and responsible for the entire loop.*
- c. Skill upgradation of existing workers and expansion of health work force according to population requirements is critical for this HR intensive programme. If workers are hired seasonally, the timeline of recruitment, training and deployment needs to be strictly adhered to.*
- d. For Dengue and Chikunguniya, IEC particularly IPC is also critical and is a human resource intensive activity. Engagement of MAS and other community organizations like resident welfare associations (RWAs) needs to be done.*

4.52. **Other disease control programmes-** As emerging public health problems in urban areas, the following services with respect to them need to be ensured:

- a. Assured drug supply through UPHCs and/or Nursing Stations for all ailments, including chronic NCDs must be assured.
- b. Provision of basic diagnostic and monitoring procedures including strip based measurement of blood glucose and blood pressure measurement at UPHC/Nursing station/sub-health centre level and transporting samples to laboratories at CHCs/Hospital levels or private laboratories (PPP arrangements).
- c. Availability of Specialists and advanced diagnostics at referral levels (UCHCs/Poly Clinic/Secondary/Tertiary Hospitals).
- d. Chronic Care/Dialysis/Chemotherapy – There is an ever increasing need of treatment for chronic renal failure, both due to diabetic and non-diabetic causes, as well as requirement of day care facilities for cancer chemotherapy. In the CD hospital in Chennai, two free beds have been earmarked for Dialysis and in Bardhaman, a low cost unit is being set up by the ULB at an upgraded IPP VIII health Post. On the other hand, a relatively large number of beds are available in ULB, State and Central

Government Hospitals in Delhi. These constitute expensive and/or catastrophic expenditures that the NUHM should have a commitment to avert. The Base Hospital in Haldwani (Uttarakhand) runs a dialysis centre in PPP mode in its premises.

4.53. **AYUSH:** AYUSH Dispensaries were being run by ULBs/State Governments in several cities visited such as Raipur, Dhamtari, Patna and Kolkata, while AYUSH Hospitals run in Delhi and Patna. These provide useful services to people with respect to their disciplines. While the study team was unable to assess the workings of the AYUSH programme in detail, the broad impression was that there has been minimal effort at co-location and the teams did not sense any demand for the same. There were also no trends of using AYUSH providers for playing medical officer roles in public health facilities. Though they could be doing so in private facilities. There were no observations made of people being unable to exercise a choice for AYUSH services- but there are issues of adequacy of drugs and providers. The AYUSH providers are however under-utilised in preventive and promotive roles. The integration and utilization of AYUSH workforce for the attainment of larger public health goals needs more thinking.

4.54. **Recommendation 10:** *As the Department of AYUSH rolls out its plans for a National AYUSH Mission and strengthening of AYUSH facilities, efforts for coordination of AYUSH with other health facilities must continue. Unlike in the rural context, the emphasis not on co-location as a means of choice for patients to access AYUSH remedies, or on using AYUSH providers in mainstream medical officer roles. Rather the premise of coordination is to ensure that that AYUSH contributes to preventive and promotive public health activities, for populations that do not relate to western systems of medicine with good referral linkages between the systems.*

4.55. **School Health Programmes:** Many states provide comprehensive school health services (Case studies: Delhi, Raipur, Dhamtari, Ambala). The States/ULBs must be able to decide the preferred model based on three alternatives available in the National School Health Programme Guidelines 2010, depending on the context and suitability of the model. State departments are also thinking about other approaches to school health under the National Health Mission such as the Rashtriya Bal Swasthya Karyakram (RBSK). However these are early days for this programme, and in most cities visited, this has not yet been rolled out in urban schools.

4.56. **Recommendation 11: School Health Programmes:** *School Health programmes in urban areas must follow principles set for rural areas. The rolling out of the Rashtriya Bal Swasthya Karyakram has been challenging given human resource constraints. The main challenge remains carefully studying existing and*

*ongoing school health programmes under the state and central departments of education and health, and building synergies across these, making optimum use of funds available. Primary research indicated fairly evolved school health programmes in Delhi and Hyderabad, and state-wide assessment of programmes would be useful. Service packages in school health programmes should include: (i) preventive health check-ups; (ii) detection and treatments of common eye, hearing and dental problems, including provision of spectacles and hearing aids (Delhi); and (iii) diagnosis and referral of complicated congenital problems particularly those that require corrective surgery including conditions of heart and skeletal systems (Hyderabad).*

**4.57. Systems Strengthening: Improving Access to Free Drugs and**

**Diagnosics:** One of the major contributory factors to poor quality of care in the public health care facility is the lack of availability of drugs and diagnostics. Primary research across states indicated that the current supply of drugs is of limited range, with the quantities being restricted. The local management for drugs, prescribed by private providers and commercial pharmacist and diagnostic labs has led to mushrooming of establishments around every public hospitals. Related to this are issues around inappropriate and irrational prescription and wastage on inessential drugs and diagnostics. The implications of this are particularly acute for the poorest and most marginalized, leading to high costs in treatment and care.

4.58. The introduction of NRHM was able to gradually change the perception on user fees and lead to its withdrawal. With the introduction of JSSK, lack of user fees began to be perceived as a positive value. However as in many states, municipal hospitals are outside the NRHM, their perceptions on user fees are of the earlier decade. But even in public hospitals where user fees are removed the awareness that it is not user fees per se but out of pocket expenditure that the public hospital has to curtail has not yet been established. The practice of prescribing drugs to be bought in private and commercial chemist stores and in prescribing diagnostics to be done in private diagnostic laboratories is widely prevalent and not seen as undesirable. This leads to a huge mushrooming of such private establishments just around every public hospital. Related to this are the problems of inappropriate and often irrational prescription and wastage on inessential drugs and diagnostics- often to the detriment of those drugs that are more needed. it also is the leading contributor to costs at the public hospital.

4.59. User fees have continued to be the practice in municipal and state government hospitals to recover costs. States even have deposited half of the revenue from user fees into the treasury in some of the poorest states, and this practice continues in Uttarakhand. But the user fees so collected are not utilised optimally either. Thus, one city visit noted that one municipal hospital holds

funds of Rs 1 crore, which could have been but was not been spent on provisions, amenities or free drugs. (case study- Bhubaneswar)

**4.60. Recommendation 12: Systems Strengthening: Drugs and Logistics:**

*There should be a clear commitment for free drugs and diagnostics in all public hospitals. This requires the following measures:*

- i. A good procurement system linked to a responsive logistics systems on the lines of TNMSC. In most contexts for economies of scale and capacity, it is best if this is part of the state procurement and logistics systems as is done for example in Tamil Nadu.<sup>80</sup>*
- ii. Essential drugs list with standard treatment guidelines, along with promotion inputs to ensure rational drug prescription and use of generic drugs.*
- iii. Building up systems of access to essential drugs for poor patients with chronic illness, so that they need not spend time on queue merely for this purpose.*
- iv. An enhanced budget for drugs and diagnostics.*

**4.61. Systems Strengthening: Infrastructure:** There has been little investment in the infrastructure of the ULBs or building more urban health centres. Even in bigger cities, where greater funding is available, the limited number of facilities continues to be a major challenge. The NUHM guidelines do not provide funds for the massive expansion that would be desirable.

4.62. There is also the issue of the location of the facilities with respect to where the poor stay. While in facilities developed under IPP and in some cities the initiatives have focused on locating health facilities in slums, in most cities, accommodating health centres within or near slum areas has not been a priority. In many cases, when health centres are located near slums, their physical access has been problematic owing to slum residents being identified as 'the other'. Findings space for health centres within slums has been an issue. Dialogues with the community and stakeholder dialogues conducted during some of the city visits showed that political will and participatory processes can lead to creation of space within slum communities. Stakeholders have recommended creation of temporary structures or substituting using mobile vehicle based services. In cases where fear of social exclusion may be felt, mobile health clinics are an option.

4.63. Another finding from across the states was that though on one hand there is such a scarcity of infrastructure, on the other hand after noon, many facilities are deserted and the entire space is very poorly utilised. Given the huge crowds in the morning, and the inconvenience of morning timings for many, an evening OPD with another complement of staff – should be almost mandatory in all such contexts. This may also be useful for those populations who reported that accessing health services in the morning meant loss of day wage.

**4.64. Recommendation 13: Infrastructure Issues:**

- i. *Locate at least 50 per cent of facilities within slums and poor habitations which are poorly served with pucca housing, piped water supply, and sanitation– as far as possible. Where not possible to locate land and a public building within a slum, look at establishing temporary structures to house the urban health centre in the slum, and where even this is not possible establish the UPHC within 0.5 kilometres from the slum or slum-like settlement.*
- ii. *Of the UPHCs some would need additional infrastructure since they are offering specific additional primary care services- like homeless recovery shelters. UPHCs or health stations located in large construction sites, or wholesale markets for example, may require make-shift infrastructure that could be assembled or frequently, periodically visiting mobile medical units.*
- iii. *In many UPHC contexts, the facility could run on two shifts with two sets of staff- with availability of laboratory services and clinical consultations on two times. This makes existing infrastructure better utilised. Also special groups that require services at a particular time and days- may have such services organised as an “UPHC on demand”*
- iv. *Where the facility is well located- ensure that it is renovated and kept in good quality with adequate aesthetics and appeal, if necessary re-building it- for land is the most important constraint.*
- v. *Use principles of universal design while designing any health facility, be it a dispensary, a PHC or a hospital. This will enable the concerns of all people including persons with disabilities to be taken into consideration. The design should take care of accessibility of physical spaces and services. Simple and visual colour coded signage can be a big help to all people including children and persons with disabilities in accessing services. An added tactile element will enable people who have difficulty in seeing to also find their way around.*
- vi. *Invest in maintenance and for security against stray animals and human vandalism.*



- 4.65. **Systems Strengthening: Quality of Care:** One of the major observations across cities is poor quality of public health care. The perception of poor quality as reported repeatedly in community interactions seems to have four dimensions- a) lack of services in matching health needs and burdens and therefore either referral to a higher facility and exacerbation of the health condition, (Case studies: Jorhat, Ambala) b) overcrowding and cursory examinations with little follow-up, and care, (Case study: Mumbai) c) high costs of care including user fees, indirect costs and demands for bribes, (Case study: Bhubaneswar, Patna) and d) rude behaviour and lack of dignity in the provider-user relationship. (Case Study: Delhi)
- 4.66. Lack of services has been attributed to supply issues around equipment and human resources, requiring more investment and inputs. The term 'general OPD services' seems to be trivialized and greater clarity is needed on the minimum service package that must be ensured in all urban areas. Problems of overcrowding require extension in timings, more human resources, and more clinical encounters shifting to the primary services. Greater investment by the state is also needed to lower the cost of care;<sup>95</sup> bribery however is a more systemic issue that needs a robust mechanism for grievance redressal. Finally, the insensitivity and rude behaviour by the provider, and the lack of dignity in patient provider relationships are important concerns, but may be reflective of general conditions of public health systems such as overcrowding, or from the culture of governance in these institutions (where free health care is not seen as an entitlement of the poor and the poor are not seen as the purpose of the government health system).
- 4.67. The city visits did however indicate a number of good practices, ensuring good quality of care and patient satisfaction. Exit interviews show that where services match needs, there is a fair degree of appreciation regarding what exists. Secondary literature also indicates ways in which quality of care in public facilities may be assessed and improved, which can be built into the frameworks in the NUHM. These include both hard issues like human resources, along with soft issues around provider attitudes and user-friendliness of services. The MOHFW has recently adopted operational guidelines that address similar issues.
- 4.68. **Recommendation 14: Quality of Care:** *There must be a conscious effort to monitor and ensure quality at every public health facility, including regular assessment of infrastructure, general hygiene/sanitation and patient satisfaction surveys. Quality assessments require identification and audits of specific physical, environmental and human resource gaps, sensitisation and training programmes*

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<sup>95</sup>Vaidya, C. (2009). *Urban Issues, Reforms and the Way Forward in India*. New Delhi: Department of Economic Affairs, Ministry of Finance, Government of India.

*for all health providers and support staff, and establishment of grievance redressal systems with community oversight. The involvement of community convergence mechanisms as checks and balances for the needs of the patients and for the service provision by the providers has been discussed in some detail in the following chapter.*

4.69. **Systems Strengthening: Human Resources:** Across the states and cities visited there are serious deficiencies in human resources deployed and providing services in the urban health care bodies. This was surprising since, unlike rural areas where fewer qualified professionals are available due to the reluctance to move or reside in rural areas, large number of suitably trained and qualified health providers are available in urban areas, working in the private sector. A major underlying factor impacting human resources in the public sector may be the reluctance towards creating regular employment positions and pay salaries that are reasonable at least with respect to existing regular employees – if not to reasonable market rates. The public health system has increasingly been relying on contractual workers employed at very low incomes, working in an institutional environment that provides little space for professional growth or a sense of sense of achievement. This reluctance to provide regular positions has been part of the reform processes of the nineties which have persisted maximally as we have seen in services under the municipalities. While resource constraint in general has been a major problem, a greater concern in large cities has been the availability of funds for health ( as compared to say physical infrastructure such as flyovers or metros), specifically investments towards human resource development, which focus on delivering services to the poor and the vulnerable. Other than large metropolises such as Mumbai or Delhi and states where municipal systems are relatively robust (Gujarat, West Bengal), ULBs are in a state of financial crunch and have poor salary structures. Shifting from regular employment to low paid contractual employees, and lately towards outsourcing of human resources to external agencies seem to erode rather than strengthen the public health system. We met nurses and technicians hired by such HR agencies and working in urban institutions. Their salaries had been fixed at about a fourth of what their regular employee counterparts were being paid- and some of those we met had not been paid by the agency for the last two months. Obviously we cannot expect much motivation from these services- and there would be an informal “work to rule “in operation. Human resource policies on recruitment for regular and contractual staff, and daily workforce management policies for contractual staff are seriously deficient. While general administrators in the urban health system have been increasingly involved in technical decisions and executive roles in health systems, their core administrative roles in building appropriate structure of rules and workforce management have been neglected. The problems of HR

with respect to the assorted cadre of community volunteers are dealt with in the corresponding section.

**4.70. Recommendation 15: Human Resources for Urban Health Care Services:**

- i. *There is a need to have minimum standards for HR deployment in each level of the service. In places where this exists to some extent, its implementation and monitoring needs greater attention.*
- ii. *Further, HR norms must be responsive to caseloads, so in areas with more patients, more health providers can be deployed. (A norm of medical staff averaging across a month 10 outpatient per working hour is an example- that is 60 patients a day or 1500 patients a month (25 days). Minimum skill sets as measured and periodically upgraded would also be the norm.*
- iii. *Greater awareness of existing policies at various levels in the health system need attention, in order to strengthen implementation of mandated systems (There must be considerable investment in policy advocacy at various levels to explain the needs for ensuring adequate workforce in health services)- and to point towards gaps between existing systems and out how far behind all comparable international standards and our own recommendations we are in this dimension of health care development. Without an investment in advocacy for putting in place an adequate workforce in public health services, it would be difficult for urban local bodies and even state governments to change policies in this regard.*
- iv. *There is an important role for medical colleges to develop human resources for health care delivery in urban sites though linking it with their urban field practice sites and taking responsibility for some UPHCs and their service areas.*

4.71. **Systems Strengthening: Health Information:** Across the cities visited health information- either on the nature of morbidity or the quantum of services being delivered or on health status and outcomes of populations – was hard to come by and often of limited reliability. Many reasons may be noted for this, including the lack of planned information design and lack of hospital information systems providing aggregate information relevant to public health needs. Lack of connectivity between medical college hospitals, private sector hospitals and in many cases with health care facilities under the municipality with the main HMIS has been another challenge.<sup>96</sup>

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<sup>96</sup>Sahay, Sundeep, and Geoff Walsham."Scaling of health information systems in India: Challenges and approaches." *Information Technology for Development*12.3 (2006): 185-200.

4.72. There has been one area of strength in the notification of diseases of public health importance and subsequent responsive action on them, which has been relatively well developed in some areas (operated by the office of the municipal/city health officer). Chennai and Delhi, for example, have a list of 22 diseases which are tracked with relative effectiveness, wherein all government facilities and 620 private health care facilities reliably report in. The diseases reported on include: Cholera, Typhoid, Hepatitis, Encephalitis, Dengue, TB, HIV, Diphtheria, Tetanus, Whooping Cough, Measles, Polio, Plague, Rabies, Scarlet Fever, Influenza, among others. This list effectively covers all infectious disease of public health importance. Delhi has initiated online reporting of birth and death registration as well as disease reporting from public and private providers. There is currently no system to track outbreaks among vulnerable groups and the notification systems for stigmatised populations or of diseases which may have stigma is less clear. Leprosy, STDs and HIV include these.

4.73. Another potential strength is that in most situations the municipal health officer is the chief registrar of births and deaths and there is readily available with him age specific mortality rates categorised into 10 to 20 main causes- a surprising wealth of information that may be adequately leveraged or built on. Even as improving coverage of the registration systems provides challenges, analysis and use of information from available birth and death information (along with cause-specific mortality) may provide us with knowledge required to build health systems responsive to the health care priorities of the people.

**4.74. Recommendation 16: Systems strengthening: Public Health Information:**

- i. *There is a need to design a health information platform where private providers could report aggregate information – either on paper or digital formats.*
- ii. *There is a need to encourage public hospitals to have hospital information systems that are able to collect and aggregate data. Knowing the problems of high overcrowding and lack of staff, it is unlikely that these could shift to the usual EMR based systems. What is needed is really a system that collects only a minimal diagnosis and aggregates salient features as required for facility management and public health needs- expanding to support provider and patient needs when they are ready for the same.*

- iii. *There is a need to strengthen the office of the municipal health officer and his access to information on notifiable diseases from both public and private facilities and to integrate this information with hospital based morbidity information and registrar of deaths based mortality information to build more effective public health decision support systems.*
- iv. *The epidemiological services including early warning systems, outbreak investigation and management and public health laboratory services (for testing of water and food samples) need strengthening.*
- v. *The best features of the Kolkata SMS based response system and the Chennai notification and response systems should be integrated and replicated across all cities and towns.*

4.75. **Systems Strengthening: Engaging with the Private Sector:** The private sector is the major care provider. No discussion of institutional arrangements is complete without a discussion on the forms of engaging with this sector so as to maximise its contribution to public health goals and to financial protection from the costs of care. Different forms of public-private engagement are emerging area in several urban areas. These have been discussed in some detail on the chapter on governance and management.

## Chapter 5

### Community Processes: Learning's and Options.

- 5.1 The most common observation across all states and cities is that there is really no major programme focussed on strengthening urban community processes in place. This is similar to the situation in rural areas prior to the start of the NRHM. Hospitals and facilities under urban local bodies did not have hospital development societies or untied funds, unlike their rural counterparts. Not only were health committees not in place (with some few important exceptions) even the presence of community based organizations and self help groups is much less. There were however some form of community health volunteer or worker in place.
- 5.2 There is a further challenge in urban areas, that in settlements of the urban poor, there are fewer organic communities than you find in villages. Even in the countryside, Ambedkar reminded us of the fiction of the idea of the village community, which he said masks the reality of a 'cesspool' of caste and gender inequalities. But the village is at least a settled and stable social entity. In cities, by contrast, people are far more socially isolated and uprooted, and live in settlements in which they lack organic, stable bonds with their co-residents. This has many consequences for health: much greater psycho-social stresses and the lack of care-givers for many poor migrants. At the same time, this also has great challenges for organising community processes, because there are no organic communities of the urban poor.
- 5.3 Data from the city reports show in several cities, there is evidence of some form of community health worker, already present in the community, although not ubiquitous, nor necessarily positioned where the needs are the greatest (where there are poor in large concentrations, or among vulnerable populations). They exist either as a legacy of past programmes (the India Population Projects), or a link worker in the RCH 2 interventions (as part of urban RCH interventions in selected cities), or as the ASHA of the NRHM becoming an urban ASHA as the areas were notified as being urban. The examples include- the Honorary Health Worker-Kolkata, Community Health Volunteer-Visakapatnam (respective Municipal corporations) Mitanins in Raipur and Dhamatari, of Chhattisgarh and ASHAs in Gangtok, Guwahati, Bhubaneswar and Trissur in Kerala.
- 5.4 **The role of existing urban CHWs:** Regardless of the nature of the intervention or the affiliation of the ASHA (either the Urban Local Body (ULB) or the health system or NGOs), and the context of its origin, the spectrum of services currently offered by these workers is narrow. It is largely limited in scope: facilitation for

services provided by the facility, and in breadth- immunization, antenatal care and family planning. Given the veritable maze that the facility network currently is, the major felt needs of the community are rarely met – by design. The ASHA/CHW are not equipped to play the role of either providing the type of information or services they need the most, nor even in facilitating their “navigation,” through the maze of health care facilities nor are their provisions in the system to make a facility “ASHA friendly”. This is likely on account of the fact that the role of the ASHA was not clarified to include a mix of roles (as has been done in the NRHM) and the level of training input, support (mentoring and drug kit) is low.

- 5.5 One observation from many towns where urban ASHAs began by incorporation of surrounding rural areas by “notification” the ASHA skill sets and effectiveness is weaker than the rural counterpart, because they lost the attention and support of the larger NRHM programme. Even in Chhattisgarh, where the Mitanins are being seen as playing a key role in community level care, particularly noted for reaching the marginalized; her urban counterpart, although evolving from the same programme does not demonstrate a similar degree of social reach.
- 5.4. **Recommendation 1:** The roles of the ASHA are dependent to a large extent on the nature of organization of services. Given the need to ensure that 80 per cent of primary care should be provided at the community and outreach or primary care facility, the role of the ASHA as a community level care provider must be defined in such a way that she contributes to the package of care provided at the community level. This needs to be merged seamlessly with her roles as a mobiliser and as a facilitator. There is also a clear need to even at the outset have a greater role in NCDs and particularly in regular drugs supply in many states.
- 5.5 **Reaching the Vulnerable:** The reach of the ASHA to marginalized communities is critical, particularly in view of the fact that the NUHM lays such substantial emphasis on particularly reaching the invisibles- the destitute, the homeless, the marginalized, those with different sexual orientations, etc. Evidence from the city reports point to the fact that the reach of the ASHA is limited, since she has not been equipped either by mandate or through her training to focus on the health needs of these marginalized groups. Also in some contexts like the Kolkata HHW, a quota of poor households not necessarily all conforming to a geographic areas are assigned to each HHW- and over time the poorest households may not have any assigned HHW.
- 5.6. Poor population coverage results in non-identification of the marginalized, poor detection of mothers and children in need and also case detection in the communicable diseases programmes; and a very limited role beyond RCH. The pulse polio programme through its Social Mobilization Network has shown that the marginalised can be reached better. Balancing population coverage for the

ASHA and ensuring reach to vulnerable populations is important and the ASHA represents the first point in the chain to enable effective coverage. In rural areas the population norm was intended to be about one per 1000 to be relaxed in cases of hamlets or dispersed habitations; in urban areas, given geographically compact areas, one ASHA could cover a population of 2500 (or covering 200 – 500 households). However the underlying principle in allocating households or a geographic area to the ASHA must ensure that the vulnerable are reached.

- 5.7. **Recommendation 2:** To ensure that marginalized are not left out the ward health committee must divide each ward into clear zones and supervises assignment of areas (by street) and households to specific UPHCs, health stations/posts or ANMs and ASHAs and people’s health committees (JAS – please see below). We should also consider that the fact that the homeless have no designated “residence”, and often live in areas such as - footpaths, by the side of railway tracks, and under flyovers. Though the database of pulse polio programme helps to identify these groups, additional planned, periodic re-mapping of the area, through sensitised facilitators working with the ward committee, providers and ASHAs must be emphasized.
- 5.8. **Selection of the ASHA:** The important lesson from the rural ASHA programme is that wherever the selection is participatory, and where attention is given to process of selection and endorsement by the panchayat and the health systems, there are fewer drop-outs and better functionality. Community based selection of the ASHA is therefore an important tenet of the NHM. But whereas a relatively greater homogeneity in rural areas facilitates this, the selection of urban ASHA on the other hand poses several challenges due to both the higher heterogeneity and the lack of accepted community leaderships and organisations that cut across the different groups; and indeed the absence most often of real urban communities. Since the emphasis is on the vulnerable and poor, both being marginalized, a sound process of selection is required to ensure both that ASHA understands the needs of the group she represents and has acceptance amongst them. We also need to balance a preference for at least class 10 or even class 12 ASHA (since we are now considering the ASHA as a long term institution providing a certain set of community specific services) against the concern that setting such high entry qualifications would not allow representation from amongst the marginalised.
- 5.9. **Recommendation 3:** Selection in the urban context will require active facilitation by sensitised facilitators. Where available, the involvement of experienced NGOs and academic institutions in supporting early mapping, identifying and mobilising potential candidates should be considered. Facilitation should include the process of identifying representatives of various vulnerable groups in a particular area, consulting them as a collective and selecting candidates from within the group or in that particular geographic



precinct to represent them. Either way, the candidate selected must be acceptable to the group, and be accountable to them. This accountability can be further reinforced if the collective then functions as the Mahila/Jan Arogya Samiti (JAS). This is further discussed below.

- 5.10. **Compensation to the ASHA:** - Remuneration packages for the community based workers vary with urban local bodies usually paying more than the NRHM/state department. Compensation packages of link workers and other community health workers engaged through the ULB ranges from Rs. 3000 to Rs. 8000. However in the NRHM/NUHM architecture, payments are an incentive system that is based on performance for a set of activities- which in many urban contexts leads to very low levels of monetary compensation. A fixed basic salary for ASHAs in urban areas are worth considering, given her larger role including but beyond RCH, as discussed below.
- 5.11. **Recommendation 4:** The main approach to payment may be retained on the lines of the recently approved guidelines on payment in the Mission Steering Group of NHM. In this approach one set of incentive payments is for a set of tasks with regular predictable periodicity- monthly meeting of MAS, UHND mobilization, attending monthly review meetings, household listing, maintaining lists of eligible couples and children to be immunized with updation on a bi-annual basis. Another set of incentives is for services provided under various programmes and will vary with caseloads and her effectiveness: such as JSY, child immunization, follow up for SAM children, visits to newborns and post partum mothers, promotion of family planning, and her contribution to the vector borne disease control programmes. The principle underlying the incentive structure is that it needs to be linked to an outcome which is defined so as to be compatible with the ASHAs roles, training and her skills. Prompt payment mechanisms should be instituted and access to electronic modes of payment should be facilitated. All of this is with the understanding that the work load is such that it can be done in about 12 to 18 hours in a week. As the package of her work increases and approaches 25 to 30 hours, a regular payment in line with minimum wages at the least becomes necessary. The payment should be graded along with the work they do, since there is a movement along the spectrum from a purely voluntary worker to a regular community health nurse/care provider. Irrespective of all the above if the work requires her to be away from her home/livelihood for the whole day- as for example when she is attending training, or a full day volunteer in a pulse polio or screening for NCDs survey, then the compensation should be for a full days wage loss.
- 5.12. **Support Structure:** An important finding from city reports is that there is no support structure in place in urban areas, with the sole exception of the first tier supervisor in Kolkata. The NRHM on the other hand has always supported a

strong support mechanism by way of training and on the job mentoring was critical. Experience from rural areas also shows that relying on existing workers in the system may not necessarily yield these results, given existing and potential workloads. The principle of support in conjunction with a strong training system, with opportunity for frequent refreshers, and on the job mentoring is perhaps the main reason why the rural ASHA programme has sustained in rural areas, and this is an important learning for the urban ASHA as well.

- 5.13. **Recommendation 5:** Where competent and committed NGOs exist, the role of training and supervision can be undertaken by them but coordinated by city/district support teams as established for NRHM. In areas where NGOs do not exist or there is reluctance or problems in engaging them, support structures consisting of ASHA facilitators coordinated by a suitable mid-level coordinator will need to be engaged.
- 5.14. **Role of ASHA in financial protection:** The use of ASHA to ensure enrolment of the poor into publicly financed health insurance schemes is welcome and could be encouraged. However, paying commissions to them to mobilise case loads for empanelled private sector hospitals under different insurance programmes has had deleterious consequences for patients and must be disallowed. While the possibility of ASHA becoming a commission agent was a risk in the rural areas, it was softened to a large extent by two factors: one that the private sector was largely non-existent in many parts, and secondly, the proportion of ASHAs who undertook this was small. But in some urban areas, “by design” the CHW is expected to recruit patients and refer to empanelled hospitals and is paid a commission for referral and follow up. Arogya Mitra in Visakapatnam is such an example. The risk of providing ASHA with an incentive designed to encourage and benefit from referrals to private sector for costlier therapeutic procedures, completely runs counter to the expectation and promise of her as a promoter of good health and preventive care. On the other hand, we could explore the role as ASHA as a gatekeeper protecting the interests of the poor from unnecessary charges or providing information on billing etc.
- 5.15. A more direct way in which the ASHA ensures financial protection is by addressing issues in access to free or subsidised care and protection from inappropriate care. As seen from the city reports, the poorest are incurring considerable expenditure on care for a range of simple acute morbidities (diarrhoea, pneumonia, malaria and other fevers) in the private sector (qualified and non-qualified practitioners) due to access barriers to public health system. When it comes to chronic illness they have to spend time, lose wages and face expenses in seeking care at crowded public tertiary care centres even when only a prescription refill is needed.

- 5.16. **Recommendation 6:** Training and skilling the ASHA to provide a range of basic curative services of low complexity and a standardised periodic nature, like the measurement of BP and blood sugar and the provision of drugs (prescription refills) for chronic diseases so that patients do not have to travel far from their residence, will mitigate out of pocket expenditures to a degree. For this role the ASHA should closely coordinate with the nursing stations discussed earlier.
- 5.17. **Recommendation 7:** The ASHA also has an important role in educating persons on the use of publicly financed insurance for the poor, so that they are able to get cashless services, are not excessively charged and so that they are not sucked into inappropriate care in the private sector. ASHA help desks could be set up in health care facilities and ASHAs empowered to ask for billing and payment details so that they could perform this function. ASHA help desks in secondary and tertiary care centres are also essential to ensure that she helps the referred patient navigate the hospital and to have adequate information and documentation so that follow up at the local level can be ensured. ASHA help desks are also especially needed to arrange for attenders for some category of vulnerable.
- 5.18. **The Mahila Arogya Samitis:** The city reports testify that where community health workers exist under ULBs, the design as conceived by programme planners, visualizes her only as an instrument to enable target populations to access their programmes, which were largely focused on RCH or TB/Malaria. For bottom up planning to occur -which is the larger vision of the programme- a single community worker alone is insufficient. She needs a group of people- a community collective- who can support the process of local planning, given their knowledge of and familiarity with their community and their environments, and their interest in positive outcomes. The limited case studies on such mechanisms as seen in the city reports demonstrate that community collectives comprised only of women (Kudumbashree in Thrissur and Kochi, Indira Kranti Padham in Vizainagaram and Visakapatnam, Sampoorana Mahila Samiti, Indore, Mahila Arogya Samiti in Bhubaneswar) are effective in articulating the needs of the communities they represent, although this is variable across contexts. The effectiveness of the local collective is quite dependent on the nature of support received by such groups, whether they have other forms of activity such as participating in micro credit programmes, livelihood efforts, and other developmental activities. The proposed Mahila Arogya Samiti under NUHM is also composed of about 15-20 persons, drawn from a neighbourhood cluster, and representatives of the community. The Kudumbashree model seen in the Kerala cities visited have useful learning's on how to make this committee more representatives by drawing one committee member from each cluster of 10 to 20 houses.

- 5.19. The NRHM also shows us that effective Village Health Sanitation and Nutrition Committees (VHSNC) can undertake village planning, support frontline workers, enable action on social determinants and undertake monitoring of public services as a way of holding the system accountable. A similar structure is desirable in the urban context, particularly as the communities of urban poor and the marginalized; need effective representation and active participation in such collectives.
- 5.20. There is however one dilemma that the urban health committees have to resolve. A repeated theme and finding of the focus group discussions- that there are many vulnerable groups and many health concerns which are predominantly male issues which women would not be able to address or perhaps even discuss. This makes the case for the introduction of a male ASHA equivalent, or at least some men in what are now a Mahila Arogya Samiti. On the other hand there is a concern, that men could dominate the committee and change the dynamics and the urban male community leader has a different status than the rural counterpart. To guard against this NUHM may prescribe that inclusion of men cannot exceed 25 per cent of any arogyasamiti. The NUHM should start by permitting a few cities to exercise this option, and then based on experience scale up as a nation-wide recommendation. Similar in specific contexts male CHWs- the equivalent of ASHAs would be permitted, but never exceeding 25 per cent of ASHAs in any ward and usually less. Once again we begin carefully, piloting the concept in a few states with clear role allocation and indicators. Again 25 % of nursing stations/health sub-centers should have a male and a female worker instead of two multi-purpose female workers.
- 5.21. **Recommendation 8:** The basic structure of a health committee would be to identify one member per ten families so that a collective of about ten to fifteen members for 100 families is formed. The number is kept small so as to ensure representation of marginalized groups. Every ASHA would be linked to between two to five such groups. For adequate representation particularly of marginalized men's groups – such as rickshaw pullers, head loaders, men also need to be part of such collectives. Existing CBOs in urban areas are often constituted around micro credit and these tend to be mostly women's groups. In the starting phase of the programme, the involvement of such collectives of women alone, even though they do not include men, could serve as a first starting point and yield lessons for planning in the urban context. As the programme matures, men could be included in the MAS evolving into "Jan Arogya Samitis", though at all times at least three-quarters in any ward would be women. One possibility is to bring in male peer-educators into their areas MAS. Care is also needed to ensure within the women's representatives, adequate numbers of single women, aged and disabled women, and women from disadvantaged castes and communities like Muslims and DNTs. In areas where

CBOs need to be created anew, they should include representatives from marginalized men's groups. ASHA will be the member convenor of the MAS and it would be supported by the FHWs and MHWs.

- 5.22. At the level of the UPHC, there is a need to have another structure that coordinates and federates the MAS and link it up with occupational groups and their collectives including those composed only of men. This could in the form of a Jan Arogya Samiti. The members would be all the heads or representatives of the MAS of that area, the representatives of collectives of vulnerable groups defined by occupation and the elected member of the ward. Its function is to plan for health services in that area, in particular identifying groups who are getting missed out.
- 5.23. **Recommendation 9:** The TRG would propose two levels of community institutions- the MAS ( Mahila Arogya Samiti ) at the neighbourhood level and the JAS ( Jan Arogya Samiti ) at the UPHC level ( or ward level where there is no UPHC ) with the ward member as the chairperson. There would be about 100 MAS (each covering a population of 500) that is federated into a JAS (Jan Arogya Samiti ). This would build ownership of the ULB, and also ensure that there could be coordinated action between different sectors and ASHAs, MAS and nursing station/health sub-centres/ANM and Male Multi-Purpose Workers working in that locality. There could be paid social workers assigned to assist these Jan Arogya Samitis.
- 5.24. **Recommendation 10:** Learning from the roll out of the programme in rural areas the NUHM should specifically ensure that some major weaknesses, gaps and errors are not repeated: These would include:
- i. Ensuring that we start with the formation of Jan Arogya Samitis and the selection of ASHAs in parallel- and ASHA is positioned as its convenor. This reinforces her capacity to mobilise and networks her with peer representatives from the various vulnerable groups in her area. It also contributes to making ASHA selection itself more participatory. (In many states in NRHM, the village committees were constituted long after the ASHAs were deployed undermining her mobilization capacity and community ownership).
  - ii. Ensure quality of training through accrediting training institutions and trainers and introducing training evaluation from the very beginning.
  - iii. Ensure that we invest early on in well trained support structures to provide supportive supervision.

- 5.25. **Recommendation 11: Legacy Management:** A non-trivial issue for many municipalities is how to manage existing cadre of link workers and community health volunteers. Where they are women and not paid a regular wage, then one could easily adopt them as ASHAs- but after going through a community consultation process. Where they are paid a regular wage- too they could be kept as ASHAs but with some additional responsibilities and training for the same- thus using to pilot new dimensions like mental health, geriatric care or cancer screening at the community level. Some of them who are qualified and capable could be trained and on a substantial regular wage, could be trained into becoming the facilitator.
- 5.26. **Grievance Redressal:** One finding from across the urban areas, is that there are no public grievance redressal mechanisms in place. This is true even in the best case scenarios. Part of the problem seems to be a lack of willingness to invite complaints knowing the poor ability to respond where there is such lack of finances and human resources. But an equally important issue is the administrative space to do it. Good grievance redressal mechanisms themselves need human and financial resources.
- 5.27. **Recommendation 12:** Provide for grievance redressal in the budget, and consider giving this function and budget to the ULB, especially if all facilities are under the state government and vice versa. The Grievance redressal mechanisms should comply with a minimum set of standards and certified as adequate. The minimum processes that should be in place is a well-publicised call number functional at least for 8 hours, well publicised contact email and postal addresses, every grievance being recorded and action taken within a specified time standards. These standards imply a definite HR and budget allocation for this function.

## Chapter 6:

### Meeting the Challenge of Convergence in the Urban Context: Essential Non-Medical Public Health Functions of Urban Health Systems

6.1. One of the major issues that the TRG addresses is “effective institutional mechanisms for convergence of urban primary health care services with other government run schemes responsible for health determinants”. This is a critical measure considering the massive burden that the poor state of these determinants imposes on the health of our population. Lack of livelihood, low incomes and poverty, and chronic low caloric intake have long been acknowledged causes of the high rates of malnutrition and stunting in Indian children.<sup>97,98</sup> Recently there have been studies that link open defecation to these indicators too<sup>99</sup>One of the major contributors to the over 4 lakh annual diarrhoeal deaths of children below 5 in the country is the extreme lack of sanitation facilities. The World Malaria Report<sup>100</sup> (2012) estimates that over 2.4 crore episodes of the disease occur annually in India, again the chief reason in urban areas being poor sanitation. The toll that such environmental conditions take on the economy of the nation can also not be ignored. The Water and Sanitation Programme of the World Bank<sup>101</sup> (2011) estimates that India loses 6.4 per cent of its GDP annually due to such poor sanitary conditions, or over Rs. 3,54,000 crores in 2012-13. At the same time increasing air pollution in cities has led to a significant rise in respiratory morbidities. The indoor use of bio-fuels for cooking has also been closely linked to high rates of respiratory, cardiovascular and other morbidities in both women and their children<sup>102,103,104</sup> while improved stoves and

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<sup>97</sup> Panikar P G K, 1980. ‘Inter- Regional Intake of Calorie Intake’. Economic and Political Weekly, Vol 15, No 41-43.

<sup>98</sup> Ramachandran P and Gopalan H S. 2011. ‘Assessment of nutritional status of Indian preschool children using WHO 2006 Growth standards’. Indian Journal of Medical Research, Vol 134.

<sup>99</sup> Chambers R and Von Medeazza G, 2013. ‘Sanitation and Stunting in India: Undernutrition’s Blind Spot. Economic and Political Weekly, Vol 48, No 25.

<sup>100</sup> World Malaria Report 2012. Available at [www.who.int/malaria/publications/world\\_malaria\\_report\\_2012/en/](http://www.who.int/malaria/publications/world_malaria_report_2012/en/).

<sup>101</sup> WSP 2011. Report on ‘Economic Impacts of Sanitation in India’. The World Bank.

<sup>102</sup> Baumgartner J. et al 2011. ‘Indoor Air Pollution and Blood Pressure in Adult Women in Rural China’. Environmental Health Perspectives Vol 119, No 10

<sup>103</sup> Edwards J H Y and Langpap C. 2012. ‘Fuel Choice, Indoor Air Pollution and Children’s health’. Environment and Development Economics, Vol 17, Issue 4

<sup>104</sup> Sukhsohale N D, Narlawar U W and Phatak M S, 2013. ‘Indoor Air Pollution from Biomass Consumption and its Adverse Health Effects in Central India: An Exposure- Response Study’. Indian Journal of Community Medicine, Vol 38, Issue 3.

behavioural changes have been shown to reduce the same<sup>105</sup>. In this chapter, we shall look at the findings regarding a large number of public health functions and services of a non medical nature that address many of these issues. Though these are not health care services, they are nevertheless essential for the health of the urban population. This chapter shall also consider what is needed for these functions to be carried out more effectively and efficiently, and how this is linked to better health outcomes.

- 6.2. Some of these public services and functions are carried out by corresponding line departments of the state government. Some are under the urban local body but in divisions and distinct from the division managing health services. Some services are under the same Municipal Health Officer or Deputy Commissioner who is also looking after health services. Needless to say, across cities and towns, across states and within states, the arrangements for governance of each of these services and the mechanisms and effectiveness of coordination between them vary widely.
- 6.3. However, what is fundamentally different between rural and urban areas is that most of these functions are not and never were with a health officer in rural areas. Whereas in the urban areas, the original institutional design seems to have been the complete integration of these functions under a municipal health officer who is a public health officer with public health qualifications. States with a public health cadre had the municipal health officer as the entry posting and a stint of this task was seen as essential for further progress in the public health cadre. The All India Institute of Public Health and Hygiene was for long the sole institute training for this post, and such training was mandatory. However, over time, more and more of these functions shifted out from under the municipal health officer – but the rate and pattern of shifting out of services and decline of the importance of this post has varied across cities and states.
- 6.4. Observing and learning from what city health officers are engaged in across the cities, we could state that in a well-developed urban health programme, the set of non-medical public health functions that a city health officer ensures would include in the least the following:
  - i. Epidemic control
  - ii. Disease surveillance

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<sup>105</sup> Yu F. 2011. 'Indoor Air Pollution and Children's Health: Net Benefits from Stove and Behaviourial Interventions in Rural China'. *Environmental and Resource Economics*, Vol 50



- iii. Treatment and disposal of sewage
- iv. Solid waste management including carcass disposal
- v. Drinking Water supply
- vi. Sanitation and Prevention of public health nuisance
- vii. Dangerous and offensive trade, licensing ( in particular slaughter house management , health safety in cinemas, restaurants etc)
- viii. Food safety
- ix. Birth and death registration
- x. Control of stray dogs- rabies control.
- xi. Implementation of welfare schemes for vulnerable populations – especially the homeless.
- xii. Air Pollution Control

In no city is a city health officer doing all of this but most are accountable for a number of these tasks. Even when he is not in charge of the implementation, he still has to monitor and support them, as it has implications for the health of the population- and many officers whom we met are aware of this and engaged with these areas. In short, the challenge in rural areas for the NRHM was how to build convergence across these services. The challenge in NUHM is how not to lose the convergence that may already exist. As health care services are being taken over by the state department in many states, inadvertently as part of turf issues, the municipal health officer post- often filled by a medical/public health officer on deputation from the state department gets withdrawn- officially or de facto. The loss of the leadership of city health officer who takes care of the public health activities like containing outbreaks of diseases gets undermined instead of being built upon, as we saw in Satara, Villupuram and Trissur.

- 6.5. In Kolkata and Chennai, we described earlier how the health officers systematically built a system of notification and alert on incidence of a communicable disease and respond to it by both appropriate administrative action and a field level response that directly reaches the source of the infection to limit the spread of the disease. So if it is dengue case, then a squad of vector control workmen looks for source of vector breeding in the

area. If it is a hepatitis outbreak, the squad – usually of sanitary workers- addresses the source of water contamination. The health officer is himself accountable primarily for the public health failure, and only secondarily for the clinical response. It is this dimension that is in danger of getting undermined.

- 6.6. The observation is that this closed feedback loop response is a feature of very few sites- more an exception, than the rule. Most cities fail to construct such a chain of action- because of a serious lack of capacity- technical, institutional and human resource linked. And this sort of preventive public health action is limited to very few dimensions. It is not for example linking chronic respiratory illness with air pollution or typhoid incidence with hotel hygiene and so on. We therefore comment on each dimension of such non-medical public health in the paragraphs below, using this idiom of the linkage between clinical and non-clinical public health action.
- 6.7. **Recommendation 1:** There is a need for the establishment of an Epidemiology Unit/ Office of Epidemiologist, with a team in the ULB. The office should have an equipped Public health Laboratory, with facilities for water and food testing, and prevention of food adulteration. The Unit should be responsible for daily monitoring and identification of disease outbreaks, and their management.. This unit should actively correlate incidence and prevalence of non communicable disease and injuries also with health determinants and recommend appropriate action by the urban local body.
- 6.8. Apart from the above described services, urban health also requires the coordinated and effective service delivery for food security, ICDS school education, and housing- all four of which are areas which have been always outside the purview of city health officers – but which have a direct bearing on health.
- 6.9. **Solid waste management:** Since cities are the centres of development and consumption, it is also centre of large scale waste generation. In all cities visited, almost without exception, solid waste emerged as one of the main problems faced by its populations especially in slum areas, and ULBs (Case studies – Patna, Villupuram, Kochi, Guwahati, and Mumbai). Also, as there is a change in the characteristics and composition of solid wastes ever since the advent of plastics that are not amenable to natural degradation process, solid waste piles up faster in the current scenario. Accumulation of solid wastes in the city limits can degrade the urban environment and adversely affect the health of the urban population. Therefore, it is an obligatory function of the Urban Local Bodies to remove solid waste from the city and dispose it safely. Source reduction, segregation and treatment of the solid waste like

composting and recycling are proposed by the Solid Waste (Management and Handling) rules, 2000. However, the growth of the urban waste is exponential leaving the urban local bodies facing the public criticism.

- 6.10. In large cities like Chennai, solid waste management is a separate department under the engineering section. In many cities visited, though collection and transportation of the waste is under the health officer's jurisdiction, treatment falls under the engineering section. Land availability for the final disposal is a major problem in urban centres. Large cities have mechanised waste treatment technologies like composting, recycling units and incineration units. For example Mumbai has outsourced almost 70 percent of the solid waste activity and it has a recycling unit which treats the bio-degradable and recyclable solid wastes.
- 6.11. In most cities and towns of India, however, the municipal health officer who is in charge of removal of solid waste in the cities therefore employs various strategies to collect the wastes systematically and transport, treat and dispose it. The ULBs employ sanitary inspectors/health inspectors for the supervision of the activities as found in the urban centres like Madurai, Kochi, Thrissur, Shimla, Pune, etc. Some of the cities have tried new ways of tackling urban solid waste, like engaging the community in door to door segregated waste collection. For example Kochi and other cities in Kerala and Vizianagaram engage *kudumbashree* women and manual scavengers respectively in door to door waste collection. Satara has outsourced solid waste door to door collection including in slums, and its transport to the dump-site, to small scale private contractors, most of whom were earlier working as sanitation workers. Shimla had the best practice of solid waste management with segregated collection and treatment. This activity has been carried out in collaboration with the Shimla Environment Heritage Conservation and Beautification (SHEB) Society. This programme has received national awards as being the best practice in this domain. The Pimpri-Chinchwad municipal corporation has also established facilities (under PPP contracts) for treatment of solid waste via traditional composting, vermi - composting and by fuel regeneration from plastics.
- 6.12. One sub-issue brought up is the major effort that goes into disposal of animal carcasses. Often this is done without adequate protection. Moreover, when properly organised, animal carcasses converted into leather and fertiliser is a source of earnings. This aspect is true for many aspects of solid waste management- properly segregated and managed; there are avenues for generation of revenue which municipalities can use, at least towards this function. But most officers on the job are not aware which technologies are available, and which appropriate. Though everyone has heard that PPP is a

solution, there is a need for greater understanding of the technical content of such contracts. For instance, the capacity of the private contractor in Guwahati to deliver on the terms of reference appears to have been overlooked before awarding the contract, while the PCMC and Satara solid waste management contracts with the private players appear to be functioning well. In Raipur a PPP with private company was established for waste management. However, due to the irrational practice of waste collection and open dumping the PPP was withdrawn.

- 6.13. Often, the brunt of the solid waste is borne by the poor whose vicinities in the slums are never cleared by the sanitary workers (Case studies: Ambala, Delhi, Kochi etc) or the collected wastes are transported and dumped in the areas where poor and marginalised live (Case study: Thrissur). The impacts of solid waste on the socio-economic and health of the people are large that it cannot be overlooked.
- 6.14. We observed across cities and towns various health issues of sanitation workers themselves. One senior officer noted that though these were regular employees entitled to a pension, few lived long enough to retire and collect it. In all towns, there were reports of much higher death rates in this category. In Shimla, and Aligarh sanitary worker death rates were as high as 3-5 per month! The Planning Commission document on occupational health and safety reiterates this finding. It states that “Epidemiological studies show that the workforce engaged in waste management services are exposed to high health risks and frequently suffer from respiratory tract infections, gastro-intestinal problems, worms, etc. Indian domestic waste contains human excreta, bio-medical waste and sometimes other toxic and hazardous wastes. Improper management of waste can therefore pose big problems for the entire populace.”<sup>106</sup>
- 6.15. As mentioned in Chapter 3, the main perceived health burdens in sanitation workers were a range of infectious disease, alcoholism and substance abuse, and even hypertension. Shimla had instituted the practice of ensuring periodic medical check-ups and providing them access to drugs for chronic illness and to de-addiction centres, with some special efforts to address alcoholism. No other urban area mentioned this, though most municipal health officers responded very favourably to putting one in place, as they too had independently made this observation and were concerned about it.
- 6.16. **Recommendation 1:** To address the issue of waste management in urban centres is to address the environmental and social aspect of a section of the

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<sup>106</sup>Planning Commission,(2011). Report of the Working Group on Occupational Safety and Health for the twelfth Five Year Plan, Ministry of Labour and Employment.

urban poor population. Given these linkages the best direction towards proper management of solid wastes in the urban centres would start from the infrastructural and technical support to urban local bodies. Monitoring of the co-ordinated action between the health and engineering departments and providing necessary technical support regarding the waste management is worth considering at the local level. The health department and NUHM's remit is unlikely to extend to doing this by themselves, and we do not even recommend it. However the NUHM may actively provide technical assistance and advocacy to ensuring this is done.

- 6.17. **Recommendation 2:** The health of sanitation workers and rag-pickers should be seen as part of an occupational health, safety and hazard prevention programme, and municipalities must necessarily be asked to put a minimum protective and responsive health programme in place. This should include protective clothing, health promotive activities, immunization against hepatitis, regular health check-ups and access to medicines and diagnostics through special designated centres and an active linkage with de-addiction centres, and a health registry that measures a list of what would be considered occupation diseases in their context. They damage their health, to keep the city healthy, and the city therefore should recognise a special health obligation to them. This would apply both to sanitary workers in the employment of the ULB, and also those sanitary workers and rag-pickers who are in private employment or self-employed
- 6.18. **Biomedical waste management:** Two kinds of biomedical waste management's systems were observed across the country. One is the biomedical waste management of the state being entirely controlled by Indian Medical Association state branch through the project Indian Medical Association Goes Eco-friendly (IMAGE). This was seen in Kerala, which is completely covered by the IMAGE project for biomedical waste management. The state health care facilities are exempted from the affiliation fee towards waste collection and treatment. However, private hospitals are chargeable. The second and dominant approach is that which falls under the direct responsibility of Urban Local Bodies. In the latter situation, there is a greater chance of medical waste getting mixed up with the municipal solid waste, which might lead to environmental and health hazards of the people suffering the waste and people who make a living out of waste trade. Therefore, there is a need for the intervention of the state health department in formulating ways of biomedical waste management. However, formation of public private partnerships should be chosen with caution as the medical wastes may turn to a tradable commodity otherwise. For example the recent study by Hodges (2013), on medical garbage explains that in Chennai, the Tamil Nadu Pollution Control Board had commissioned two firms for biomedical waste

management and the firms were engaged in the plastic scrap trade from the biomedical wastes from the hospitals in Chennai. Since the plastics used in the medical wastes has a greater recycling value unlike the reused plastics that fill the municipal solid waste stream, the PPP for biomedical waste management required more caution<sup>107</sup>. However PPP model for biomedical waste management in Satara was slightly better, where both public and private sector health facilities were included and the waste seems to be managed as per CPCB standards.

- 6.19. **Recommendation 3:** Most urban bodies do not have an adequate system in place for bio-waste management. There is a need to build a system that is compatible with the rest of solid waste management, yet does not allow a mix up. Again the role of the municipal health officer where this is not directly under his control is strong advocacy and a feedback loop with health disease notification especially amongst sanitary workers.
- 6.20. **Water supply and sewage treatment:** Increasing population and development has increased the demand for augmented water supply in the urban centres. In cities water and sanitation are mainly carried out by the PHED or engineering department. In many urban areas visited, the availability of clean drinking water was an issue. For example, women of Patna complained of the lack of clean water for drinking, and other household chores. It has been observed from the city visits that slums are not often connected to water or sewerage lines forcing them to depend upon the hand pumps or any nearby water sources. In Ambala, for example the slum Anajmandi is listed in the PIP, but PHED officials interviewed reiterated that they are not bound to provide the services to the non-notified slums. Also due to the rapid expansion of the cities, the urban local bodies are poorly resourced, unable to cater to the needs of the newly added and growing populations.
- 6.21. Disposal of domestic sewage from cities is one of the biggest sources of water contamination in India. The Central Pollution Control Board reports indicate that the number of sewage treatment plants in the cities is less in number than the actual number required. Therefore, in the urban centres there is a shortage of installed capacity to treat the sewage generated. Percolation of sewage water into the drinking water line is also a major issue. In Kerala it has been reported that drinking water is emerging a huge issue due to the usage of open well and single pit septic tanks. Due to the increased demand cities often go for the recycling and reuse of water

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<sup>107</sup> Hodges, S (2013). Medical Garbage and the making of Neo-liberalism in India, *Economic and Political Weekly*, 48(48):113.

6.22. **Recommendation4:** Whether notified or non- notified, a large population of urban poor reside in the slums. Therefore, it should be mandatory for the urban local body to provide drinking water supply to the areas uncovered at present. The central schemes for infrastructural development in the urban centres like Jawaharlal Nehru National Urban Renewal Mission (JNNURM), Basic Services for the Urban Poor (BSUP), Urban Infrastructure Development Scheme for Small and Medium Towns (UIDSSMT), and the Integrated Housing and Slum Development Programme (IHS DP) should be utilised specially for developing the water supply and sanitation network in the cities. The role of NUHM in this context could be listed as follows:

- i. Maintain a list of areas where safe drinking water is not available- as a sort of red list of dangerous potential areas of disease outbreak.
- ii. Document outbreaks of disease and trace back reported water borne diseases to these areas. Scientifically locating the point source of every outbreak and take/recommend action on this- documenting such recommendations too.
- iii. Provide short term measures including IEC and local disinfectants of water for these communities.
- iv. Provide technical assistance to improve safe water supplies to vulnerable communities.

6.23. **Community toilets:** The good news is that there is much greater acceptance of community toilets across urban areas than reported a few decades back. Almost all the cities had community toilets and there was a clear demand for them. In Chennai, it has been reported by a community that there are community toilets- but inadequate in numbers to meet the users' needs. The very willingness of at least some users to pay such high rates of use testifies to this. The bad news is that financial barriers now figure as a major problem of access, and where these are exempted, we still have not learnt how to manage these effectively. Different urban areas are engaged with this problematic. In some urban areas its maintenance has been outsourced to private agencies- often Sulabh (Case studies: Ambala, Pimpri- Chinchwad). In others, self-help groups (Viluppuram) manage it, and in still others it is by the urban local body. Often, the maintenance of these was found to be problematic. Moreover, out of pocket expenditures could be as high Rs. 5 per toilet usage and Rs. 20 for a bath (reported from Ahmedabad) and a disproportionate part of this burden falls on the poor and homeless. But if

these were to be withdrawn, alternative institutional solutions for maintenance must be provided. As of now, there is no clear best practice.

6.24. **Recommendations 5:** An Out of Pocket Expenditure (OOPE) per usage of the toilet facility is financially unviable for the urban poor like homeless, and is often the reason for resort to open defecation. Therefore, the OOPE incurred to use the public toilets need to be waived. The maintenance of community toilets should be the responsibility of Urban Local Body, but by means of a locally devised institutional strategy that is most effective and suitably incentivised. One way could be a sort of pay for performance, where the ULB reimburses a contracted agency- like community organisations like SHGs, CBOs based on some structured feedback.

6.25. **Slaughter Houses:** One of the major tasks of the city health officer includes the licensing of what have been called historically “dangerous and offensive trades.” Air pollution, maintenance of hygiene in slaughterhouses, and hotels, all fall under this category. The pattern of institutional arrangements for each of these functions varies across states, but in all, the municipal health officer figures centrally. Kolkata, for example however had a separate officer for regulation of health trades and a food safety cell which looks after food safety- both under the ULB. In Chennai, other than these functions, the city health officer takes a particular note of the air condition in the cinema theatres to particularly contain the spread of infectious diseases like TB, Influenza, etc. This was not reported from any other urban area. In some states, food safety is not under the ULB. The overall impression is that except in large cities, no urban area is addressing these issues at all. The team visiting Tumkur actually validates that there is no health licensing or inspection in place for slaughter houses. Our recommendations must therefore cater to this lack, as follows:

6.26. **Recommendations 6: Slaughter Houses:**

- i. Modernization of slaughter houses can be undertaken on PPP mode or by the ULBs themselves. Doing so ensures efficient and safe use and disposal of viscera, blood and other products. However due emphasis is needed in protecting traditional livelihoods of butchers by co-opting them to modern systems
- ii. Refrigeration in modern systems.
- iii. Municipal health officers must retain a role in slaughter house hygiene- and trace back diseases that emanate from poor hygiene, sound alerts and use this as advocacy to put better mechanisms in place.



**6.27. Recommendation 7: Food Safety- Hotel Hygiene and Sanitation:**

- i. This is a major responsibility of the ULB; the municipal health officer has the main role of organising inspections and acting on violations.
- ii. Effectively carrying out of this function needs a workforce with appropriate qualifications and support. A food safety officer, reporting to the municipal/city health officer is in most situations essential to ensure leadership for this team.
- iii. Food safety would include checks for food adulterants under the Act.

**6.28. Birth and Death Registration**–This is an important function of the ULBs.

**Recommendations 8:**

- i. Expansion of online Birth and Death Registration Services needs to be undertaken across towns and cities along with the expansion of public service kiosks and their integration with other municipal services.
- ii. The digitalization of old birth and death certificates, and online availability of records.
- iii. The availability of the birth and death certificates should be decentralized to UPHC level and not just confined to the ULB headquarters.

**6.28. Management of Cremations/Burials:** In many cities and towns-municipal health officers remain in charge of cremation and burial grounds. Even where not in charge, they are involved or need to be involved for a) ensuring prompt and quality death certification, b) in reducing pollution by shifting over to modern methods like electric crematoria and c) in reducing the costs of management of death –at least from the hospital to the home or cremation grounds, and finally d) to prevent spread of diseases during the disposal of bodies. Hearse Van services are run in some cities on similar lines as Ambulances. The State provides it on payment of reasonable rates or by NGOs/Voluntary bodies. It is important to provide the technical assistance and support needed for city health officers and other public authorities to play this role.

**6.29. Recommendation 9 : Air Pollution:**

- i. Monitoring and controlling air pollution in many areas comes under the remit of Pollution Control Boards. But often these are ineffective

or not even established with the necessary capacity to monitor, and respond to air pollution. There is a need to emphasise the urgency of this, as respiratory disease is a common and increasing cause of urban deaths.

- ii. High levels of pollution get directly reflected in increased incidences of respiratory disease and even deaths, especially among the elderly. Further, poor and the homeless are most vulnerable to such pollution. Good aggregate data is essential to respond to this problem, and this requires a public health information architecture where information from private facilities is also tapped.
- iii. Some aspects of air pollution as relates to occupational health fall under the factory inspector. Some under the regional transport officer. Coordinating and ensuring all these inputs using feedback loops from disease surveillance data and from air quality monitoring data are important is an important public health function.

**6.30. Recommendation 10: Road Safety:**

- i. Injuries, subsequent to road traffic accidents are a major cause of highly complex, urgent health emergencies. Again it is the poor and the homeless- the archetype is the pavement-dweller who is notoriously vulnerable to these accidents. While the subject of emergency response systems has been discussed earlier, the role of the public health officer in containing this is important to understand.
- ii. Road traffic accidents are notifiable to the police department. Careful analysis of this data would provide critical feedback to road transport and safety officers of the transport department and to the traffic police on the areas where preventive action is required. Again it is a data analytics based public health feedback loop that becomes the main remit of the municipal health officer- a role currently not attended to in most cities and urban areas, despite the increasing incidence of accidents.

**6.31. Recommendation 11: Rabies Control and Stray Dog Problem-** This is a key public health requirement keeping in mind the increasing number of dog/animal bites. In fact this is an important issue of technical assistance to states. The following actions are mandatory.

- i. Developing dog pounds for sterilizing and vaccination services

- ii. ABC (Animal Birth Control) Programme expansion
- iii. Provisioning of free anti-rabies vaccine (ARV) at UPHC level
- iv. Notification and publicity related to all rabies cases with feedback and responsive action from public health teams to identify and trace back the source and take preventive measures.
- v. Provisions for the public to submit alerts and feedback on both dangerous animals in the urban milieu and on effective action through call centres. Special call centres are not essential- but such calls can be streamed to a response team for this task. This is more important in some cities/urban areas than in others.

**6.32. The Control of Vector Borne Disease and General Lessons for Epidemic**

**Control:** At the time of epidemics, most cities exhibit two kinds of control activities. They are i) state health department and ULB work in co-ordination to control the situation ii) state health department notify the urban local bodies to control the situation. It has been found from the city visits that the states that act in co-ordination have performed better. The implementation of NVBDCP has been discussed in chapter 4. In essence better action coordinated with the following processes in place:

- i. A good system of disease surveillance with notification of diseases from the public and a large set of private facilities being fed to a nodal point.
- ii. Feedback from every actionable report to the public health officer, to the local health officer and to a designated and trained response team, equipped with some sort of response protocol.
- iii. Both of the above reporting to the same officer.
  - a. The notification of a disease should be seen as an opportunity to increase evidence and accountability for preventive public health action- and not only for a curative response.
  - b. The protocol of response being scientifically valid and appropriate- not merely visible and publicity oriented. (thus a dengue report is responded to by a patient search for indoor domestic breeding sources and not

just a highly visible but questionable effective fogging operation)

- c. Enough staff in the preventive action team dedicated and supervised on this task. (a case has been made citing the Delhi example for dedicated vector control workers)
- d. Active participation of organized collectives of communities in the preventive and responsive efforts.

6.33. Currently very few urban bodies could be said to have all 7 of the above measures/ standards in place. However there are best practices in each of these standards, and some urban areas which have most of these in place. The integration of disease surveillance of the city with the IDSP is weak in many urban areas. Though there are some good practices, many urban areas do not have adequate disease surveillance in place. And though there is some mechanisms of response to dengue and malaria, a public health response to most other outbreaks and disease incidences is not in place.

6.34. It follows that every urban local body should have a municipal health officer to carry out the public health activities in their jurisdiction. Often it is reported that the health officers who are from clinical background fail to look at the social determinants of health from a larger perspective. This is only partly true. What stands out is the need for a public health orientation with good quality technical support and access to relevant knowledge resources in such areas. A mere public health qualification does not necessarily ensure this. It is here the importance of technical support in implementation of social determinants of health becomes important.

6.35. In most of the cities that fall under the type 2 category, it can be observed that due to expansion of the city by notification and due to lack of the resources with urban local body, primary health services in the city are looked after by the ULBs and the primary health care in the expanded areas have been taken care of by the department of health. However, the infrastructural facilities are often provided by the ULBs. However, when it comes to the services *other than the clinical services* discussed in this chapter, there is a general tendency of gross neglect from the state and local governments.

6.36. **Recommendation 12:** Epidemic Control requires, at the least :

- i. A system of notification of diseases where information from both public and private sector is pooled. The 22 diseases list is a good starting point. It could also include some major actionable non communicable disease-strokes, heart attacks, admissions for exacerbations of chronic respiratory diseases, road traffic accidents, burns.
- ii. A well worked out response system with protocols of rapid action in certain communicable disease outbreaks and appropriate policy or administrative action for others.
- iii. Feedback and involvement of both the ward health committee and the MAS and local urban health centre in the response action.
- iv. Not just response to crises but also fixing priorities in extending public services like piped water supply and underground drainage should be linked to epidemiological feedbacks. For instance, if an area reports high levels of stomach infections because of fouled drinking water, this should weigh strongly to give priority to extending piped water supply to this area.

6.37. **Integrated Child Development Scheme:** The status of Anganwadi (ICDS centre) across the urban centres reveal that the issues range from lack of Anganwadis to cover the poor and marginalised population of the city to lack of space and infrastructure for ICDS programme. An urgent attention towards provision of the ICDS services to the slums has to be carried out under the urban health mission in collaboration with the ICDS department. Dhamtari has an “Urban Anganwadi”, where the ICDS collaborates with Self-Help groups in order to provide meals to the children. It is observed that lack of data sharing between the departments has worked against the better implementation of the programme. For example, from the city reports, no interaction between AWs and Health Dept except for Vizianagaram has been observed in case of data sharing. In Vizianagaram the monthly report is send to the DM&HO rather than ICDS department.

6.38. **Food Security:** Few urban areas have planned efforts to address the malnutrition levels of urban poor or ensure food security. A few cities like Chennai, Delhi and Raipur have opened up low cost canteens or hotels which serve hot cooked food at very affordable prices, meant for the poor and utilised by the poorest, but of such quality that even the middle class find it convenient. The AMMA canteens of Tamil Nadu are an example of this. Delhi too has such eateries in place. School meal programmes are another

mechanism of food security that is accessible to most school going children- though the large number of children outside schools does not have this access. Anganwadis serving hot cooked meals in urban areas, or even providing take home foods in urban slum settings, are much less than in the rural areas.

6.39. **Recommendation 12:** Both health department and the ICDS department should have data on ICDS centres and their functioning for co-ordinated action and effective implementation of ICDS. Food security programmes need to be under the purview of both the MAS and the ward health committee- which should be seen as ward health, sanitation and nutrition committees (WHSNC) – along the lines of VHSNC.

6.40. **Convergence of Slum Redevelopment and the National Urban Livelihood Mission:** Urban poverty includes three broad dimensions of residential vulnerability, social vulnerability and occupational vulnerability. All these vulnerabilities are inter-related and to overcome them, schemes and programmes of slum redevelopment and National Urban Livelihood Mission are planned. As discussed in Chapter 3, occupational vulnerabilities have a direct bearing on the health of the urban poor due to precarious livelihoods, dependence on informal sector for employment and earnings and poor working conditions. Convergence and effective implementation of these programmes has great potential to help improve urban health and improved health would also contribute to making these programmes successful.

6.41. **JNNURM:** Introduced by the ministry of urban development to improve the quality of life and infrastructure of urban centres, the coordination of the JNNURM and its sensitivity to issues of urban health and vulnerability need to be examined further. Observations from the field suggest a lack of coordination. It was reported from Madurai that JNNURM was used to build the open drains and since there was no proper disposal system, the open drains became a breeding ground for mosquitoes. In Kochi, JNNURM funds have been used to construct solid waste management infrastructure. However, the treatment plant in Brahmapuram has been built on a wetland without taking into consideration the environmental effects and therefore, the floor has sunk rendering the plant dysfunctional. Other cities which availed services from JNNURM include Delhi, Ahmedabad, Bangalore, Chennai, Patna, Bhopal, Pune, Vishakapatnam, Indore, Guwahati, Raipur, Shimla, Gangtok. The cities have been helped by the building of infrastructure- but health impact assessments of projects and measures to ensure synergy with urban health have not been a part of the design a priori or even post hoc, for that matter.

- 6.42. **Recommendation 13:** Health Impact Assessments need to be included as a part of urban health development efforts. Large scale urban projects and urbanization projects must go along with measures to ensure occupational safety and healthy working and living conditions of huge inflows of the labour that they create. The impact of the project on health of urban populations, other than their own workforce should also be a part of the routine, with tools to assess this and organizations which have the capacity to do so.
- 6.43. **Promoting Healthy Life Style:** Growing of medicinal plants and herbal gardens in all public parks and open spaces in urban areas should be encouraged. Studies indicate that the poor are using medicinal plants for their health needs even in urban areas. There is continuing wide use of herbal home remedies, especially by the migrants who retain links with rural areas, and a revival among the middle class. However, the poor are losing the free access to plants that they did have in urban areas as the natural green areas are disappearing and only ornamental parks are being created instead. This must form a part of the primary level health care that is being assured to the poor.
- 6.44. **Recommendation 14:** Public spaces for wellness, exercise, recreation should be considered a public health priority. Synergy across departments and ministries, including sports and youth development, women and child development, urban development as well as AYUSH, can help to ensure that such spaces are available, appropriately maintained, accessible and optimally used by the urban poor.

## Chapter 7

### Financing Urban Health

- 7.1 Patterns of Urban Health Financing:** Broadly, financing for urban health is drawn from four sources; The budget for health and related services in urban local bodies, the expenditure incurred from state government budgets, the central budget, and out of pocket expenditure- almost all of it as fee for service and a very small part as pre-payment through insurance mechanisms. It is difficult to estimate the actual expenditure from all these four sources – especially the amount expended by the state government and by the urban local body. However we could safely generalize a) that the major part of total health expenditure is from out of pocket expenditure and b) that except in the large cities the major part of public health expenditure is from state health department budgets and c) that the contribution of other sources of financing of public services- essentially insurance and public private partnerships is at this point of time very limited. Generating exact figures for even public health expenditure for each urban area is a challenge for the future. At present, what information we collected was far too perfunctory and poorly validated for presentation.
- 7.2 Central Contribution to Urban Health:** The central contribution has hitherto been minimal- taking largely the form of a) the urban RCH programme under NRHM, b) some strengthening of district hospitals and CHCs (many of which are located in towns with populations above 50,000) under NRHM c) the services provided by tertiary care hospitals in a few major cities especially but not only in Delhi and d) the small but prominent and increasing contribution of the publicly financed insurance programmes – notably the RSBY. This scenario is set to change with the introduction of the National Urban Health Mission.
- 7.3. High OOPE and its adverse consequences:** There is considerable information available from out-of-pocket (OOP) payments from the NSSO (60<sup>th</sup> round) data and there are a number of readily accessible secondary literatures<sup>108109</sup> analyzing this data. The limitation is that the data dates back to 2004, but the good news is that the next NSSO round on morbidity and cost of care (the 71<sup>st</sup>round) is currently ongoing. What we know from this data could be summarized as follows:
- i. 6.2 per cent of total households (6.6 per cent in rural and 5 per cent in urban) fall into BPL as a result of total healthcare expenditure in 2004. In absolute terms, around 63.22 million individuals or 11.88 million households were

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<sup>108</sup> Berman, P., Ahuja, R., Bhandari L. 2010. The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings, *The Economic and Political Weekly*, Vol XLV No 16. NewDelhi.

<sup>109</sup> Chowdhury, S. 2011. “Public Retreat, Private Expenses and Penury—A Study of Illness Induced Impoverishment in Urban India.”



pushed BPL due to healthcare expenditure in 2004. ( a study by Chaudhury 2012, concluded that 6 million of urban population was impoverished due to OOP medical expenditure and further that urban Muslims, scheduled caste, casual labour and lower middle income households were easily the most vulnerable to the financial implications of ill-health. puts the extent of impoverishment )

- ii. Of this, around 1.3 per cent (1.3 per cent in rural and 1.2 per cent in urban) of total households fall BPL due to expenditure on inpatient care while 4.9 per cent (5.3 per cent in rural and 3.8 per cent in urban) of these households fell BPL due to expenditure on outpatient care. In effect, 79.3 per cent of impoverishment is due to outpatient care and only 20.7 per cent of impoverishment is due to inpatient care.
- iii. Across income quintiles, effect of healthcare related expenses is highest in second poorest quintile in urban areas and middle income quintile in rural areas.

7.4 More recent findings from specific studies also corroborate this. Study<sup>110</sup> by Alam 2013, measured the catastrophic expenditure on health by the urban slum dwellers in Delhi. Using multiple threshold levels for both the catastrophes — total consumption budget (catastrophe 1) and non-food consumption budget (catastrophe 2) — the results clearly indicate that an overwhelming share of sample households (n=2010) have been facing serious catastrophe because of high out-of-pocket expenses on health. At the lowest threshold level (i.e. the health budget over 5 per cent of total consumption expenditure), there are 51 per cent of the urban households exceeding this limit. The same at the 10 per cent threshold level, which is generally considered as a catastrophic health spending by most of the analysts, it turns out to be 32 percent in urban areas. Furthermore, the results of this study indicate that almost over a tenth (11.6 per cent) of the urban households spend more than a quarter of their total consumption budget on health care. Lower caste people, particularly the Scheduled Castes (SC) communities, fall into the same pattern.

7.5 This finding was again and again validated by almost every field study that we did, including Delhi, Ahmedabad, Bhubaneswar, Kochi, Indore, Patna and more. Among the poorest, almost every hospitalization was a catastrophic health expenditure-requiring borrowing of money. In the cities visited, only in the urban hospitals and facilities of Chennai was there a serious effort at reducing out of pocket expenditures. In others, though user fees were modest or negligible, out of pocket

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<sup>110</sup> Alam M, Tyagi R. 2009. A Study of Out of Pocket Household Expenditure on Drugs and Medical Services: An Exploratory Analysis of UP, Rajasthan and Delhi. Population Research Centre Institute of Economic Growth

expenditures on drugs were high and even diagnostics done internally were being charged in public hospitals- albeit at rates which were less than in the private sector. Care in the unregulated private sector was as expected more expensive and contributes even more too catastrophic health expenditure. Earlier sections have detailed the constraints and issues under which public provisioning of services fails to provide the financial protection against costs of care, that it was meant to provide.

- 7.6 Policy approaches to engaging with the private sector to provide financial protection and even quality of care are three-fold- a) regulatory mechanisms, b) public private partnerships and c) insurance mechanisms. Of these the latter two could also be considered forms of alternative financing where the private provider brings in the investment and the human resources, and public financing has to only purchase services from the private provider. to understand the effectiveness of all three mechanisms of financial protection, there is a wealth of both secondary literature and observations from the city visits that provide valuable insights. Even on regulation, though the central clinical establishments act is still to be rolled out fully, many states have their own laws and the issues that arise with their implementation vis a vis the needs of the poor are instructive. Similarly, though one could argue that these are early days for publicly financed insurance, the programme has matured in many states visited. And as for PPPs, there is almost continuous experience over 20 years of efforts to explore this alternative- from which we could learn.
- 7.7 **Private Sector Regulation: The concerns:** With regard to regulation, no current regulatory approach has even attempted to look at costs of care. Indeed the first efforts at regulation are all so tightly related to inputs - like infrastructure, HR and equipment, that their expected effects on costs may be adverse. Delhi does have requirements for compulsory registration of medical facilities. But the visiting team was informed that of the 1200 nursing homes only 600 have registered. The other nursing homes do not register because they fail to have all necessary inputs (or because they self-select out of this requirement- a loophole that exists in the regulation). However, and this is the worrying feature, a substantial portion of deliveries being recorded as home deliveries are happening at these nursing homes. The Delhi home delivery rate is surprisingly high, and for a nation heavily prioritising institutional delivery, this is counter-intuitive in a capital city. Much of this has to do with being turned away at the door of overcrowded public maternity sites, and recourse instead to this “low-quality “on-registered private sector- which nevertheless has in most situations a qualified doctor on call. Knowing the contribution they make, the Delhi administration goes slow on cracking down on them which highlights the problems of regulation based on quality alone in a context where there is insufficient public sector capacity.

- 7.8 This interplay between the diverse patterns of private provisioning, their differential access to poor, their fate in a regulatory architecture, the potential ways of government to interact or improve quality are all areas that need further study- and we have identified many potential sites for the study. But at this point of time and this level of inquiry, we can only flag this dimension.
- 7.9. **Public Private Partnerships:** On public private partnerships, there has been a rich body of experience and many compiled data bases and published papers to draw information, supplemented by visiting some of the leading examples of such on-going partnerships. One broad opening statement could be that as strictly defined – a PPP – is a sharing of investments, risks and rewards- and of such there is none surviving which could be called successful especially in primary health care- though there have been many attempted. We come across a new wave of such experiments being planned as urban health solutions- for example in Bhubaneswar, largely with World Bank Support- but these are early days and the current leaderships do not seem aware of the past efforts in this direction. In contrast there are rich collections of PPPs that have survived and worked- and are continuing to do very well, that we could learn from.
- 7.10. One important “successful” form of PPPs is the outsourcing of urban UPHCs to not for profit NGO agencies. We have reports of this from Odisha, Gujarat and Andhra Pradesh. The usual terms are that the budget for the entire set of services is provided as a grant in aid, the consumables are supplied by separate arrangements, the area of service provision and the package of services are fixed and no user fees are allowed. Typically the NGO brings in no money, though deep pockets and influence are useful to cope with delays in payment by the government. The main driver for this form of PPP is that it brings in additional management capacity to attend to these needs. An important supplementary driver is that it is easier to deploy health workers through this route- both easier to justify with finance, since there are no long term commitments to the staff, and that the task of HR management including that of recruitment is off-loaded, and that supervision potentially is better. The main limitation is that arising as they do from the urban RCH PPP model, their care packages, financing and HR strategies are limited to extremely, counter-productively, narrow interpretations of RCH services, thus ignoring a large proportion of health care needs. There is, of course, unevenness in the efficiency of service provision across states and even across NGOs- and scope to improve contracts and payments and selection processes- but the bottom-line is that this works, and where public management capacity is limited and sanctions for further staff difficult- this is a way to go forward. The only concern is that at the depressed wages the HR gets, and the nature of their contractual employment, whether one can really build skills and expand on their roles. But as against nothing in place- this is a start.

- 7.11. Other successful and much needed models of PPPs are management contracts to NGOs for catering to special needs of particularly vulnerable groups. Examples of this are the shelter for urban homeless women who suffer from mental illness run in PPP mode by KMC and an NGO; also the Banyan tie-up with the state government for homeless women in Chennai.
- 7.12. Yet another successful form of PPP for closing critical gaps in essential clinical services- where the complexity is high, public provision is difficult due to the problems of attracting and retaining the required specialists and moral hazards of over-consumption are inherently low- for example a Cancer chemotherapy and Dialysis Centre to be started on PPP mode in Bardhaman, by upgrading a near defunct health post using Municipal and MPLAD funds. We also have the same success if the PPP is made not because public provision is impossible, but because the capacity of public providers is exceeded, for example in cataract surgery- another area where PPPs have worked successfully for long.
- 7.13. Yet another successful form of PPP is the Dial 108 services- where a management contract with a specialized ambulance service provision agency- brings about cashless ambulance services to the entire population. Dial 108 has been operational since the last few years and has provided critical support in referral where there was a big gap previously. People seem to be quite satisfied with the service. However, one problem observed (this could be an exception) is that they pick up patient/accident victim only if the person has an attendant. This is not the management instruction, but if there is no second person with the patient, the driver and paramedic in the 108 vehicles have to take out time and make various arrangements (diagnostics, medicines etc) in the hospital for the patient. However, this unwritten rule followed by the 108 results in denial of emergency referral services to the homeless/single people or people involved in an accident while travelling alone. A related development is the 102 services that focus on maternal referral transport that has started a few months back. In the Delhi visit, there were complaints against this service by the community and even by the ANMs and other health workers. Recently the Director, Health Services has passed an order stating that 108 will not take any pregnancy and delivery related referrals and instead the patient will have to wait for the 102 vehicle. The concern expressed was that this could lead to denial of services and negative outcomes in case of maternal emergencies and complication, given the efficiency of the latter.
- 7.14. Success however eludes the outsourcing of diagnostics path labs on PPP mode. One example we find is from Bihar: The facility provides space for opening a centre to private agency, free of cost to patient, agency reimbursed at fixed rates; However, MOs stated that quality of care was an issue. The alternate model of

outsourcing to a government or para-statal run specialized diagnostic laboratory- a feature of both KMDA and of Chennai, seems to be working well. Contracting CT and MRI scans to TNMSC also seems to be working well. Possibly the lower risk of moral hazard leading to over use and inappropriate use for commercial gains is responsible for this. However, there is scope for experimentation and improvement in this area.

- 7.15. Outsourcing of clinical services where considerable clinical judgment is called for and standardization is poor has been the most difficult- and we do not have anything that could be deemed a successful model. For that matter we have no successful partnerships with commercial providers except through the insurance route. The most important experiment in this area is undoubtedly the Chiranjeevi programme, which did bring about considerable a reasonably successful effort at private provisioning with public financing even if it were for a narrow spectrum of care – only the three stages of labour so to speak- and even if it did so at the cost of wittingly or unwittingly undermining public provisioning in this area and even though we are not sure of its contribution to health outcomes. The real concern is to see how this plays out. Reports from some districts that after public provisioning in this area has declined, private providers who now face no competition and who have established their market have chosen to exit the scheme- pushing the majority of deliveries into private provisioning and OOP financing is the most important current concern with the scheme. But our information is preliminary, and before any firm conclusions, this requires further study.
- 7.16. **Insurance:** Both the presence and expectations of insurance in the urban context is much higher. There are two expectations of insurance. First, that publicly financed or subsidized insurance would improve access and cost protection to the poor in an environment where the presence of providers is literally in surplus. Second, that it would remove much of the middle class from demanding/putting pressure on public services who could choose amongst multiple insurance products and providers. A third and more recent expectation is that it would bring more financial resources and pressures for improving quality to cash-strapped public facilities. A modest number of studies have explored these possibilities. The city visits also came across these issues both in community visits and in public sector exit interviews.
- 7.17. Secondary literature opinion on this issue seems to indicate that the OOP for an episode of hospitalization for someone under coverage is less if he/she has insurance coverage- though it is not necessarily cashless. Sometimes, the remaining OOP can be quite high. There is however no literature on whether at the community level there is a social protection effect or any improved health

outcomes. The few studies that have looked at it seems to indicate that there is none- and paradoxically the OOP in the insured may be the same or even higher.

- 7.18. The city visits and group discussions seem to confirm this interpretation. Firstly even in areas of high coverage, most people in the slums had been enumerated or “IDed” but only a proportion of them had received the cards and of those who had cards and required hospitalization – very few had been able to enforce their entitlements to cashless services –in both public and private sector. Of greater concern, there are well-documented reports of actual denial of services in the private sector. It is clear that empanelled private hospitals under RSBY do not consider the possession of a card as an entitlement to provide the services to those who produce it. Considerations of both ability to pay and status continue to predominate. This has been best document from Chhattisgarh, where private hospitals have been empanelled in both Raipur and Dhamtari under RSBY/ MSBY (Mukhyamantri Swasthya Bima Yojana) in Chhattisgarh- RSBY’s most successful state. But while essential hospitalization is denied, Dhamtari has been made ‘infamous’ in the media due to a huge number of hysterectomies under RSBY that were deemed unnecessary. Irrational treatment, unethical practices and out of pocket expenditure is rampant and most people reported having to pay at private hospitals despite the RSBY card. Further, the community was not aware of the actual list of hospitals, nor of any grievance redressal mechanisms. In fact most of the people with whom the team interacted, were not aware that the private hospital is not allowed to take extra money when providing services under RSBY/MSBY. People felt it was given and natural that they will need to spend some extra money when going to a private hospital even with an insurance card.
- 7.19. Other insurance schemes that were encountered during the visits were : MMA Scheme for BPL population by Gujarat Government, and the Chief Ministers Insurance scheme in Tamil Nadu.
- 7.20. It does therefore appear that the most promising route to improving access and financial protection, not just for the poor, but even for a considerable section of all classes is public provisioning based on adequate and appropriate public financing- and while there should be efforts to improve on insurance mechanisms- these have only a limited contribution to make and that too would be available, only if there is a viable public sector to fall back upon.
- 7.21. The key questions therefore are a) what would be adequate public financing and b) what would be the share of this that would come from NUHM, what from state government, what part from ULB and finally what part of it would be OOP/insurance mechanisms and c) what needs to be done to improve efficiency and equity in public health expenditure from all the above sources.

- 7.22. The first two questions require an understanding of what is current per capita public expenditure in urban areas, what part of it goes to the poor, and what is the relative contribution of these different sources. We would be presenting estimates of these based on case studies- but currently we do not quite know the answers. We present below the current estimates of funds potentially available and the estimation of requirements for just the standard UPHC- without any special services.
- 7.23. The NUHM provides for approximately Rs.22,500 crores in this plan period, amounting to Rs.1.017 per capita urban population covered. Considering the three years left in this plan period, it amounts to Rs.339 per capita per year, of which 23 per cent (around Rs.80 per capita per year) is capital cost and the remaining recurrent cost (Rs.261 per capita per year). Of the Rs.22,500 crores, approximately Rs.2,650 crores (12 per cent of the total plan allocation) is made available in the current year (2013-14). This includes the state share of Rs.650 crores, the remaining Rs.2000 crores being the central share. The mechanisms of its disbursement among the states are not based on the difficulty weight (as in the case of NRHM allocations), but on a 50-50 weightage to urban population and estimated slum population. This is because a difficulty criterion is more applicable to far flung rural and tribal areas, whereas in cities, the need is determined more by the population, especially slum populations. The State-wise urban, slum and BPL population, along with central and state allocations for 2013-14, is given in Table 7.1 below. The estimation of BPL population being very subjective and controversial, only urban and slum population was considered for the disbursement formula.

**Table 7.1: Urban, Slum and BPL population by States and Union Territories, along with NUHM resource envelop for 2013-14**

State/UT	Urban population	Slum population	BPL population	Resource Envelop for 2013-14 (Rs. Crores)		
	<i>Census 2011</i>	<i>Estimates for 2011 by MoHUPA</i>	<i>Estimates for 2004-05 by NSSO (in lakhs)</i>	<i>Central share</i>	<i>State share</i>	<i>Total</i>
<b>A. High Focus States</b>						
1. Bihar	1,1729,609	1,683,954	27.09	49.20	16.40	<b>65.60</b>
2. Chhattisgarh	59,36,538	2,111,546	16.39	38.43	12.81	<b>51.24</b>
3. Jharkhand	79,29,292	931,912	10.63	31.04	10.35	<b>41.39</b>
4. Madhya Pradesh	2,00,59,666	6,393,040	68.97	121.90	40.63	<b>162.53</b>
5. Odisha	69,96,124	1,736,064	24.30	37.21	12.40	<b>49.61</b>
6. Rajasthan	1,70,80,776	3,826,160	40.50	86.41	28.80	<b>115.21</b>
7. Uttar Pradesh	4,44,70,455	10,878,336	100.47	234.83	78.28	<b>313.11</b>
<b>B. Hilly States</b>						
1. Himachal Pradesh	6,88,704	87,281	0.17	2.76	0.31	<b>3.07</b>
2. Jammu & Kashmir	34,14,106	494,180	2.34	14.36	1.60	<b>15.96</b>
3. Uttarakhand	30,91,169	826,257	7.75	17.08	1.90	<b>18.98</b>
<b>C. Other States</b>						
1. Andhra Pradesh	2,83,53,745	8,188,022	45.50	163.18	54.39	<b>217.57</b>
2. Goa	9,06,309	154,759	1.62	4.07	1.36	<b>5.43</b>
3. Gujarat	2,57,12,811	4,662,619	21.18	118.29	39.43	<b>157.72</b>
4. Haryana	88,21,588	3,288,292	7.99	58.73	19.58	<b>78.31</b>
5. Karnataka	2,35,78,175	3,631,147	53.28	101.55	33.85	<b>135.40</b>
6. Kerala	1,59,32,171	533,278	13.92	47.98	15.99	<b>63.97</b>
7. Maharashtra	5,08,27,531	18,151,071	131.40	329.84	109.95	<b>439.79</b>
8. Punjab	1,03,87,436	2,798,256	3.52	57.62	19.21	<b>76.83</b>
9. Tamil Nadu	3,49,49,729	8,644,892	58.59	185.58	61.86	<b>247.44</b>
10. West Bengal	2,91,34,060	8,546,755	26.64	169.10	56.37	<b>225.47</b>
<b>D. North Eastern States</b>						
1. Arunachal Pradesh	3,13,446	98,248	0.07	1.89	0.21	<b>2.10</b>
2. Assam	43,88,756	1,070,835	0.93	23.15	2.57	<b>25.72</b>
3. Manipur	8,22,132	75,197	0.14	2.99	0.33	<b>3.32</b>
4. Meghalaya	5,95,036	205,176	0.12	3.78	0.42	<b>4.20</b>
5. Mizoram	5,61,977	105,720	0.11	2.63	0.29	<b>2.92</b>



State/UT	Urban population	Slum population	BPL population	Resource Envelop for 2013-14 (Rs. Crores)		
	<i>Census 2011</i>	<i>Estimates for 2011 by MoHUPA</i>	<i>Estimates for 2004-05 by NSSO (in lakhs)</i>	<i>Central share</i>	<i>State share</i>	<i>Total</i>
6. Nagaland	5,73,741	83,220	0.09	2.42	0.27	<b>2.69</b>
7. Sikkim	1,51,726	13,321	0.02	0.55	0.06	<b>0.61</b>
8. Tripura	9,60,981	131,080	0.14	3.96	0.44	<b>4.40</b>
<b>E. Union Territories and Smaller States</b>						
1. Andaman & Nicobar	1,35,533	33,722	0.27	0.72	0.24	<b>0.96</b>
2. Chandigarh	10,25,682	332,473	0.36	6.29	2.10	<b>8.39</b>
3. Dadra & Nagar Haveli	1,59,829	26,083	0.16	0.70	0.23	<b>0.93</b>
4. Daman & Diu	1,82,580	9,187	0.14	0.58	0.19	<b>0.77</b>
5. Delhi	1,63,33,916	3,163,430	15.83	77.31	25.77	<b>103.08</b>
6. Lakshadweep	50,308	1,560	0.05	0.15	0.05	<b>0.20</b>
7. Puducherry	8,50,123	136,899	1.34	3.73	1.24	<b>4.97</b>
<b>Total</b>	<b>37,71,05,760</b>	<b>9,30,53,972</b>	<b>682.02</b>	<b>2,000</b>	<b>650</b>	<b>2,650</b>

7.24. Given the huge gaps between the money required and the money available, there is a need to phase this. The general understanding is to take this in phases and for this to start up UPHCs and ANMs. We estimate that not counting supplies the entire costs of a unit of 50,000 population would cost approximately Rs. 65 lakhs a year, amounting to Rs.129.64 per capita per year. The detailed estimates of health services planned under NUHM for a given 50,000 population, assuming 35 per cent of that to be slum and other vulnerable population, is given in the Table 7.2 below.

**Table 7.2: Cost of Services under NUHM for 50,000 population**

	Physical Number	Amount (Rs.)
Population covered	50,000	
Estimated Slum and Vulnerable population	17,500	
<b>Urban PHC services</b>		
PHC operating cost (including staff salaries)	1 UPHC	20,00,000
PHC united grants	1 UPHC	2,50,000
Drugs and Consumables	@ Rs25 per capita	12,50,000
		<b>35,00,000</b>
<b>Outreach services</b>		

ANM (salaries and mobility support)	5 ANMs	7,50,000
Special Outreach Session (only for slum and vulnerable population)	2 ANM areas	9,60,000
		<b>17,10,000</b>
<b>Community Processes</b>		
ASHA (incentives)	10 ASHAs	20,000
MAS (untied grants)	50 MAS	2,50,000
		<b>2,70,000</b>
<b>Training Support</b>		
Training of Doctors	2 Doctors	10,000
Training of ANMs	5 ANMs	25,000
Training of ASHA	10 ASHAs	1,00,000
Training of MAS	50 MAS	5,00,000
		<b>6,35,000</b>
<b>Overheads</b>		
Programme management support @ 6 per cent of total cost		3,66,900
<b>Total (Rs. per year)</b>		<b>64,81,900</b>
Cost per capita (Rs. per year)		129.64

7.25. Efficiency of public health expenditure requires a number of mechanisms to be strengthened. We list these as follows:

### **Recommendations:**

1. Efforts must continue to increase budgetary financing for NUHM – at least to reach what has been spelt out in the cabinet approval for the scheme and the 12<sup>th</sup> Plan projections. The importance of this is not only to improve central support, but to catalyze and improve state and municipal contributions.
2. Efforts are particularly needed to improve municipal contributions through advocacy. This must be focused on those cities where the ownership of both facilities and non-medical dimensions are with the municipal corporation and in all million plus cities. A normative objective of reaching half way the best-case benchmark of 10 per cent of municipal budgetary allocations should be actively advocated. (Currently it ranges from 0.27 per cent in Vizianagaram, to 0.83 per cent in Kochi to about 10 per cent in Chennai and Delhi- but there is a need to check what all are included in each of these budgets under health )

3. There is a need to protect and expand all activities related to non-medical public health in all towns and cities irrespective of the governance arrangements. Since the NUHM and health departments would have even less purchase to do so, once urban health care facilities and move out of urban local body control (which is the major direction of movement), one must look to clauses introduced into MOUs with urban bodies and some financial support for a certain minimum set of interventions/activities that would ensure that urban bodies do not reduce attention to these functions and that the office of the municipal health officer and the convergent role that this office plays is retained. A substantial part of this financing could go to institutionalized technical and resource support under the local body for ensuring that these functions are modernized and carried out effectively and efficiently.

A minimum set of services under a UPHC should be costed, excluding the costs of drugs and supplies, which would flow separately. It would however include the following: the tasks related to building and maintaining a population based case records for an approximate population of 50,000 for those services that are included in the package, the staff of the UPHC, the staff of the health posts/nursing stations/health sub-centres under the UPHC, the costs of outreach sessions, MAS and ASHAs under this UPHC. The costs of each individual item under this set would be the same as already approved in the norms- but these would be delivered as a package so that we know exactly what level of population coverage we have achieved with a certain fund allocation.

To this minimum set of services- the PIP should add those specific additional services that are required for meeting the needs of specific vulnerable groups, drawing from the budget head provided for this purpose and indicating at which UPHC or which secondary/tertiary care facility this additional service would be located. Indicative budgets for each of these vulnerable specific supplementary packages (VSSP) are to be worked out.

4. Funding to tertiary care facilities would be largely limited to improving and facilitating the experience of primary care and its referral from these facilities, especially for vulnerable.
5. Funding to secondary care should be planned carefully – and proportionate to the case loads being managed. The re-imburement principle could be used.
6. Maternity homes and the requirements of maternity care of whatever type has been prioritized and funding to support quality and improve access to care in pregnancy should be eligible for financing under NUHM, wherever it is delivered.

7. Financing for human resources would provide a basic minimum staff for all facilities and then add on staff if there is high outpatient or in patient caseloads. Such additional staff would be merited only where quality of care is assured – and measurable by some basic measures/indicators- for example the maintenance of case records of chronic illness patients and some other care categories, special services through afternoon and evening clinics and so on. Essentially it is to ensure that all the staff has a 8-hour working day which is fully utilized in service delivery.
8. All care provided in public services is free of charge – as measured by out of pocket expenditures on medical costs- and not only by absence of user fees. In particular all primary health services must be completely free to all users.
9. Token user fees with easy access to exemption may be required in some areas of overcrowding in secondary and tertiary care facilities but this must be put in place only after feedback referrals are well in place. The test of a feedback referral loop is a patient of chronic ailments like diabetes and hypertension, asthma and epilepsy and mental health having occasional consultations with specialists at the higher facility, but then followed up regularly at the UPHC/nursing stations level where access to drugs, periodic standardized simple consultations including diagnostics is made available. Referral from the primary level will allow exemption from this token fee and easier access to the specialist by name- allowing for the necessary patient doctor relationship that is required for chronic illness management to build up.
10. The non-negotiable bottom line is that all primary health services should be completely free for users. This should mean, in the least, no medical costs- whether as user fees or in terms of prescriptions for drugs and diagnostics to be purchased.

## Chapter 8

### Governance for Urban Health- including the governance for urban health care services

- 8.1. A simple understanding of governance is the relationship between the owners and the organization. The institutions of governance mediate this ownership. Management on the other hand is the set of processes that converts the inputs available and provided to achieving objectives of the organisation, within the broader framework of implementation that governance provides. A well governed and managed urban health system should be able to deliver the health care services and achieve health care outcomes effectively, efficiently, and the services should be responsible to the needs of the people and accountable to them who are ultimately the owners of public services.
- 8.2. There are two major institutional frameworks of governance in the urban context. The first is the elected urban local body and its executive. The second is the state government and its department of health. The latter's actions could be further mediated through the directorate or the state and district health societies. To the extent that hospital development societies express local ownership and community organisations express needs and monitor services these too are important instruments of accountability and responsiveness and therefore contribute to good governance.
- 8.3. The main functions or services- in other words the mandate – of the urban health services could be seen as constituted by the following.

Medical College Hospitals	Epidemic Control	Food safety
Other secondary and tertiary care hospitals	Disease Surveillance	Air Pollution Control
Urban Primary Health Centres, and Equivalents and Mobile Medical Units	Solid Waste Management	Clinical Establishment Regulation/Health Trade Regulation
Health Posts, ANMs providing outreach services	Sewage and Sanitation Services	Road Safety Measures
Ambulance Services	Provision of safe drinking water	Bio Medical Waste Management
Health Programmes- RNTCP, NVBDCP, HIV control and their staff	Rabies control and stray dog management	Licensing of dangerous and offensive trades- including inspection and safety of hotels, slaughter houses, and cinemas
Community Health Volunteers- especially ASHAs and link workers	Shelter for Homeless and Welfare functions	International Inoculation
MahilaArogyaSamitis	Management of death, cremation and burial grounds	Occupational Health Regulatory Aspects
	Birth and death registration	
	Occupational Health services	

- 8.4. One way of addressing the question of governance is how to ensure that the complete set of functions above is achieved. We must remind ourselves – that with all its limitations the original design of the urban local body of earlier times saw this as a continuum under single technical officer- be it a commissioner or the city health officer. But as there is increasing complexity and sheer growth in numbers and certain functions get marginalised while certain others specialised. Thus, a multitude of organisations and institutional frameworks emerges. To some extent, this is inevitable- but we need to ensure coordination – for the technical reasons outlined in chapter 6, and also for reasons of governance.
- 8.5. The constitutional position, especially after the introduction of the 73<sup>rd</sup> and 74<sup>th</sup> amendment of the constitution makes health services a part of the mandate of the local bodies. There are good reasons for this- the most important being the principle of subsidiarity (which states that functions are best governed closest to the users , but with sufficient distance as required by practical considerations and to ensure against local self-interests.).Potentially services under local bodies are both more accountable and more responsive. This remains an important principle. However on the other side there are concerns about capacity, and about the ability to govern increasingly complex technical services at much decentralised levels. There is also a political call.
- 8.6. Given the complexity of these factors the NUHM framework leaves this decision to be made by the state government. The TRG considers this issue and while agreeing that states should make the final call on it would like to emphasize the following guidelines:
- i. In all large metros- all urban health services – both of health care delivery and non-medical are under the urban local body and this must remain so- and be strengthened.
  - ii. In all cities above two lakhs ( or should it be one million ) where urban local bodies are able and willing to contribute to financing- say upto 5 per cent of the total municipal budget for health, there is a strong need to preserve the same architecture as in the metros. In deciding on this, one must consider the existing health and seriousness with which the urban local bodies are managing health care facilities and their desire to do.
  - iii. In cities and town where health care services are being handed over to the state department of health, the participation of the elected urban local body and its executive at all appropriate levels should be maintained. And further a public health qualified officer, preferably of the health department should lead a significant part of the non-

medical public health functions, ensuring continuity and feedbacks between the preventive and the curative functions.

- iv. In all the above three situations a clear memorandum of understanding between the urban local body and the state health society should guide the funding from NUHM clarifying the expectations as regards deliverables and the roles of respective organisations.

8.7. One finding from many best practice sites in community processes is the need for a ward level coordination committee where all the Mahila/ Jan Arogya Samitis are represented and where the urban local body coordinates with peripheral facilities, providers and community based organisations. Irrespective of governance arrangements at the higher levels, this should be put in place across all urban areas.

8.8. A closely related issue is the institutional arrangements for management. Whatever the governance mechanism if the expanding work and financing is not matched by a suitable strategy of management- there are going to be major constraints. Making do with existing staff in the name of not creating parallel structures is simply not an option. However, the structure of directorates and ministries do not allow the creation of additional posts of deputy directors or secretaries and even if created does not necessarily provide the sort of multi-disciplinary, multi-level team that such management is going to require. Strengthening PMUs is therefore the main way forward that states are thinking and we would endorse this. However there is concern about duplicating the existing PMUs of the NRHM and creating the NUHM as a parallel structure- a danger that everyone is agreed should clearly be avoided. A set of principles to guide the establishment of city/town level PMUs could therefore be useful.

8.8. The following guidelines could be provided:

- i. Metros would have city specific PMUs – broadly equivalent to what is created for a district PMU structure- only with a much better provision of technical expertise on the non medical public health functions.
- ii. Large cities PMUs would be under the district PMUs of that district and the chief medical and health officer – but with a distinct PMU structure largely corresponding to what a block would have- but enhanced by some more staff depending on the number of facilities and the extent of roles of the municipal health officer. If the city is the state capital or has a population over two lakhs and is distinct and separate from the district headquarters town, there is case for an additional programme

management structure- so that though it reports to the district health society like any block officer does, its PMU size may be larger than the

- iii. The PMU would be under the city health officer wherever funding is to the ULB under the MOU.
- iv. PMU staff needs an appropriate HR policy so that the technical HR policy can be built up and retained. This is a follow up action to the current TRG report.
- v. PMUs will need technical support- from both a suitable state level resource support agency and earmarked technical support agencies.

8.9. Another major issue of governance is with respect to access to knowledge resources. Indeed many municipal health officers stated this as an even more important requirement than money or management structures- since they have no access to modern state of the art solutions and options and best practices in many of the functions that they are performing. The fact that they are medical officers is one reason for their lack of information, but because many of them by training or experience are public health, they are keenly aware of this need. It must also be recognised that no one set of qualifications or experience would be enough to manage such diverse functions. Access to knowledge resources requires a strategy- which includes in the least, partnerships with suitable academic or technical bodies, space for hiring a multi-disciplinary team, opportunities for exposure to and training on innovations and best practices and latest developments in these areas and participation in knowledge networks. NUHM requires a budget line that recognises and financially support these needs.

8.10. There must be better coordination with ESI facilities and railway and other public sector undertaking managed health facilities and the urban health programmes.

8.11. Governance systems have also to address the challenge of ensuring that insurance and public private partnerships that are meant to serve the needs of the poor actually do so. Contracts must be designed to ensure this, and followed up with good quality monitoring which would include community monitoring and gate-keeping roles.

8.12. Much work is also required to look at ways of engaging with the private sector. Public private partnerships with not for profit organisations to attend to special situations is welcome and already taking place. The larger challenge is to prevent exploitative practices like irrational care, unnecessary referrals made for earning commissions, and malpractices of many sorts through appropriate regulation. Other forms of engaging and even encouraging private providers working in poor communities, that does not require transfer of funds includes improving quality of



care through training, quality circles, supply of vaccines, inclusion of their clinics as DOTS providers and sputum collection and access to free diagnostics frequently required but unaffordable for the poor like sputum examination for MDR-TB.

- 8.13. Yet another major governance mechanism is a functional grievance redressal system, and a helpline- with clearly laid down standards for these, so that they serve the purpose for which they are intended. The grievance mechanism should cover not only public facilities but also all empanelled private providers in government financed insurance programmes and facilities under public private partnerships. It should also engage communities constructively, as indicated in sections 5.26 and 5.27.
- 8.14. In addition to analysis of routine health information, there is a need to institutionalise measures for a simple sample survey and exit interview process which informs us about costs of care, and the nature of access to services periodically, especially as regards to the vulnerable. MOUs with a local academic institutions and a standardised methodology can achieve this with a periodicity of once every two years and this would help planning in major way.

## **Chapter 9**

### **National Urban Health Mission**

#### **The TRG Recommendations**

The Report makes recommendations throughout, explaining the rationale at every point. This summary chapter tries to draw in the recommendations from the entire Report, to list together what is being recommended, without elaborating on the rationale.

The approach paper of the Urban Health Mission lays down clearly the principle that whereas these services will be universal, they will be designed in ways to ensure effective primary health services for the urban poor (even while not excluding all other segments of the population). Accordingly all services offered by Urban Primary Health Centres under the Urban Health Mission will be universal, but - in the spirit of affirmative action and the Gandhian maxim 'Last Person First' - sensitively designed to cater specifically to the needs of variously disadvantaged urban populations. However, the services should be also available and accessible and utilized by other sections of the urban population.

Not all these recommendations are for implementation with NUHM funds. State governments and urban local bodies may also consider these recommendations and come forth with the funds and reforms required for this. But the NUHM has to go beyond its first task of funding the urban health systems, to advocating, guiding, technically supporting and catalysing these changes.

#### **9.1. City Level Vulnerability, Facility and Service Mapping**

The TRG recognises that the NUHM Framework for Implementation has provided for mapping of all urban health facilities and poor households. The process of mapping of the poor must essentially be a process of making the vulnerable visible to the health care systems, and capturing their problems in access to the services that are needed most.

The TRG recommends that mapping the spatial distribution of health facilities and services is important, but this must be co-related with mapping sensitively and comprehensively the actual presence and dispersal of the poor and marginalized populations in the city, their socio-economic vulnerabilities and health burdens, as well as their problems of access to health services.

It would be useful for the survey to involve not just the local body and health department of the state government, but also trade unions and collectives of urban poor

groups – such as of rickshaw pullers, construction workers, rag-pickers, sex workers, homeless people, single women, disabled peoples collectives, organisations of the aged, homeless and street children – youth groups, and colleges of social work, social sciences, and urban planning. It is not only health, management or IT technical expertise, but the insights and contributions of social scientists and community based organizations that would help develop good mapping outputs.

The starting point for the vulnerability survey and mapping should be to map all settlements of the poor- whether they are notified as slums or not. It can use inputs from prior efforts like the documentation done by Rajiv Aawas Yojana of both notified and non-notified slums, if these are available for the city. The process of mapping must identify vulnerable and urban poor settlements by determinants like areas with housing with *kutchra or makeshift* roofs and walls, areas which lack piped water supply or sewerage and drainage facilities, areas of extreme over-crowding, areas endemic for malaria or dengue and prone to disease outbreaks etc. The survey should also carefully map resettlement colonies; clusters of urban homeless persons and temporary migrants; red-light areas; construction labour camps; factory worker and scavenger colonies; leprosy colonies; urban villages; and impoverished inner-city areas.

In addition to areas where urban poor populations live, the mapping should also identify parts of the city where high concentrations of unorganised working populations work, such as wholesale markets, land-fills, labour *addas*, railway and bus stations etc., and the nature and size of vulnerable populations, health needs and access to services of these informal working populations.

After the Vulnerability Mapping, the second part of the mapping exercise is the Health Infrastructure Mapping, which should include outreach services, primary, secondary and tertiary health services, both private and public, and of central, state and local governments, including inter alia CGHS, state government primary health units, community and district hospitals, medical colleges, ESIC hospitals and clinics; also ICDS centres.

The process of mapping should also include access audit, where it considers whether the location of PHCs or any other social barriers exclude access to vulnerable groups including disabled and aged people, and suggest in consultation with the community which location would be most useful. Though GIS based maps are essential- they are not sufficient. The final output “map” is thus both a drawing showing geo-spatial distributions and an explanatory text.

The Vulnerability Map should be super-imposed on the Health Infrastructure Map. When concentrations of vulnerable are over-laid with and carefully co-related with existing health infrastructure available in the city and the services they provide and issues of access- the gaps, needs, imbalances and mismatches are made visible. The

purpose of mapping is to draw up city health plans under UHM that would be able to correct these multiple imbalances and gaps, and address vulnerability more comprehensively.

The “map” is a dynamic document, and the vulnerability and facility mapping should be updated at least once every year.

## **9.2. Organization of Services at the Community Level: Nursing stations, ASHAs and Community Volunteers**

The NUHM Framework for Implementation provides for a female health worker/ANM in urban areas for a population of 10,000 to 12,000. Such a population cluster would also have approximately 5 ASHAs. Given the existing constraint in funds and the very low baselines in health posts and ANMs, this is understandable. However the TRG would like to make a case for phase-wise upgrading this lone female health worker per 10,000 populations with 5 ASHAs to a three person health facility which could be named a Nursing station or a nursing station cum health sub-centre- ideally of two female health workers and one male health worker- all with equal remuneration.

These could be located in independent buildings or co-located in UPHCs, maternity homes, and in all other secondary and tertiary care facilities but providing outreach services to the population of 10,000 living in the immediate vicinity. But in large parts of the city one may need to rent in a room or make use of available other government department premises in the evenings to operationalize this nursing station/sub-health centre. The important point about location is that this should be as close to where the catchment population live or work as possible.

The nursing station as a concept differs from the rural sub-centre in that it does not provide delivery services- but **it provides all primary health care which does not require the intervention of doctors, including health and nutrition counselling, health literacy activities, preventive and promotional health activities, vaccination and ante-natal care services. Most important it is an important point of supply of drugs initiated by doctors- but where nurses do the follow up tests, counselling and regular free medication is a must.** Examples are TB, for mental health problems, leprosy, hypertension, diabetes, epilepsy, asthma and some other NCDs, dressing of wounds. These could also be sites for counselling for substance abuse, and for disability, geriatric and palliative health care including domiciliary care. They would also be able to support vector control activities- and organise with the ASHAs much of the preventive and promotional health care that is needed.

Most nursing station would be open at certain fixed hours mainly in the evening but if required also in the mornings - as finalised in discussion with local communities. If

there are three health workers per nursing station cum health sub-centre, this should be possible.

The role of the 5 ASHAs in supporting the FHW- proposed for expansion into a nursing station - is important. It would include their current roles in facilitation for safe pregnancy and immunization and family planning, but also include a substantial contribution to screening for and primary prevention related to NCDs. Since there are significant single male urban populations with large disease burdens like TB, for every five ASHAs at least one male community health worker with the same or very similar work profile could be considered.

The basic FHW qualification is ANM certification, but where it is available a GNM certification is also equally valid and preferred. Similarly for ASHA there is a case for preferring 12<sup>th</sup> class pass women, since they could later get trained and upgraded into full time community health nurses. Both categories of workers would require appropriate in-service training for them to handle this task.

The Supreme Court has directed that all slum populations must be fully served by ICDS centres. Since each ICDS centre serves a population of 1000 persons, 10 slum-based ICDS centres will be linked to each slum-based sub-health centre. There should be a strong organic linkage with the ICDS centres, the ASHAs, the Multi-Purpose Workers and the UPHC, especially in matters of nutrition and health of infants, young children, and expectant and nursing mothers; and also in the implementation of all national programmes such as TB, leprosy, mental health and blindness prevention.

In addition to the above- the TRG recommends a programme to encourage community health volunteers – as part of Mahila Arogya Samitis/ Jan Arogya Samitis and even independent of them. The major part of these would be peer educators belonging to specific vulnerable groups- for example rag-pickers, or sanitation workers, CSWs etc. Another set could be community volunteers who work in adolescent friendly clinics located in adolescent hang-out locations or amongst unorganised workers etc. A third set would be young volunteers who extend domiciliary support to aged and disabled people, as well as support to take them to health services.

The members of the Mahila Arogya Samiti should also be seen as community health volunteers since they are drawn in a representative fashion from each cluster of houses and are expected to convey back relevant information on access to services and health practices and behaviours that are desirable. Again for involvement of men in the process, it would be important and some cities may experiment with Jan Arogya Samitis where up to 25 per cent of members could be men. Others could bring them in as invitees and not regular members.

### 9.3. Making UPHCs Accessible to the Poor - Issues of Location and Responsiveness.

The NUHM Framework for Implementation provides for one UPHC for every 50,000 population. This will be achieved by both by adapting and upgrading existing facilities, and adding new ones.

The geographical and social distribution of UPHCs within the city must maximise access for the urban poor. Certain guidelines would help ensure access to the poor.

- i. **At least 50 per cent of all Urban Primary Health Centres (UPHCs) must be located within or near (at a maximum distance of 0.5 kilometres) settlements and habitations of urban poor persons and unorganised workers**, including slums, both notified and non-notified; slum-like habitations of areas of sub-standard housing stock with very high density characterised by housing with *kutcha* roofs and walls; areas with lack of piped water supply, underground sewerage and drainage, and extreme over-crowding; or in slum resettlement colonies; urban villages; landfills, and red-light areas; factory worker and scavenger colonies; leprosy colonies; construction workers' camps; and impoverished inner-city areas. Only in cases where after all efforts to find land *within* these habitations for UPHCs fail, these can be located at a maximum distance of 0.5 kilometres from the boundary of these settlements. For ensuring that at least 50 per cent of all UPHCs are located in or near settlements of the urban poor, a UPHC would be considered serving settlements of urban poor neighbourhoods if at least two-thirds of the catchment population are residents of what this note has designated to be urban poor habitations.<sup>111</sup>
- ii. About 5 to 10 per cent of all UPHCs will have special additional services that would be meant for homeless populations and street children, and temporary and circular migrants. Such services include mobile clinics as well as recovery shelters. Mobile units, whose package of services would be similar to nursing stations, would provide fixed time services to unreached areas, such as of scattered slums, temporary migrant populations, and scattered homeless persons.
- iii. **The UPHCs in the remaining parts of the city, areas which are not slums and in which the majority of residents belong to the middle classes with decent housing and civic infrastructure could be about 30 per cent of the whole.** Active utilization of at least these UPHCs would have its own challenges, but such utilization would bring popular support to strengthening UPHCs and also provide considerable relief and financial savings to the non-poor sections as well, apart from serving domestic help populations who live in upmarket areas. Thirty per cent

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<sup>111</sup>Based on local situation the cities may manage this distribution by establishing some UPHCs for 75,000 population, and can also establish one UPHCs for even as low as 10,000 population for a specifically vulnerable or isolated slum cluster. (see para 7.15.1 of NUHM framework for implementation)

UPHCs will be located in non-poor areas of the city. Whereas services for dedicated urban poor UPHCs will be intensive, those serving the better-off parts of the city can be more extensive- serve larger populations, even up to two lakhs. For these UPHCs, existing public health centres such as CGHS and ESIC dispensaries should also be incorporated and upgraded.

- iv. About 5 per cent of UHM budgets in the city should be utilised for catering to the special health problems and needs of the poor, especially where such a need is articulated by collective of such workers. This may take the shape of a special clinic in a designated UPHC or even a special clinic in a medical college held on a weekly basis, or it could involve help-desks, or special training in specific occupational ailments or mental health issues of the health personnel in particular UPHCs, provision of attenders to certain category of patients, diet requirements and the stocking of particular drugs and consumables. This would respond to the very varied type of health care needs that was noted in the FGDs with different vulnerable groups- domestic workers, rag-pickers, head-loaders - aged and disabled people, etc- much of which is currently available only in tertiary centres and difficult if not impossible to access for these poor. Further to institutionalise a process of responsiveness to special needs we could require city health planners to provide formats and processes through which certain occupational groups of the urban poor or social categories could ask for special services or point out exclusions- and the state would in consultation with them decide on how much of this can be provided , where and how.

#### **9.4. Special UPHCs for Homeless Populations and Street Children**

A rough estimate of homeless persons in any city would be about 1 per cent of the total population of the city and 0.5 per cent would be street children. This could be used to check whether the mapping process has been rigorous and sensitive enough. Free services are not enough to reach them- further affirmative action is required.

UPHCs which are tasked with affirmative action to reach homeless groups, street children, temporary and single migrants, must be equipped with additional facilities, including a) mobile clinics for dispersed homeless populations, and b) **recovery shelters of at least 30 beds each for enabling homeless persons who are discharged after treatment for serious ailments like TB, accidents, cancer and others, requiring bed-rest and special nutrition.** The detailed design of a homeless recovery shelter is given in the annexure.

In addition, in coordination with railway and state transport authorities, **each major railway station and inter-city bus station should be persuaded to run one nursing station especially for street children, combined with a help desk and drop-in centre for these children.**

## 9.5. Measures to Ensure Inclusion

- i. It will be the explicit mandate of the UPHC to provide priority services to urban poor people, especially those in most difficult circumstances such as street and slum children, the aged, disabled, single women, unorganised workers in unsafe occupations, and survivors of violence (domestic violence, sexual assault, caste and communal violence).
- ii. There will be **no requirement of any document to prove identity, address or citizenship for a person accessing a UPHC for primary health care. No persons shall be turned away from any UPHC on any ground for a service which is on the assured services list of the facility, including lack of documents, lack of caregivers, location, homelessness, disability, gender or nature of ailment or sexual orientation.**
- iii. Sensitivity needs to be built on problems of identity with respect to standard formats. For example children of sex workers and single mothers would find a form with only mothers name very friendly and one with only a father's name as hostile. In particular, **all forms under the UHM should ask for mother's name only, instead of father's or husband's name.** A transgender person, who the hospital does not want to record as a woman or man, would require to be identified as trans-gender. Formats design should have the flexibility for these concerns.
- iv. Since the majority of unorganised workers are unable to access health facilities during morning hours because this would involve loss of a day's wages, **all UPHCs and The Nursing station should open preferably 24 hours, but if not possible then surely from 3 to 9 pm daily.** The exception will be UPHCs catering to red-light areas, which will operate in morning hours. Women staff will be ensured security protection to enable them to work in evening and night hours. Where one shift outpatient wards are very crowded, a second shift with its own complement of staff would provide better services and would optimise use of the infrastructure.
- v. **End-to-end computerisation will ensure that patients will not have to preserve their medical records.** For patients who are street children, homeless, migrant, nomadic or residents of non-notified slums, it is difficult to preserve paper records. Copies of these will be available in hard form wherever a patient demands, to cater to mobile circular migrant populations. Identity codes or bio-metrics are useful for this, but UHM should provide a choice from multiple codes and do not make it mandatory for receiving care.
- vi. **UPHCs should have a special focus on geriatric and disabled persons' care. All UPHCs must have a special help-desk for the aged and disabled, and also fast-track counters for them.** Staff in sub-centres should provide domiciliary services to home-bound old and disabled persons. There could be Sunday Clinics especially for the



aged, in which local youth volunteers bring the aged to the clinic and help them within the UPHC. In hospitals in one evening a week, the UHM could also run special poly-clinics for the aged and disabled.

- vii. In planning primary health services of the UHM, it must be remembered both that disabled people have health problems just like other non-disabled populations (an obvious fact which is often forgotten because caregivers and health providers often focus so much on the disability that they forget that the disabled person is also a person like any other); and that specific disabilities often have high chances of specific co-morbidities.

#### **9.6. Design of UPHCs: Service Package, Human Resources, Referral Linkages and Infrastructure.**

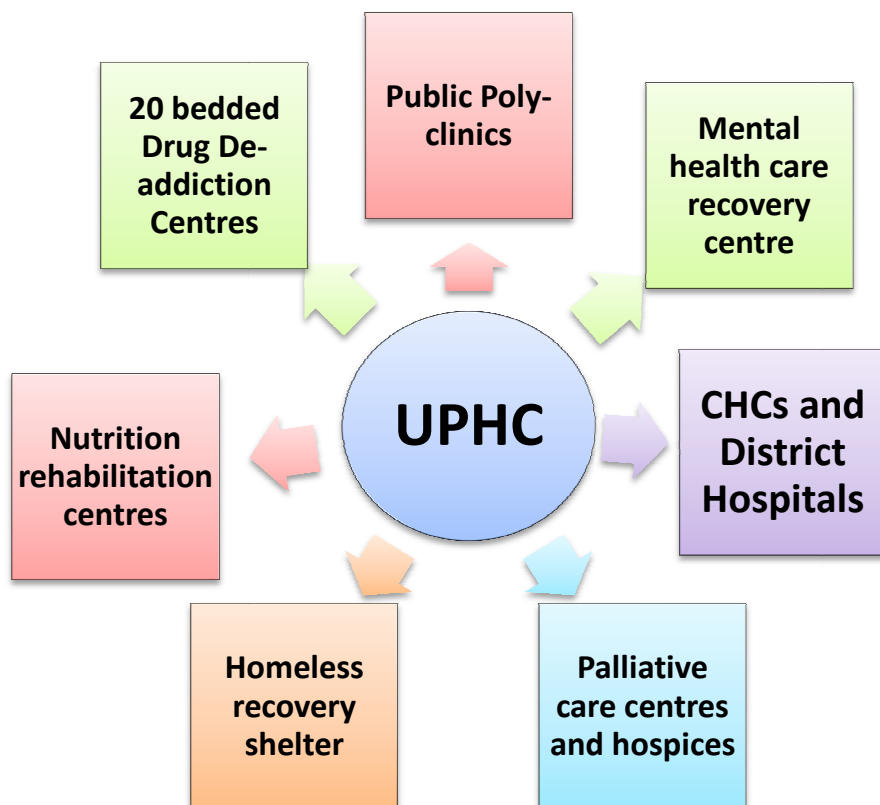
- i. The revised NHM Framework of implementation provides for a comprehensive list of primary care services. There must be an effort to establish all these services from the very outset. We note that most urban dispensaries and urban PHCs visited - whether run through PPPs or run directly by state governments, tend to focussed exclusively on a limited spectrum of RCH care. **UPHCs will not only need to integrate all vertical disease control programmes, it must also cover at least the preventive, promotional and curative services given in the NHM framework document.**
- ii. The NUHM Framework of Implementation provides for one regular and one part-time medical officer for an UPHC. While this is acceptable as a starting position given resource constraints, there must be the flexibility to add on one more medical officer if the regular outpatient clinic is over 50 patients per day (not counting those coming for immunization, or just to collect medication). Thus most UPHCs that are even moderately functional will over time have at least three medical officers, of whom at least one will be male and one female, with minimum qualifications of MBBS. There would also be one medical officer trained in Indian Systems of Medicine, in states where co-location is the accepted strategy.
- iii. **Each UPHC will also have a Help Desk and Counselling Centre run by a trained social worker, preferably a medical social worker.** Her/his duties will include to advise and support the patient, offer advice about preventive and promotional health such as clean water and sanitation, breast-feeding, child rearing practices, life-style issues and occupational health. The social worker will have special duties to support survivors of violence, children without adult protection, old and disabled persons. This position will be filled by social workers placed on deputation from urban poor collectives, organisations which are part of Jan Swasthaya Abhiyan network ( a health rights network) , or other reputed health rights NGOs.

- iv. **Each UPHC will be equipped with basic diagnostics, and for the rest it could be site for collecting samples and conveying the results.**
- v. The NUHM framework does not currently envisage any beds at the UPHC level. Though this could be the starting norm for the present, the TRG recommends that for certain situations and services (especially where secondary services are not there or are overcrowded), the UPHCs should be “Upgraded” over time. Upgraded UPHCs could have twelve bed facilities, for short term hospitalisation, uncomplicated deliveries, recuperation, drug de-addiction, and sometimes for special referral services, given below. Such attention should also be given to mental health conditions, which are often co-morbid with other health challenges.
- vi. Referral mechanisms from UPHCs to secondary and tertiary health care centres need more systems in place. Patients so referred should receive facilitation at the higher facility. For example referred patients could have a green card which ensures that a help desk attends to them, helping them navigate the complex hospital terrain for meeting the right doctor and getting diagnostics done on a fast track basis. Or an amber card could allow them access to collect their regular medication or get a more complex dressing done, without going through the queue and so on. Another important component of referral is the feedback from secondary and tertiary care facility to the primary care provider so that follow up in the primary care centre is enabled.

To enable such continuity of care and to assure quality of care the development and dissemination and use of standard treatment protocols for all major ailments affecting urban populations, should be strictly adhered to. Correspondingly, generic medicines should be listed and purchased for all these ailments, and sufficient stocks of these medicines should be available at all UPHCs at all times. Here it is important that critical areas like mental health are not ignored. There is a need for both training in mental health issue for all UPHC doctors and nurses and enough stocking of mental health medicines in nursing centres and UPHCs.

- vii. **Other than referrals to higher facilities- UPHCs should have two way referral linkages with a number of supportive health care facilities. These include for example a) designated Public Poly-clinics or specialised diagnostic clinics b) Free residential and out-patient 20 bedded Drug De-addiction Centres c) Free residential 20 bedded mental health care recovery centre d) Nutrition rehabilitation centres e) Homeless recovery shelter; f) palliative care centres and hospices. (See figure below)**

**Fig. 1 Comprehensive Referral Alternatives from UPHCs'**



- viii. Attempt must be made as far as possible to redeploy, extend and refurbish existing infrastructure, rather than create fresh infrastructure. The facility mapping undertaken would indicate available public health institutions, including state government and ULB dispensaries and hospitals, CGHS clinics and ESIC hospitals. There should be clear central government guidelines that all these health institutions should be regarded as a common pool to ensure over time universal primary health coverage in urban areas. Since a great number of these existing facilities would be located in non-poor areas, UHM can invest in additional rooms, staff, equipment and drugs in these institutions to provide UPHCs in these non-poor areas at relatively low levels of initial investment.
- ix. Imaginative use can be made of the existing physical health infrastructure for the UHM. **Most of the above facilities as well as out-patient premises of medical colleges are usually vacant in the evenings, which is the most useful time for health-seeking by urban poor populations. These spaces should be used for running poly-clinic OPDs as a first referral from UPHCs. These could also be**

**deployed on Sundays such as for special geriatric clinics.** Where UPHCs and secondary hospitals are crowded and busy a second shift OPD from 3 pm to 9 pm, with a separate contingent of health personnel, may be able to reach the poor much more effectively.

- x. Unless an existing building is available in the slum, typically each slum UPHC will be prefabricated strong and secure structures, which have the additional quality of being quickly constricted and easily dismantled and relocated if necessary. No relocation will be permissible without the prior creation of a fully functioning UPHC in the relocation site.
- xi. In designing UPHC and other health infrastructure, care should be taken from the start to make these disability-accessible. It is always more costly to try and make facilities accessible after they are constructed fully. Also we will need to go beyond the ramp and the rail here. Accessibility is not merely important for physically disabled persons, but for persons with other disabilities as well. The standard designs for UPHCs require some relooking at from the point of view of accessibility (including safety and maximal utilization of all services within the facility). Simple things like good visual, colour coded signage, rails at important places, height of counters, grab handles in toilets etc. will actually be useful for all people and not just children and persons with disabilities. Universal Design Guidelines prepared by the International NGO Partnership Agreement Programme are given in Annexure 5.
- xii. All urban medical colleges are required to have urban health centres as a field practice site, and this is administered under their public health programme. This must not only be reiterated, it should not duplicate coverage by other urban PHCs and it should demonstrate how services are delivered efficiently and effectively. These are to be used for training of medical graduates and postgraduates on primary care and its organization. Effective and willing medical colleges could be incentivised and given administrative control of cluster of urban PHCs. The urban PHCs along with one of the secondary health centre, should be community outreach program of the medical college as a whole with rotation of doctors from all departments and not community medicine alone.
- xiii. In addition, UPHCs in partnership with local medical colleges located in urban area should be required to conduct a survey of special occupational health problems of urban populations in the specific catchment of each UPHC. It may be found, for instance, that head-loaders suffer from particular spinal and orthopaedic problems; workers in stone quarries from respiratory problems, and so on. Such attention should also be given to mental health conditions, which are often co-morbid with other health challenges. Medical colleges will train the doctors in these health problems again in compulsory 3 month modules. Specialists in medical colleges will also be available for visits to the UPHC, or referral clinics in the medical colleges or

weekly tele-medical conferences with all PHC doctors for any complicated cases for which they wish for guidance.

- xiv. For ensuring the adequate availability of quality of care in all public health facilities ranging from the UPHC to the medical college hospital, a number of system strengthening measures are required. These have been detailed in section 4- and cover human resources, quality assurance systems, drugs and supplies logistics and the architecture of public health information systems.
- xv. Each of the major national health programmes- especially RNTCP and vector borne disease control programmes, National AIDS Control Programme, leprosy control programmes as well as the National Mental Health Programme (NMHP) have urban specificities and on these also some recommendations have emerged. ( see sections 4.12 to 4.16)
- xvi. While staffing UPHCs, care will have to be taken to not further starve Rural PHCs of trained health personnel. **The salaries of Urban PHCs should not be higher than that of Rural UPHCs. There should be a ban on all forms of private practice by doctors serving in public health facilities- along with non practicing allowances which assurance of a reasonable pay package.**
- xvii. Finally, inadequate attention is given to wellness and promoting healthy lifestyles. This is partly the case because the health system is heavily tertiarised and attention given, correspondingly to drug, diagnostics and care. There are structural requirements for health promotion, including access to information, as well as health-promoting products, activities, and spaces that tie in with other urban governance issues. These have to be duly addressed. Public spaces for wellness, exercise, recreation should be considered a public health priority. Synergy across departments and ministries, including sports and youth development, women and child development, urban development as well as AYUSH, can help to ensure that such spaces are available, appropriately maintained, accessible and optimally used by the urban poor.

### **9. 7. Community Processes, Transparency and Convergence**

- i. At the level of each UPHC, there should be an Empowered Local Health Committee called the Jan Arogya Samiti (JAS), with the local elected ward member, and representative of each of the occupational groups in the catchment of the UPHC and of the chairpersons/representatives of the Mahila Arogya Samitis (MAS) of the area. If there are a large number of MAS under a UPHC catchment area, then The JAS could take one representative from each cluster of 3 to 4 MAS. The majority would be women, but because the UPHC provides comprehensive health services to the entire population including large and vulnerable single male populations, there could be a

maximum of 25 per cent men represented in the JAS. Other than this we should ensure that at least 25 per cent JAS members will be below the age of 30 years, and 25 per cent above the age of 60 years. The Social Worker appointed in UPHC would be an observer in Local Health Committee and help perform the secretariat function of the JAS.

- ii. The Mahila Arogya Samiti would be established in the neighbourhood level- as envisaged in the NUHM Framework. The selection would be in the pattern of Kerala's Kutumbshree, beginning with a neighbourhood area being constituted out of compact groups of 10 households each, and they would select a member. There would usually be one MAS for every 500 population- which means about 10 members. In the few instances where the majority of households in a neighbourhood are of single men, then the representative would be a man. The ASHA is the convenor and the FHW or MHW of the nursing station/sub-health centre would be an observer.
- iii. In areas currently not served by UPHCs, the option is to construct these as Ward Arogya Samitis that links or federates the MAS in that ward area.
- iv. The stated objectives of the JAS would include 'optimising use of the existing health services and suggesting ways of improving them' as well as 'addressing the social determinants of health'. Wide experience, including of the Mitandin experience in Chhattisgarh has shown that community involvement *before* the implementation of the medical initiative is crucial for 'community ownership'. Developing a social worker/health counsellor-NUHM interface may be the way to go for this component, to be created *as the first step* of implementation of the NUHM. (Even with low fund allocations as of now, it would be possible to undertake this.)
- v. Each Jan Arogya Samiti on the other hand will prepare a UPHC Community Health Plan, based on an assessment of the social and economic profile of the catchment area, and their specific health burdens and health needs. These would include also the non-curative health determinants of health. They would also conduct yearly social audits of the services extended by the UPHC, and it will be the duty of the City and State Urban Health Mission to study and introduce correctives in response to these social audit reports, and will place their action-taken reports in the public domain.
- vi. The stated objective of a MAS is more mobilisational, providing support to the ASHA in her work and also being an institutional mechanism of reaching her and receiving her services, and through her all other primary care services.
- vii. Each Jan Arogya Samiti will working closely with the MAS and ASHAs in that area also recruit Community Health Volunteers and peer educators from among young

women and men in the settlements; and also recent retirees. They will not be paid, but will provide special services, such as accompanying and home care for the aged and disabled, health counselling, preventive work for vector diseases and NCDs, and so on. They can also be trained for morbidity mapping, and also for extending voluntary or modestly paid home-based services for the aged or disabled.

- viii. Like in the rural areas, the ASHAs would be a major component of the community processes. Their selection must be based on a cluster of MAS making the selection, helped by a facilitator, and then getting it endorsed by the ward committee. Age criteria can be increased to 12<sup>th</sup> because potentially more women with such qualification are available, and because they can go onto becoming community health nurses. But if the community finds a less or qualified woman more suitable, education alone should not be a barrier.
- ix. Unlike in the rural area, from the outset there may be more expectations of her in facilitating access to a wider range of services. RCH services however would be the priority. Other emerging roles include assisting patients to navigate the secondary and tertiary care hospital and safeguarding the interests of those enrolled in an insurance programmes – in terms of securing cashless health care services as an entitlement, without unnecessary care.
- x. Given the increasing range of work expected from the ASHA, if the work load approaches 25 to 30 hours per week, then a regular adequate compensation becomes essential and NUHM needs to provide for it.
- xi. There will be a major role for health literacy by the community health volunteers, peer educators, ASHAs, nurses, MPWs and staff of UPHCs. Functional inaccessibility or inability to navigate health system has been identified as the key barrier for health services utilization especially for urban poor. 'Health literacy' has been advocated by the WHO as a tool to overcome this. World Health Organisation describes health literacy as 'the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health'. **Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve health. Health literacy has following key domain; 1) Feeling understood and supported by healthcare providers, 2) Having sufficient information to manage my health, 3) Actively managing my health, 4) Social support for health, 5) Appraisal of health information, 6) Ability to actively engage with healthcare providers, 7) Navigating the healthcare system, 8) Ability to find good health information, 9) Understand health information well enough to know what to do. Health literacy can be a vital tool for community empowerment as well as monitoring of functioning of health care system.**

- xii. Successful establishment of community processes and their institutionalisation requires good support structures and mechanisms and close linkages and support from NGOs. It also requires accredited training institutions and trainers for ensuring quality of training. It also requires absorbing pre-existing community health workers into the NUHM design re-assigning them appropriate levels and functions and providing them with new skills where required.
- xiii. For necessary transparency, the UHM will notify minimum necessary information on websites and notice boards about the functioning of the UPHC, including guaranteed services, patient load, disease patterns, drug availability and distribution, staff availability and attendance, and disease and mortality patterns.
- xiv. There should be a clear budget line for grievance redressal systems, along with standards and operational guidelines to ensure that these are set up soon and become well functional.

**9.8. Meeting the Challenges of Convergence:**

- i. There are a large number of public services and duties which have a direct and immediate bearing on urban health. In each of these areas- whether under the direct control of the municipal health officer or not, the health department has an important role to ensure the health of populations.
- ii. These are listed below in Table 6.1 as follows:

**Table 6.1 Distribution of Public Services and Duties as Observed in TRG Fieldwork**

<i>Under Municipal Health Officer</i>	<i>Under municipal health officer in some cities- but separate departments in the others</i>	<i>Under other departments always- but health department having important roles to play</i>
<ul style="list-style-type: none"> <li>• Disease surveillance &amp; Epidemic control</li> <li>• Vector control</li> <li>• Dangerous and offensive trade, licensing ( in particular slaughter house management , health safety in cinemas, restaurants etc)</li> <li>• Food safety.</li> <li>• Birth and death registration.</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment and disposal of sewage</li> <li>• Solid waste management including carcass disposal</li> <li>• Biomedical waste management</li> <li>• Drinking Water supply</li> <li>• Sanitation and Prevention of public health nuisance</li> <li>• Control of stray dogs- rabies control.</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated Child Development Services</li> <li>• School Health</li> <li>• Implementation of welfare schemes for vulnerable populations – especially the homeless.</li> <li>• Housing schemes.</li> <li>• Road Safety.</li> <li>• Food security programmes</li> </ul>



	<ul style="list-style-type: none"> <li>• Air Pollution Control (often under pollution control board)</li> </ul>	
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iii. In each of these above 18 areas there is a specific contribution for health officer to make. These have been detailed in the main text.

iv. The few general recommendations for these non-medical public health interventions are:

a. In each of the above 18 areas there are some cities which are a best practice site- and there are good learning's from most sites. Also in each of these areas new technologies have made a major difference in the last one or two decades and city health officers have little access to such knowledge. **An active technical support arrangement that is able to help urban areas learn from these best practices and adapt it to their needs would have an immediate impact.**

b. Even where municipal health officers are not directly in charge of this area, they should monitor the provision of these services- and co-relate it to disease incidence/prevalence. They could also use disease outbreaks to feedback to the providers of these services and thus close critical gaps- for example tracing the source of a hepatitis outbreak, dengue outbreak to vector breeding, or co-relating sudden increases in asthma and acute exacerbation of chronic respiratory illnesses to air pollution, rabies and dog bite incidences to stray dog control, or road accidents to road safety measures and so on. There are some good examples of this- but far too few.

c. In particular, the UHM should regularly report to the local body and state governments about disease patterns linked with environmental causes, such as water contamination or over-crowding, and it should be the duty of the state and municipal governments to incorporate and report back on corrective measures to prevent further health consequences, such as by introducing piped water supply or underground sewerage.

d. User fees even for these services have adverse consequences. In particular the prohibitive costs in public toilets and baths needs to be withdrawn- and alternative institutional mechanisms of maintaining this found. There is however considerable demand for public toilets now (as compared to a decade or two earlier) and a major programme to expand this would be well received.

- v. Convergence with ministry of social welfare, urban development, education and other relevant departments at primary level is essential, and mechanisms for this will need to be developed both at city municipal and state levels. Services such as drug de-addiction services, homeless shelters, drop-in shelters and residential hostels for homeless street children, short-stay homes for survivors of domestic violence, and many other such social infrastructure, are critical components of a comprehensive health response system.
- vi. Growing of medicinal plants and herbal gardens in all public parks and open spaces in urban areas should be encouraged. Studies indicate that the poor are using medicinal plants for their health needs even in urban areas. There is continuing wide use of herbal home remedies, especially by the migrants who retain links with rural areas, and a revival among the middle class. However, the poor are losing the free access to plants that they did have in urban areas as the natural green areas are disappearing and only ornamental parks are being created instead. This must form a part of the primary level health care that is being assured to the poor.
- vii. Public spaces for wellness, exercise, recreation should be considered a public health priority. Synergy across departments and ministries, including sports and youth development, women and child development, urban development as well as AYUSH, can help to ensure that such spaces are available, appropriately maintained, accessible and optimally used by the urban poor.
- viii. Health impact assessments need to be included as part of all large scale urban health development efforts. The methods and capacity to undertake this needs to be developed and SHRCs working in tandem with public health schools working in multi-disciplinary university or research institute settings may need to pioneer this. Also large scale urban projects must go along with measures that ensure occupational safety and healthy working and living conditions for the huge inflows of labour they create.

### **9.9. Governance and Financing**

- i. The NUHM framework for implementation and the 12<sup>th</sup> Five Year Plan, envisaged a certain minimum public health expenditure. The single most important requirement is to make this level of funding available to the urban areas.
- ii. There is a need for a carefully planned advocacy to improve both municipal and state government financing for the scheme. ULBs must be encouraged to spend 10 % of their budget and state governments 5% of their budgets on health- and proportionately urban health would benefit.

- iii. In metropolises, both the medical and non-medical aspects of public health will be managed by Municipal Corporations. In others, the medical services will be managed by state governments, but non-medical services in the main would continue to remain under the city health officer and the urban local body.
- iv. There is a need to provide for adequately staffed and technically supported programme management units to all city health societies- both for the organisation of health care services and for non-medical aspects of public health.
- v. State departments of health and urban local bodies must both take active interest in the role of the city health officer and its multiple roles. There is a need to ensure that a person with good public health experience and qualifications, backed by a robust technical support mechanism, leads this office.
- vi. **All primary care services and curative care services from public hospitals, including essential drugs and diagnostics will be entirely free and cashless. No user fees of any kind will be chargeable. The immediate step forward would be a clear policy articulation in this regard.**
- vii. A clear commitment to employ in a sustainable and well supported manner the minimum public health workforce needed to deliver all primary health care services is a must. However the deployment of human resources must match requirements – as assessed by actual case loads and nature of services needed- so that there is no under-utilisation of human resources at any level.
- viii. **All UPHCs will be ordinarily managed by public authorities. The only exception will be where the state government decides to allocate responsibilities for these to urban poor collectives and unions, youth and women collectives, and reputed not-for-profit NGOs.**
- ix. If the NUHM resource envelop provided is much less than the 12<sup>th</sup> Plan or NUHM framework projections, then there is a need to phase inputs. This could be done in terms of number of UPHCs sanctioned. When a UPHC is sanctioned it should imply the funds required for not only the UPHCs, but the nursing stations, and ASHAs and JAS and MAS that go along with it. This would include the special services required by vulnerable groups also. Most cities already have some experience of it when they outsource UPHCs to NGOs. The challenge now is to greatly increase the package of services delivered in line with the NHM framework as well as learn to spend and account for resources allocated on these lines to public facilities.
- x. Financing to tertiary care facilities from NUHM would be largely limited to improving and facilitating access as part of continuity of care from the primary care centre- especially for the vulnerable.

- xi. Funding to secondary care hospitals from NUHM budget should be proportionate to the case loads being managed. Within this maternity hospitals would have a priority and hospitals that are known to cater to large numbers of poor population must also be prioritised. Without such case load based additional financial support, these hospitals will be unable to limit out of pocket expenditure on drugs, supplies and even fail to manage hygiene and safety.
- xii. In order to institute effective checks on over-medicalisation which is a likely outcome of the implementation of free drugs, a strong regulatory machine needs to be in place, including steps to promote rational and ethical practice by all doctors-- public and private--must be initiated *before* the NUHM is implemented. The experience of the NRHM itself shows the impact of a pre-existing private sector and its malpractices that act as barriers to strengthening the rational public services. In the urban areas this influence is likely to be even greater, and therefore must be checked. While the mechanisms may be created as the NUHM progresses, building in mechanisms in the framework of the NUHM is important if it is not to become a vehicle for expanding the commoditised healthcare that is pervasive in the health services today.
- xiii. Engaging the private sector is a major goal- and one must recognise that the many of these clinics are providing primary care to the poor. Involving them in quality circles, providing access to free drugs from the nursing station cum sub-health centres and free diagnostics and referral support at polyclinics and urban public secondary hospitals, training inputs, their participation in disease surveillance measures- would all help to use their efforts towards achieving public sector goals. Implementation of the clinical establishments act to improve quality of care is also an essential part of engaging with the private sector, but while taking caution against escalation of costs or even decreasing access to services. Insurance currently covers only secondary and tertiary level hospitalization and here there is a need to protect the poor from unnecessary care or denial of services. Insurance currently plays no role in primary health care and we do not envisage such a role for it in the immediate future as well.

## **9.10. Conclusion**

The Urban Health Mission aims to offer universal health services to all urban populations who seek health care, but the TRG is convinced that the pivot of all its design architecture must be ensuring free, high-quality, geographically and socially accessible, respectful, and comprehensive primary health care services to all urban poor populations. This must be the talisman and the ultimate benchmark for all health services.

In one of the last notes Gandhi left behind in 1948, he wrote: "I will give you a talisman. Whenever you are in doubt, or when the self becomes too much with you, apply the following test. Recall the face of the poorest and the weakest man whom you may have seen, and ask yourself, if the step you contemplate is going to be of any use to him. Will he gain anything by it? Will it restore him to a control over his own life and destiny? ... Then you will find your doubts and yourself melt away." Today we would replace "man" with "woman", but otherwise there could be no better guide as we set out to make decisions about the design of India's Urban Health Mission.

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- Based on local situation the cities may manage this distribution by establishing some UPHCs for 75,000 population, and can also establish one UPHCs for even as low as 10,000 population for a specifically vulnerable or isolated slum cluster. (see para 7.15.1 of NUHM framework for implementation)

## Annexures

### Annexure-1 TRG Members

1. Mr. Harsh Mander (Chairperson)
2. Ms. Poonam Muttreja, Executive Director, PFI.
3. Dr. Vandana Prasad, New Delhi
4. Mr. Biraj Patnaik, New Delhi
5. Ms. Radhika Alkazi, New Delhi
6. Mr. Bejwada Wilson, New Delhi
7. Dr. Shekhar Sheshadri, NIMHANS, Bengaluru
8. Ms. Vandana Gopikumar, Chennai
9. Mission Director, JnNURM and Joint Secretary, Ministry of HUPA, New Delhi
10. Joint Secretary (ICDS), Ministry of Women & Child Development, New Delhi
11. Joint Secretary (NUHM), MoHFW
12. Principal Secretary (HFW), Govt. of Maharashtra
13. Principal Secretary (HFW), Govt. of Uttar Pradesh
14. Secretary (HFW), Government of NCT of Delhi
15. Smt. Gayatri Rathore, MD (NRHM), Government of Rajasthan
16. Shri Prateek Hajela, MD (NRHM), Government of Assam
17. Shri Vikram Kapoor, Commissioner, Chennai Municipal Corporation
18. Shri. Khali Ahmed, Commissioner, Kolkata Municipal Corporation
19. Dr. Arun Bamne, Executive Health Officer, Municipal Greater Mumbai
20. Dr. C.S Pandav, Professor & Head, Centre for Community Medicine, AIIMS, New Delhi
21. Dr. Sudhir Gupta, Addl. DDG, DGHS
22. Dr. Anil Kumar, CMO, DGHS
23. Dr. Antonio Duran, WHO
24. Dr. A. Gunasekhar, Technical Officer, WHO
25. Dr. T. Sundararaman, NHSRC, New Delhi                      Member convener

## Annexure-2

### Members of Working Groups

#### **Working group 1**

1. Mr. Harsh Mander
2. Ms. K. Anuradha
3. Dr. Kishore Kumar.
4. Dr. Ratnaboli Ray
5. Dr. RadhikaAlkazi
6. Dr. Sainath Banerjee
7. Dr. Tariq Mohammad
8. Dr. Nisreen Ebrahim
9. Dr. Gautam Bhan
10. Dr. Praveen Kumar Gurunath
11. Dr. Amita Joseph
12. Dr. V. Augustine
13. Dr. Sudipto Chatterjee
14. Dr. Devaki Nambiar – Convenor

#### **Working group 2**

1. Dr. Poonam Muttreja
2. Dr. SCL Das
3. Dr. Vikas Desai
4. Dr. Kapil Yadav
5. Dr. Chanderkant Lahariya
6. Dr. Ritu Priya
7. Dr. Rajib Dasgupta- convenor
8. Dr. Sanjay Pandey
9. Dr. Vandana Prasad
10. Dr. K Chaudhary
11. Dr. P. Kuganatham
12. Dr. Shashank Vikram
13. Dr. Suresh Mohammad
14. Dr. C S Pandav
15. Dr. Anil Kumar
16. Dr. Ganapathy Murugan
17. Mr. Augustine Veliath
18. Dr. Geeta Pillai
19. Dr. K. Shashikala
20. Dr. Nirmala Murthy
21. Dr. Mukesh Kumar Sharma

22. Dr. Ratnaboli Ray

### **Working group 3**

1. Dr. Bijit Roy
2. Ms. SulakshanaNandi
3. Dr. Swati Mahajan
4. Dr. RakhalGaitonde
5. Dr. Anjali Chickersal
6. Dr. Satish Gogulwar on Behalf of Dr. Abhay Shukla,
7. Mr. Somayajulu
8. Dr. Phanendra Babu
9. Ms.Indu Capoor
10. Mr. V R Raman
11. Dr. Pradeep
12. Dr. ArundatiMuralidharan,
13. Ms. Reshmi Mohanty
14. Ms. Sona Sharma
15. Mr. Arun Srivastav,
16. Ms. Jyoti Jagtap
17. Dr Rajani Ved- Convenor

### **Working group 4**

1. Dr. Sundararaman
2. Dr. A Gunasekar
3. Dr. Antonio Duran
4. Dr.Ravi Duggal
5. Dr. Soumitra Ghosh
6. Dr. Krishna D Rao
7. Mr. Pallav Bhatt
8. Dr.V R Muraleedharan
9. Dr.N Devadasan
10. Dr.Gautam Chakraborty
11. Dr.Shankar Narayanan
12. Dr.Samik Choudhary
13. Dr.MitaChowdhury
14. Mr.V R Raman
15. Dr.Chandrakant Lahariya
16. Dr.Moneer Alam

## Annexure-3

### A. Template for U-PHC

#### Proposed Human resource at URBAN PHC

#	Staff Category	Number proposed under NUHM framework	As suggested by TRG
1	Medical Officer	2 (1 regular and 1 part time)	Both should be regular with flexibility to add on one more medical officer is the regular outpatient clinic is over 50 patients per day
2	Staff Nurse	3	3
3	Pharmacist	1	1
4	Lab Technician	1	1
5	Public Health Manager/ Community Mobiliser	1	1
6	LHV	1-2 Depending upon number of ANMs	2
7	ANMs	4-5 * Depending upon the population	There should be one ANM per 5,000 population
8	Secretarial Staff including for account keeping and MIS	2	2
9	Support staff	1	1
10	Social Worker	0	1

#### Package of Services

The assured services provided by staff of U-PHC are as follows.

##### 1. Reproductive and Child Health

- i. Care in pregnancy- all care including identification of complications, but excluding management of complications requiring surgery or blood transfusion.
- ii. All aspects of Essential Newborn Care

- iii. Care for common illnesses of newborn and of children- identify, stabilize and refer life threatening conditions beyond the approved skill sets of the mid level care provider.
- iv. Immunization
- v. Universal use of iodized salt.
- vi. All aspects of prevention and management of malnutrition, excepting those that require institutional care.
- vii. All family planning services except female sterilization.
- viii. Provision of safe abortion services - medical and surgical.
- ix. Identification and management of anemia,
- x. Common sexual and urogenital problems which can be treated syndromically, or diagnosed with point of care diagnostics, and identification of those which need referral.
- xi. All public health measures that lead to improved maternal and child survival and lower RCH morbidity.
- xii. All health education and individual counselling measures needed for promotion of desirable health behaviours and health care practices and change from inappropriate health care practices and behaviours, related to RCH.
- xiii. All activities under the RashtriyaBalSurakshaKaryakram- at Anganwadi and school level
- xiv. All laboratory support needed for the same.
- xv. Patient transport systems that can bring and drop back patients for example sick infants up to one year of age, institutional delivery, for disability, and address problems of access due to lack of transport.

## **2. Emergency and Trauma Care**

- i. Prevention and appropriate management for bites and stings- snakes, scorpions, wild animals.
- ii. Management of poisoning, including food poisoning.
- iii. Complete first aid including management of minor injuries
- iv. Stabilization care in poisoning and major injuries and ensuring referral through emergency response systems.

## **3. Control of Communicable Disease**

- i. Screening for leprosy, referral on suspicion, and follow up of cases with confirmed diagnosis and prescribed treatment.
- ii. Referral of suspect tuberculosis, family level screening of known patients, and follow up of cases with confirmed diagnosis and prescribed treatment.
- iii. HIV testing, appropriate referral and follow up of specialist-initiated treatment.

- iv. All measures for the prevention of Vector Borne Diseases; early and prompt treatment for these diseases, with referral of complicated cases.
- v. Control of helminthiasis.
- vi. Reduction in burden of waterborne disease, especially diarrhoea and dysentery, typhoid and water borne hepatitis, prompt and appropriate care leading to reduction of mortality and morbidity due to these diseases.
- vii. Reduction of infectious hepatitis B and identification and referral for the same.
- viii. Primary care for other infectious diseases, presenting as fever especially ARI, UTI with referral where institutional care is required or where diagnosis is not ascertained.

#### **4. Non-Communicable Disease**

- i. Screening for breast and cervical cancers in all women over the age of 30 and oral cancers in all males.
- ii. Screening for mental disorders, counselling, and follow up to specialist initiated care.
- iii. Detection of epilepsy and stroke and follow up to specialist initiated drugs and rehabilitative measures.
- iv. Screening for visual impairments, correction of refractive errors and referrals for the rest.
- v. Screening for diabetes and hypertension in all population above 30 annually.
- vi. Ensuring follow up on doctor initiated drugs in diabetes and hypertension- and secondary prevention – so that no complications develop.
- vii. Prevention – primary, secondary and tertiary preventive care in rheumatic heart disease. (prevention of rheumatic disease, prevention of rheumatic heart disease, and prevention of mortality and excess morbidity in rheumatic heart disease).
- viii. Primary and secondary prevention in COPD and bronchial asthma, with provision of follow up care in patients put on treatment by specialists.
- ix. Counselling and support to victims of violence.
- x. De-addiction services as preventive measures against all harmful addictive substances- tobacco in the main, but also alcohol and addictive drugs.
- xi. Community based geriatric care support.
- xii. Preventive and promotive measures to address musculo-skeletal disorders- mainly osteoporosis, arthritis of different types and referral or follow up as indicated.
- xiii. Community based rehabilitative and disability care support

#### **5. Special Services for Vulnerable (not in all but some chosen U-PHCs)**

- i. Recovery shelter



- ii. Community based nutrition rehabilitation centre
- iii. Drug de-addiction centre
- iv. Mental Health Rehabilitation Centre

### **B. Template for Nursing station and sub-health centres**

#### **Proposed Human Resource at Nursing station and sub-health centres**

Staff Category	Number
Female Health Worker	2 (one female health worker per 10,000 population)
Male Health Worker	1
ASHA worker	5 ASHAs per Nursing station and sub-health centre

#### **Package of Services**

##### **a. Outreach services**

- i. Health and nutrition counseling
- ii. Health literacy activities
- iii. Preventive and promotional health activities
- iv. Vaccination
- v. Ante-natal care services

##### **b. OPD Care**

- i. Supply of drugs- for TB, mental health problems, leprosy, hypertension, diabetes, epilepsy, asthma and some other NCDs
- ii. Dressing of wounds

##### **c. Counseling for substance abuse**

##### **d. Domiciliary care for disability, geriatric and palliative health care**

## **Annexure 4**

### **Homeless Recovery Shelters**

#### Introduction: The Need of a Health Recovery Shelter

The idea for a health recovery shelter for homeless people arises out of the need to address the large burden of disease and chronic illness afflicting this population. One major fallout of too few functional public health centres to respond to the needs of these people -- and problems in access to ones that do exist -- is the prevalence of deaths on the streets.

Our compilation of police records shows that 174 homeless people died in ten locations in New Delhi in the first three weeks of January 2014 alone. The average age of the deceased was 41.7 years, indicating that life on the streets claims people at their prime. While the media reports homeless deaths each winter as complications arising from the inability to withstand the cold, studies at the Centre for Equity Studies shows that death rates are even higher in the summer. It is possible, however, to generalize that a large share people succumb to weather conditions after months or years of compromised immunity due to chronic health and nutrition ailments in absence of proper care.

Homeless shelters for men and women in response to the 2010 Supreme Court directions are coming up in many cities, and ailing residents of these shelters can be directed to primary, secondary and tertiary care services as needed. A mobile street medicine unit maybe devised additionally to find and treat dispersed homeless people on the street and, in cases of need, link them to care provided by existing public hospitals.

Even after homeless persons are admitted to these hospitals – which is in itself a struggle- they are discharged eventually with advice to go back to your family and rest at home. But what happens to homeless persons and single migrants who have no family and no home. Our studies indicate that often simple injuries become permanent disabilities; and people die in the heat and the cold of curable ailments like TB.

The recovery shelter is devised as a place for homeless patients to obtain follow up care after being discharged from the hospitals. The objective of the recovery shelter, therefore, is to provide patients a safe and clean environment with trained medical and nursing staff to restore their health to full capacity so they can lead be restored to good health and lead a dignified and productive life.

### Rationale: Filling Gaps in the Existing Public Health Infrastructure

The normal process of care for a patient who is treated in a hospital can be characterized by two phases. The first is curative care. The patient receives treatment from a doctor and a staff of nurses. When the patient is stabilized, the doctor discharges the patient from the hospital. This does not mean the patient has fully recovered. Only, that the patient may receive further treatment at home, including additional visits to the doctor, and as importantly, rest in a clean and safe environment. This phase is referred to as ambulatory care. For people on the streets and also other single migrants, both types of care are difficult to access. The mobile street medicine unit provides the link between the patient and public health institutions for primary care. The health recovery shelter provides a safe environment where a trained doctor and nurses monitor and administer medications, food, and counseling. Filling this gap is essential in the cases of patients suffering debilitating and widespread diseases like tuberculosis. Treatment for TB is undergone at the home. Homeless people are prone to succumbing to such diseases on the streets in absences of diagnosis, the lack of clean environments, and habits such as drug and alcohol use that exacerbate the symptoms.

### Services Offered

The health recovery shelter provides medication, nutrition, nursing care, and referral services (linkages to public hospitals, or ambulatory care) for 30 persons at a time. The shelter houses infectious disease patients and those who've suffered physical injuries. The majority of infectious disease cases are tuberculosis, pneumonia, lung diseases, liver disease, and bronchial asthma. We also treat some HIV cases and in a few cases, men who suffer both HIV and tuberculosis. The majority of physical trauma cases are caused by road accidents. Some people suffer from tropical ulcers, or initially innocuous abrasions that become inflamed and infectious due to living conditions and habits on the streets.

2 nurses provide three meals a day to each patient, equivalent to 1,800 calories. The meals include rice, vegetables, roti, dal, or porridge, and also eggs and milk if resources permit. The nurses also monitor vital signs and hygiene (bathing, nail cutting, hair cutting, shaving, and sponging), document each patient's progress through detailed files, and monitor the referral services.

The referral service is a vital component of this program. A volunteer or caretaker is assigned a patient and is responsible for taking the patient to the hospital where he was originally diagnosed and discharged. In cases of emergencies that occur at the shelter, which may or may not be life threatening, the caretaker or volunteer is responsible for attending to that patient immediately, which includes notifying the nurse and doctor, and taking the patient to his assigned hospital.

Currently, the shelter lacks diagnostics, which is also integral to the range of required care.

### Staffing:

#### **Current**

A medical social worker is envisioned as the coordinator of institution, who is responsible for monitoring all linkages to public health institutions and establishing networks and relationships with a range of special care providers and specialists, which could assist the patients in diverse ways. They would also be responsible for non-medical aspects of treatment, including providing psychosocial care, or linking patients to such care.

Each recovery shelter should have one visiting doctor who monitors cases of patients and checks their status on a daily basis. He also runs a clinic just outside the shelter, which is open to homeless men in the area. There are cases of men who are admitted to the recovery shelter through the clinic, as well as men who come from the streets to the clinic and are taken directly to one of the nearby hospitals for immediate treatment. Each day, the doctor sees patients in the recovery shelter for an hour.

Assisting the doctor, two nurses per each 8-hour shift provide the range of nursing care. There are also 3 caretakers each, for each 12-hour shift. A cook also provides 3 meals a day.

Caretakers – 3 caretakers each 12-hour shift

#### **Required**

##### Hardware/Consumables

**Supplies:** dressing, forceps, trays, needles, and blades

**Equipments:** beddings, toiletries fans, bulbs, almiras, clothing from donations, stretchers, walkers, crutches, TV, utensils, examination room, examination table, screens.

##### **Medicines**

**Required:** separate toilet and bathing facilities

##### Linkages

**Local secondary and tertiary hospitals, including TB, trauma and mental health facilities**

**Old age homes and Homes for Single Women**

**Drug De-addiction Services**

## Annexure 6

### UNDERSTANDING URBAN HEALTH: A GUIDELINE AND TOOL-KIT

#### Chapter- 1

#### **The Background, Objectives and Outcome**

The National Urban Health Mission (NUHM) seeks to improve access to primary health care in urban areas, with a focus on the urban poor and marginalized vulnerable populations. For designing sensitive, responsive, and relevant urban health policy and action, it is important for planners and programme managers to interact directly with the community and with vulnerable groups for whom the programme is intended. It is also important for them to establish a dialogue with programme implementers and providers at different levels, for they too have much knowledge, a considerable part of which is tacit knowledge and from which the planner must draw upon.

This publication is a tool-kit to assist state programme managers and technical support groups to conduct a rapid assessment and situation analysis that could be used to make the individual city or town health plans. This tool does not cover how these are integrated into the state NUHM programme implementation plan, nor touch upon the drafting of the NUHM PIP for which there are other guidelines.

The plans are being made in a context where public funds are limited and there are large gaps in both access to services and in ensuring financial protection from the growing costs of health care. Moreover there is a growing burden of disease and a rising costs of care that leads to a further worsening of the gaps.

Though the immediate context of the study and the planning is the NUHM, we remind ourselves that in some cities the NUHM contribution is only a small part of their total health budget. Further in all towns and cities there is the potential possibility of raising much larger revenues from the city's own economy and from the state budget and even from philanthropic institutions. And thus once the plan is made the city's leadership can choose how to mobilise resources to meet the health priorities.

We also note that planning is not for the purpose of resource mobilization alone. There are many areas where the main requirement is access to knowledge resources, or technical support and to institutional reform and improved governance. The plan must indicate and inform action in these fronts.

And finally we note, that this is not a study that we recommend for annual situational analysis. This is a base-line study that should inform a city planning effort over a plan period. It could be supplemented by structured sample surveys on access and cost of care in larger cities, but for most towns this would be adequate as a base-line for future evaluations.

**Objectives of the Study/Situation Analysis:**

Thus the purpose of study or situation analysis report must be able to answer the following questions and provide the information on the following themes

- a) What are the health services currently available, to what extent are they being accessed and to what extent are these health services responsive to the needs and context for the poorest and most vulnerable sections of the population.
- b) What is the urban poor doing to cope with their burden of disease and costs of care and their choices regarding both immediate and long-term arrangements required for their health care.
- c) What services do public facilities and providers offer, and what are the limitations/problems they face in expanding the range of services, the access to services, the quality of care and the financial protection of public sector provisioning.
- d) How do we prioritize universal access to primary health care and within this prioritize preventive and promotive health care. What are the institutional structures and community processes that are present and how do we build on these.
- e) What is the health related roles of the urban local body, and how do we enhance their performance. What is the level of contribution/ convergence of health related sectors and how do we improve on this.
- f) How do we engage with different types on non-government agencies and private providers to supplement the capacity of the public health systems, and use their energy and investments to contribute to public health goals?
- g) What is the distribution of roles, responsibilities and powers between the ULBs and state line departments for the governance and management of health and health related services

and the institutional readiness and organizational capacity to deliver and expand on their roles. What is the fiscal space and financial resources made available for urban health?

**The Outcome or Deliverable:**

The immediate end point of situation analysis is a comprehensive urban health review report. The structure of this report is indicated below.

**THE FINAL CITY URBAN HEALTH REVIEW REPORT**

1. Profile and brief social history of city:
2. City Map with locations
3. Population of city - Demographics
4. Slum Population (Notified/de-notified), SC/ST, Religion
5. Growth of the city- by birth, migration and area inclusions.
6. City health budget: Total sources and division between primary, secondary and tertiary
7. Governance of Urban Health Care:
  - i. Roles and responsibilities of Department of Health
  - ii. Roles and responsibilities of Urban Local Body
  - iii. Roles and responsibilities of other departments of health.
8. The Organization of Primary Care – a descriptive note elaborating number and type of facilities and ownership. It would include secondary and tertiary care facilities and their linkage arrangements. The latter are sites of secondary or tertiary care- but also of primary care.
9. Access; Costs of Primary Care: a feedback from the community and vulnerable groups. (This could be before/ after next section. Put in boxes- which at times could be more than a page)
10. The Primary Health Care Centers-
  - a. Services available and the gaps vis a vis the mandate.
  - b. Financial barriers to access.
  - c. Other barriers to access-eg: timing, location.
  - d. Quality of care issues- in terms of effectiveness, safety, satisfaction.
  - e. Quality with reference to infrastructure, staffing, equipment
  - f. Quality with reference to support systems- procurement of drugs and supplies.
  - g. The mechanisms of monitoring and technical support.
11. The Urban Hospital (same sub-headings as for 10 above).
12. The History and possibilities of Partnerships and insurance programmes.

13. Health Related Public Services and their organisations

- a. Sanitation including toilets, sanitation.
- b. Drinking water provision
- c. ICDS and care for the pre-school child
- d. School education and school health.
- e. Food security- PDS, mid day meals, ICDS
- f. Food safety- hotel and slaughter house regulation
- g. Air Safety.
- h. Occupational Health.- special reference to sanitation workers- but also to industry.
- i. Registration of births and deaths,
- j. The management of death- cremation, burial, hearse vans.

14. Perceptions of management, providers and the community on the way forward. The divergences and overlaps with current thinking on urban health care planning.

15. Recommendations- but with reference to what NUHM PIPs are already suggesting.

***Note:** while writing each of the above 15 sections information is drawn upon secondary data, discussion with officers, facility visit, provider and user responses, and community interactions- as is relevant- making it clear what source one is drawing from and discussing the contradictions between perceptions if there are any.*



## Chapter -2

### General Guidelines for the City Health Review:

To write the city health review report, we need to collect different types of information from a number of sources. We have organized the tools required for collection of this information into three sections. Each of these sections has a number of sub-sections.

The three sections are:

#### **Tool- Kit Section 1 : The Focus Group Discussions Guidance Tool :**

This assists a planner to conduct a focal group discussion with vulnerable populations and specific communities. This tool helps define the community group, understand their health needs, current levels of access and barriers to health care, their expectations and their efforts to secure their entitlements.

#### **Tool- Kit Section 2: State Healthcare Services Study Tool:**

To gather information on Organization of Health Care Services and health programmes and other functions of the state health and family welfare departments. This has four parts.

- i. An interview schedule related to management and governance functions.
- ii. An interview schedule for information collection in urban hospital. This also has a section that interviews individual providers.
- iii. An interview schedule for information collection in an urban primary health care facility.
- iv. A semi-structured exit interview or community level interview for a set of 10 patients- which could be outpatient or inpatients.

#### **Tool- Kit Section 3: The Urban Local Body Study Tool:**

To gather information of the functions of the ULB as related to health, its financial contribution and potential to expand this and the services provided under its leadership. This too has two parts. The first part is to the leadership of the urban local body. This same tool could be used with the elected official, the senior generalist administrator and the municipal or city health officers.

The second tool explores the inter-sectoral areas and the respondents are the officers in charge of managing solid waste and sewage, drinking water and sanitation, ICDS and child welfare, and education.

Please note that to get a complete picture on any one area, multiple respondents would need to be interviewed, separately or together, and if in some areas the same question elicits different responses, this too must be recorded. One could use multiple copies of the same questionnaire if the interviews are conducted separately. Or , if multiple respondents are answering as a group, it is recorded in the same questionnaire with variations – usually on perceptions and recommendations- being recorded in.

### **Secondary Data:**

Before setting out on the study, one begins with getting all the secondary information in place. The most common forms of this are reports on health put out by the state department or the city health office. There could also be studies done by local academic institutions- many of which may be unpublished. Plans made under NUHM or to the state government for funds are also valuable sources of information. Basic city profile and demographics are also essential and acquired from reliable secondary sources.

### **Selection of interview respondents and visit sites:**

Based upon available information one draws up a list of the key officers on the state department of health side and of the urban local body. They would help complete much of the state level interview schedules. We would find however that there are significant portions where a single respondent is unable to provide the answers- but almost always, they would be aware of who has to be contacted to provide the required information- and we just need to move from person to person till all the information we need is acquired.

The same principle holds even during the facility visit or community visit. No single respondent may be able to give the required information and we may need to identify more and more respondents till we get the information required.



**Reporting the Information:**

In addition to the instruments for collecting information, these guidelines recommend a final structure of presentation of the information gathered using these tools. The report would include a list of all the documents and notes that have provided inputs.

This tool-kit standardizes to some extent the minimum informational requirements for making a city health plan and a state NUHM plan. To a lesser extent it even standardizes the process of collecting this information. We hope this tool kit is useful to all town/ city health planners and programme-managers.

**Writing up the Report:**

The report is written using the broad outline provided in the first chapter, under the heading deliverables. It draws up information from each of the three primary sources above as well as from secondary data.

## Chapter - 3

### Tool- Kit Section - 1

#### COMMUNITY DIALOGUE AND FOCAL GROUP DISCUSSIONS WITH VULNERABLE GROUPS

##### ▪ Objectives of Community Dialogue/Focal group discussion

1. To understand the community's own perception about themselves and their identity especially, in relationship to marginalization and vulnerability;
2. To gather their experiences with respect to health and illnesses and their health seeking behavior and the response of health care system;
3. To understand their barriers related to access of all health and health related public services;
4. To understand the community's expectations and preferences with regard to the organization and access to health care;
5. To learn the efforts made by the community through organization, or any form of mobilization to improve their health conditions and cope with their circumstances, so that the plan could build on these
6. To understand the processes of convergence between departments and thematic areas, between different levels of community institutions and governance.

##### ▪ Whom to dialogue with:

- Plan for 3 to 5 focal group discussions at least.
- Each group should represent a vulnerability along one of the three axes-
  - Occupational (rag-pickers, sanitation workers, sex workers, domestic workers, unorganized home based manufacture);
  - Housing (homeless, temporary shanties, railway line/canal/sewage line bordering houses, etc)
  - Or Social disadvantage (dalit families, fisher-folk, street children, trans-gender, geriatric age group etc).

- Also, you may in addition, identify some areas by geography/habitation eg: inslum. There could be multiple vulnerabilities.
- Identification and mapping of all vulnerable groups in the city may already have been done. The possible sources for such information are:
  - Municipal office's list of "notified" and "unlisted" slums.
  - Listing of infants/households for polio immunization:
  - Non-Government organizations working with vulnerable populations.
- The choice of which groups to meet could also depend on access. An NGO with past experience in this work would not only help identify them, but also facilitate access to them. Such facilitation is essential for most groups. Facilitation could also be by some group/union/CBO which has contacts and trust in that community. If someone they trust introduces the study team, then it is far more likely that they would be open and forthcoming in the dialogue.
- At least some of the groups identified should have been organized previously as a CBO / association/ union or any other formal or informal collective, through whom we should approach the community.
- In most situations the FGD would be supplemented by a) observations and b) individual in-depth interviews may be done to get a deeper understanding of specific processes.
- The site of focal group discussion is important. Certain vulnerable groups are best brought to a closed room where privacy could be ensured and there are not others crowding around passing comment and sniggering. Also it allows for slow patient discussions. FGDs organized in the middle of slums are noisy and often become chaotic, but they could be much more productive of many types of information. An experienced facilitator or study team makes better choice of sites.
- Advisable to have no more than 8-15 people per FGD. Those organizing the FGD must be familiar with the methods of facilitating the dialogue, steering it into relevant issues, allowing space for the dialogue to evolve and then carefully documenting the discussions in text, and later subjecting it to analysis. In most such FGDs the group is homogenous in that they share the same vulnerability- but heterogeneous in that there are both men and women, both elderly persons and young people, both working population and those staying at home etc.
- It is envisaged that we would spend about 2 days for conducting 4 to 5 FGDs.

### **Organizing the Interaction:**

- The study team should have at least 3 persons- sharing the work. Ideally one person leads the dialogue, maintaining eye contact with the group at all times and not bothering too much on notes. Another is focused on documenting the entire conversation- both on tape and on notes. A third keeps an eye on the interview schedule and the tools, prompting and reminding on areas to be covered. Of course all three would do all these tasks, but one person has the main responsibility.
- Explaining ourselves. To both facilitating agency and the community we need to explain why we are undertaking this dialogue. Clarify that we cannot promise that the changes will all come into existence in the coming months or even years, but their views would be properly articulated and represented.
- Also assure the participants that we do not require names or personal histories and will exclude any information they feel at any point should not be finally included. Only with permission of all involved, would photos or recordings be made – and these would be used only to help us make our case and understand the situation further. If they have any questions or concerns, they can be in touch with us.

## **FGD TOOL**

### **Vulnerable Groups and Community Processes**

#### **1.1 . About Vulnerable People as a Community:**

- 1) From when have you been staying here? Where do you all come from? Same place or distance places? So what brought you together here? How was the community formed? Are there shared roots, experiences, needs that helped create the community?
- 2) Do you identify yourself as being part of a specific community? If yes, please tell which community you belong to? (This question reveals the understanding of members about their community identity with respect to caste, religion, occupation, geography, or any other shared services).
- 3) What is the occupation or occupations that each of you are involved in? Are there any other occupational groups in your area? What do you do to earn a living? Are you employed throughout the year? If not, how many days on an average you work for an year?
- 4) How often do you get paid? (daily / monthly?). How many days per month do you get work/Do you get work?
- 5) What are the activities that you do as a community? (interactions, meetings etc)
- 6) Do you pay rent? How much and to whom? How secure and safe is the house? If the house is owned by you, is the land also owned by you? What are the threats of being displaced from here? Of fire, or floods or physical dangers of any other sort.
- 7) How do you overcome the extreme weather conditions?
- 8) What are the other threats of vulnerability that as a community or as individuals you face?
- 9) Do you associate yourself with any other community organizations? How do these organizations identify themselves?
- 10) Do you have a cordial relationship with others in the neighbourhood and in the community with other groups?



## 1.2 . About Health Issues and Health Services:

- 1) What are the health problems that you face? How frequently do you fall ill? Were you or anyone in your family ill in the last one month? Was anyone hospitalized in the last one year?
- 2) Where did you go to when you went ill the last time? (private or public health centre) Give reasons for why you choose the specific health facility?
- 3) What do you think, are the causes for your health problems?
- 4) Do you directly go to service provider in case of illness? Whom do you like to seek help from in case of illnesses? Why?
- 5) What are the services you get in the government health centres? Which is the nearest government center where you could go to
  - a. For a pregnancy check up?
  - b. For child-birth?
  - c. For immunization?
  - d. For a mild fever or cough?
  - e. For a more serious fever or pain that is persisting?
  - f. For a chronic condition- like diabetes or hypertension?
  - g. For a hospitalization for accidents or any serious illness?
- 6) How far you have to travel to access these medical facilities? What are the problems in access to care in these facilities? How much does it cost you for a visit to the above health centre?
- 7) For which of the services as listed above is care sought for in a private sector? What were the costs? The reasons for preference- explore both negative reasons- why government was not preferred (no services available, long waiting time, rudeness, no time given to seeing patient, costs of care etc) and positive reasons ( my regular doctor, reliable and kind, convenient timings
- 8) Do you get the necessary drugs and diagnostics in the government facilities- or do you have to buy them outside with payments? How many days' free drugs do you get? For a chronic patient like diabetes or hypertension- are you able to access free drugs throughout the month/year? How often are you able to go? Which would be a convenient site/process for access to such care?

- 9) For women, in case of recent pregnancy how do women confirm pregnancy? Where did the delivery occur? Who helps them reaching to a hospital for delivery? After delivery whether they get/where they get post pregnancy check-ups? What are the costs involved in each of these stages? Are there women who deliver at home? Why are they unable/unwilling to access a health care facility for delivery?
- 10) Are there tuberculosis patients in the group- or can they introduce us to some? What is their experience with access to care and drugs?
- 11) What are the problems for which you are unable to access any type of help/services? Can you give some example where this happened for you or anyone else you know in the community?
- 12) Is your family covered by any insurance scheme? Do you have a card for it? Which members of the family are covered and which are left out? Do you know what the sum assured is and in which hospitals you are eligible to free care? Have you made use of the card to get any free services so far? If so the details? If you or family members have been ill but despite this unable to access free services- what are the reasons?

### **1.3 . About Access to other Services and Relationships:**

- 1) Do you have an adequate and regular food supply? Do you have a ration card- and are all members of the family on it?
- 2) What food supplementation programmes does any family member access- eg: school midday meal, anganwadi meal, any others
- 3) What is the access to drinking water? Is it clean? Is it safe? How many hours of access? When? Where do you go to if there are problems in access and how responsive are the authorities on this?
- 4) What is the access to toilets? How clean and usable are these toilets? Are there user fees and if so how much? What is the extent of defecation in the open? What efforts have been made for more toilets- and why do you think these were not improved upon?
- 5) What is the arrangement for disposal of solid wastes/rubbish? Where are these disposed most?
- 6) Please describe about the vector control measures in place? What is done to reduce breeding sites? Problems of sewage and stagnant water- how are they being addressed.

- 7) What is current quality of housing? Are there any schemes or programmes they are aware of and/or have availed?
- 8) What is the current situation in access to Electricity and lighting? Are houses electrified? What are the payments? How often and long are the power-cuts?
- 9) Child care: do you have an ICDS Centre (Anganwadi) in the neighbourhood? Do you avail services from them? What are the services you avail through ICDS centre? What is the coverage of these services as against the total requirement for this service. Is supplemental food available in these centers?
- 10) Are there any crèche services? Do you need them?
- 11) Are you able to send your children in school? Approximately what percentage of children never go to school and what percentage of child are out of school at 5<sup>th</sup> class or at 8<sup>th</sup> class If they do not go, then what do they do during the day? Is the school mid day meal programme functional?
- 12) Are there school health programmes? How often does doctor or nurse come- are they aware of the school health programme at all?
- 13) Are you given a fair treatment when you approach the government authorities gaps in any of the above services?

#### **1.4 . About Community's Expectation on Services:**

- 1) Describe the hospital/ facility that you would like to go for your everyday health problems that require out-patient care? (If not government then ask next question- Should the government run this? Why?)
- 2) What services should be provided in this facility (both essential and optional).
- 3) If government were to provide a regular supply of free drugs to those with chronic illness like diabetes or asthma etc- where and how best to do this? What timings would be convenient?
- 4) What would you suggest be done to improve the current access and quality of in-patient care?
- 5) Do you need any service other than the hospitals to deal with illnesses? (Example- recovery shelters after hospital discharge for homeless, sickness compensations, social security for daily wage earners?)

- 6) Do you have a community health worker? If government appoints a community health worker to represent your interests what would you like them to do for you?
- 7) If government would constitute a committee to look after your interests who would represent you on such a committee?
  - i. At what level should the committee be formed? (basti, slum, ward etc)
  - ii. What should be the role and responsibilities of the committee?
  - iii. What kind of support is needed to sustain the committee? (for e.g. training etc.)
  - iv. Can government take any steps to enable this committee to effectively represent your voice and bring necessary changes? If yes, what are they?

### **1.5 . About Organizations and Efforts made by themselves to get Better Health:**

- 1) Are you or members of your group organized as a community?
- 2) Did anybody or organization help you in organizing?
- 3) How often and where do the community members meet? (slum, worksite, any other place)
- 4) Were health issues one among the concerns to organize yourself into a community?
- 5) Do you address health related issues collectively at present?
- 6) What were the challenges faced by the community while mobilizing for health issues?
- 7) Did the community mobilization help in improving health of the community?
- 8) In case of any complaints who can the community members approach to?
- 9) How in your opinion can this community engagement be sustained?

### **1.6 . NGOs in Action:**

- 1) How did the organization facilitate community mobilization?
- 2) What are the terms of engagement of the NGO- government funded, based in its own funds etc and for what services/ activities? What are mechanisms to monitor their action?
- 3) What are the key lessons for its sustainability?

## **Chapter-4**

### **TOOL - KIT SECTION II**

#### **THE ORGANIZATION OF HEALTH CARE SERVICES AND RESPONSIBILITIES OF STATE DEPARTMENT OF HEALTH AND FAMILY WELFARE**

##### **Objectives:**

- To understand how the institutional structure of health care service delivery with reference to the population of the city/town. This would include:
  - a. How the population of the city is divided into zones or other sub-units for the purpose of organization.
  - b. Who are identified as vulnerable or marginalized sections, and as slums and where these are located within the city.
  - c. What are the special efforts at reaching the health care to these sections.
- what are the different categories of public health care facilities and the numbers in each category and their distribution across zone- medical college, specialist hospitals, general hospitals, district hospitals, sub-district hospitals or community health centers, primary health centers, health posts, dispensaries, diagnostic facilities, cost controlled pharmacies
- What are the services available in each of these facilities?
  - a. To what extent the official or perceived mandate of the facility, and its governance and financing limit the availability of services?
  - b. To what extent does the availability or gaps in infrastructure, human resources, supply chain management and work ethic contribute to the availability or the lack of services with respect to the mandate of the facility?
- What are the institutional provisions for access to knowledge resources needed for governance, management and service delivery. This could be with respect to management information systems and analytics, learning from other cities or other experiences, and partnerships or networks with knowledge institutions.
- What is institutional capacity and mechanisms with respect to the following:
  - a. Leadership roles/participation by/ coordination with elected members and officials of urban local bodies.
  - b. Convergence of all health related services is taking place- whether they are under ULB or under different departments of state government or under the department of health.

- c. Ensuring health outcomes - each organization in the system has the necessary capacity and is delivering the expected outputs.
- d. Framework of rules especially in areas like financing,HR policies, procurement is adequate for the purpose.
- e. Partnerships with non-governmental agencies (commercial and not for profit) for reaching health goals are adequate in terms of task allocation and in terms of contracting and contract management.
- f. Stewardship function of the government with respect to private sector
- g. Regulatory functions of the government for the achievement of public health
- h. Institutional frameworks required for community processes and participation

**Process:**

1. Interview with state and district health officers. The numbers and choice of officers will depend on who all would be able to comment on and contribute to information on the above agenda. Though the questionnaire is constructed as if it would be asked to the chief medical officer of the district, or state- in practice- the same tool would be used with a number of state and district officers- each of whom may shed light on only some part of the questionnaire. Thus one of them who was most informative would be designated the main respondent and the others the supplementary respondents.
2. Once the above interviews are done, using the list of facilities a sample of each type of facility is drawn up and visits are organized to these. Broadly they could be categorized into hospitals with in-patient care and facilities providing only ambulatory care. For each of these we gather information from the officer in charge and from providers working in these facilities. Where possible this must be supplemented by exit interviews or interviews of a few inpatients to understand out of pocket expenditures, problems in access and overall satisfaction with care provided and the category of users the facility is attracting and catering to.

## **2.1 Interview Schedule for Collecting Information on Organization of Health Services and Responsibilities of State Department of Health Responsibilities and Functions**

### **Mapping the Urban Health Context:**

1. What is the urban population of this town/city? If it is part of which district and what is the population of district as a whole?
2. Is there a list of slums available? What percentages of the urban population are in slums? What are the other vulnerable sections?
3. What is the increase in city/town population in the last decade? What part of this expansion is due to expansion in city limits- by which a number of earlier semi-urban areas and even nearby villages is included? And what part could be attributed to in-migration?
4. **Types and numbers of primary healthcare institutions:** (all facilities with less than 4 beds providing non specialist care- health posts, sub-centers, PHCs, UHCs, dispensaries, AYUSH, mobile medical units others)
  - a. Under Municipality/ Urban Local body:
  - b. State government –
  - c. any other public undertaking ( eg state medical college, labour department etc)
5. **Types and bed strength of government hospitals** – that is facilities with over 4 beds) – CHCs, municipal hospitals, district or sub-divisional hospitals, maternity homes, medical colleges etc)
  - a. Under Municipality/ urban local body
  - b. state government ;
  - c. any other public undertaking- eg ESI, railways, etc)
6. **Morbidity and Mortality:** Is there any information on morbidity patterns and mortality. From demographic and health surveys, from local surveys, from registrar of births and deaths, from disease surveillance programme, from hospitals that are collecting and analyzing- whose data would act as sentinel sites. Any other sources. Is there any data related to sub-groups especially of the vulnerable.
7. **Area Allocation and Coverage : -**
  - a. Is there a clear allocation of every area with respect to primary care providers?

- b. Are there slums- “notified” and “unlisted”- where the population has no notified primary care provider? (Suppose there is a child without immunization, who would be responsible to identify and get the child immunized-? repeat same question for pregnant women, TB suspected case- to probe what they mean by coverage).
  - c. If there are such areas- how big, how many and where are these areas- and what are the occupational and social features of these populations.
  - d. Are there populations in each zone which have no household number? Which are these? These could be areas where only for pulse polio every household is covered? (Check with pulse polio register to understand this. Often listed as migrant in the pulse polio register!) How much such population/households exist outside the designated slum areas.
  - e. Is the coverage/access effective in slums (There could be notional coverage- an ANM is assigned but for 20,000 population and she visits only a small part of this area. Probe whether such situation exists and again describe these areas and their populations).
  - f. What is the difference in density of facilities/coverage between newly included areas and the earlier city/town limits?
- 8. Human Resources of Municipal Health Care Facilities:** What is the staff strength sanctioned and present in municipal facilities what are the HR issues [vacancies and shortfalls in sanctions]: state separately for primary care facilities and for hospitals:
- a. Specialists and doctors
  - b. Nursing staff
  - c. frontline health workers- ANMs, MPWs,
  - d. ASHAs
  - e. technical staff in health programs;
  - f. public health officers
- 9. Drugs and Diagnostics and Equipment:**
- a. Is there a separate budget for each of the above?
  - b. How is drugs and supplies procurement done- facility level, municipality level or taken from state government?
  - c. Are there Standard Treatment Guidelines, generic drug policy etc in place?



- d. Are most drugs and diagnostics available within the health care facility? Or do they have to be purchased outside
- e. If available within facility - are drugs and diagnostics for free or charged? How are charges?
- f. Is the logistics system responsive to needs? Is it able to avoid stock-outs of drugs?
- g. What is level of equipment availability and gaps- which services cannot be delivered despite HR being present due to lack of equipment?
- h. Is blood available? Are blood bank services available?

**10. Referral transport and referral linkages:**

- a. Are there ambulances? Is it part of a call center based ambulance service?
- b. What are usual sites of secondary and tertiary referral? When there is a referral made from primary level to secondary or tertiary care- Is there any advantage over patient having gone directly? Are there feedbacks received and a two way communication established between primary and secondary or tertiary levels of care?

**11. Bio-medical waste management:** What is the level of service provision?

**12. RKS and ancillary services :**

- a. Are RogaKalyanSamitis [RKS] in place?
- b. Are user fees present? How significant are the charges – main sources of earnings?
- c. Does RKS look at patient amenities and ancillary services-
- d. How is diet, laundry, security, sanitation and hygiene, infrastructure maintenance etc organized in these facilities– outsourced, by contract, by regular employees
- e. How effective are these support services

**13. Financing mechanisms:**

- a. What is extent of funds from state and central budgets?
- b. What is the proportion of funds which are generated locally- and of these the contribution from user fees?
- c. What is the income from other sources- e.g. RSBY and other insurance schemes

#### **14. Organization and delivery of RCH services**

- a. Immunization
- b. Family Planning
- c. School Health
- d. Ante-natal care
- e. Care at delivery including linkages and continuity for Emergency Obstetric Care
- f. Post natal care
- g. Abortion Services

On each of the above provide an estimate of the “proportion of population in need” who get effective coverage, the constraints, the areas with poor coverage, the participation of the private sector and NGOs. In large cities, this could be explored for a zone- or sub-region of the city.

#### **15. Organization and delivery of disease control programs:**

- a. TB and leprosy
- b. HIV/AIDS & RTI/STI/
- c. vector borne diseases;
- d. rabies control:
- e. NCDs;

On each of the above provide an estimate of the “proportion of population in need” who get effective coverage, the constraints especially with respect to vulnerable sections, the areas with poor coverage, the participation of the private sector and NGOs. In large cities, this could be explored for a zone- or sub-region of the city.

#### **16. Training and capacity building activities for providers.**

#### **17. What is the role of state government in**

- a. Collection of information on morbidity and service delivery
- b. Mechanism for disease reporting and notification [list of notifiable diseases];
- c. Epidemiologic services: surveillance networks; outbreak investigation and management; public health laboratory-
- d. IEC campaigns

**18. The Private Sector:**

- a. Is there data on the number of private hospitals, clinics and beds?
- b. Is there information on the nature and range or quantity of services provided?
- c. Is there any systematic collection of information on morbidity or health care from them?
- d. Is there any regulatory system in place- what aspects are brought under regulation? What are the issues?
- e. Are there any partnerships for health care service delivery? What is the past history and experience of Public Private Partnerships [PPP] in urban health services.
- f. What percentage and number of private hospitals are empanelled in pro-poor publicly financed insurance schemes.
- g. What other forms of engagement with private sector- quality circles, training of private providers, microscopy centers, disease notification etc.

**19. Roles and coordination of state government and ULB:**

- a. Coordination between ULB authorities and facilities and state government institutions for prevention and control of major health problems [e.g. water borne diseases; vector borne diseases; RTI/STI/HIV/AIDS; family planning; immunization; under nutrition; school health and midday meal.
- b. Inter-sector coordination- in child care, ICDS, water and sanitation, education etc between state government and ULBs.

**20. NUHM Progress:**

1. Components and services strengthened in urban areas under the National Rural Health Mission [NRHM] so far: frontline health workers [ASHA, ANM]; outreach services; clinical services
2. Urban health services under the National Urban Health Mission [NUHM]: current priorities
3. Planning process so far:
4. Interactions between state and ULB
5. Interactions with community groups, District Health Society, elected representatives

6. Plans in place for addressing urban inequities [vulnerable groups; spatial disadvantages]

## **21. Management Perceptions:**

Respond to the following three areas of decision making. These are a few key issues on which we have to take a call. With respect to your city what would be your recommendation/perception:

A. Statement: Urban Local Bodies do not have capacity and motivation to manage the public health and therefore

- Option 1. We should place all such functions under the state mission and directorates directly.
- Option 2. We should take curative care at all levels and primary health care under the health department- but leave preventive and promotive and regulatory activities of public health with the urban local body.
- Option 3: in option 2, above, we should have a planned development of capacity and then or in parallel shift more responsibilities to the urban local bodies.
- Option 4: we should have a planned development of capacity and then in larger towns- shift both preventive and curative care into the urban local bodies.
- Option 5: capacity will develop only if there is a transfer- begin with a transfer.

In each of the above options discuss the pros and cons.

B. Poor and vulnerable groups [e.g. homeless people, sex workers, street children, elderly, have special needs, those in unauthorized settlements etc should be the major focus of urban primary health care. Therefore:

- a. Option 1. We need to first put in place a urban primary health care system and then when services for the poor are well established, then only would be able to build in affirmative action to reach the poorest.
- b. Option 2: we need to ensure that from the very outset there is affirmative action to build the most vulnerable that is built into the programme.

- c. Option 3: An excessive focus on the most marginalized would mean less attention to get the basics of health system in place. The responsibility of reaching these sections has to be shared with other agencies and not only our own.

In each of these options discuss the pros and cons.

- C. For Urban Primary Health Care what would be the role and forms of engaging the private sector – not for profit, and commercial- through area contracts, through outsourcing facilities, through current insurance schemes, through new insurance design – others.
- D. Any other areas where there is a divergence expressed- examples on community processes, on the role of mahila arogya samitis, on the ASHA etc. Explore reasons and perceptions of the management- at different levels.

**22. Management Recommendations :**

- o Suggestions for design and implementation of NUHM from the management staff interviewed:
  - i. for the programme in the state as a whole
  - ii. for that specific town/city.

**2.2. Interview Schedule for Collecting Information on the Urban Public Hospital**

**1. Mandate**

- a. What is the population covered by this facility? By geography? By intent? In practice- where do the users come from?
- b. Provide details of quantity of services provided by broad category:

S.No.	Service	Yes/No	Average no. in a day
a.	Does the hospital provide 24 hour services?		
b.	OPD Care?		
c.	Indoor Beds available		
	Male		
	Female		
d.	Average bed occupancy rate		
d.	Emergencies		

**2. Specialist Services available and provided:** (there is a judgement call required for some of these responses. Thus if a cardiologist is providing services- there is no problem, but if a general medicine person is running a special cardiac clinic or managing an ICU then also we would call it cardiology services provided by a general physician. However if he is handling cardiology cases as part of general OPD, then we would answer NO for cardiology services. And so on)

S.No.	Service	Yes/No	Average No. in a month	Who provides them	Content of Service Provided
a.	General Medicine				
b.	Cardiology				
c.	General Surgery				
d.	Obstetrics& Gynaecology				
e.	Paediatrics				
f.	Anaesthesia				
g.	Orthopaedics				
h.	ENT				
i.	Ophthalmology				
j.	Dermatology and Venerology				
k.	Dental Care				
l.	Mental health/Psychiatry				
m.	Ayush				
n.	Plastic Surgery				
o.	Pathology				
p.	Blood Bank				
q.	Physiotherapy				
r.	Minor Procedures				
s.	Others (specify)				

### 3. Diagnostic and other Para Clinical Services

S. No.	Service	Yes/No	Average No. in a month	Who provides them	Content of Service Provided ( give in brief the range of tests done)
a.	Laboratory				
b.	X-Ray				
c.	Ultrasound				
d.	ECG				
e.	Blood Transfusion and Storage				
f.	Physiotherapy				

#### 4. Support Services

S. No.	Service	Yes/No	Average No. in a month	Who provides them	Content of Service Provided
a.	Medico legal / post-mortem				
b.	Ambulance Services				
c.	Dietary Services				
d.	Laundry Services				
e.	Security Services				
f.	Housekeeping and Sanitation				
g.	Inventory Management				
h.	Waste Management				
i.	Office Management (provision for computerized medical records)				
j.	Counselling Services for Domestic Violence, Gender Violence, Adolescents, etc.				
k.	Others (specify)				

#### 5. National Health / Disease Control Programs

S. No.	Service	Yes/No	Average No. in a month	Who provides them	Content of Service Provided
a.	TB/DOTS?				
b.	HIV/ICTC				
c.	Vector Borne Diseases				
d.	Non-Communicable Diseases				
e.	Mental health services				
f.	Disease surveillance				
g.	Others (specify)				

#### 6. Linkages:

- a. What is the process of referral?
- b. Are there guidelines on when to refer and when not to? What are the most common causes of referral?
- c. Is there any measure or records of numbers referred?

- d. When do we refer on hospital ambulance and who pays for it.
- e. What is the number/proportion and type of cases referred up who are referred back for follow up?

**7. Governance and Management:**

a.	Who is head of hospital and what the second level managers is.	
b.	What is the mechanism of governance? To whom does hospital leadership report to – for administrative, salary purposes	
c.	Who supervises/reviews clinical work of hospitals- to whom do they refer cases which they cannot handle	
d.	What are the roles RKS is playing? What is the degree of public participation? What is the area of its supervision and its powers?	
e.	Is there are quality management system in place? What are the efforts to address issues of quality	
f.	What part of the finances is raised from user fees and locally? What part from the state? what part from	
e.	What are the efforts to make the hospital woman friendly, baby friendly, to address issues of social exclusion, to provide help-desks and support to patients.	
g.	Mechanism of Grievance redressal in place.	

**8. Infrastructure**

S.No.	Name	Yes/No	Remarks
a.	Hospital area		
b.	O. T.		
c.	ICU/high dependency ward		
d.	Waiting Spaces adjacent to each consultation and treatment room		
e.	General Wards		

**9. Public Health Engineering Services**

S.No	Name	Yes/No	Remarks
a.	Electricity		
b.	Generator		
c.	Piped water supply		
d.	Drainage and Sanitation		
e.	Cleanliness		
f.	Fire Protection		
g.	Residential Quarters for all medical and para medical staff		



**10. Equipment Gaps-** (Only note those equipment where there is an appropriately skilled provider available, and providing the services, but lack of equipment is a cause for referral away>)

S. No.	Equipment	No available, Available but not working	Remarks

**11. Drugs ( need to check whether drugs appropriate to services are available - and if so how many days free supply will a patient get per visit).**

S. No.	Name	Yes/No	Remarks
a.	Availability of drugs for RCH services		
b.	For common acute medical illness –esp. antibiotics		
c.	For medical and surgical emergencies		
d.	For main chronic NCDs		
e.	For TB, HIV leprosy		
f.	Medical Store facility for indoor patients		
g.	Are Standard Treatment Guidelines available?		

**12. Human Resource Issues**

S. No.	Issue	Required	Sanctioned	In place	Vacant	Remarks
a.	Specialists					
B	Doctors					
C	Nurses					
D	Paramedics					
E	Technicians					
F	Support staff					

Are those present having necessary skills? Are there training programmes in place?

**Provider Interview: (could be used for doctor or nurse)**

1. Name of Respondent (optional) .....
2. Place of posting .....
3. Post.....
4. Posted since .....
6. Of services your institution provides? Which are the most utilized? Which are the least utilized?
7. Who are the most vulnerable groups in your area? How do you identify them and target service delivery?
8. What are their barriers to accessing and utilizing services?
9. What challenges do you face in rendering services to them?
10. What changes do you suggest in providing and improving services for them?
11. Where do you refer patients when required? What are the obstacles for accessing referral services? What are your suggestions to improve referral services?
12. What constraints do you face in delivering the program? [Infrastructure; staff shortages; supply logistics; diagnostics; ancillary services; travel]
13. What are your interactions and experience with private providers and NGOs?
14. What are your experiences regarding user fees/charges and RogiKalyanSamiti [RKS] in the specific context of vulnerable groups?
15. What are your suggestions for priorities for the NUHM, particularly for organization and delivery of primary health care services for the vulnerable sections of your town/city?

**2.3. Interview Schedule for Collecting Information on the Urban Public Primary Health Care facility (includes health posts, dispensaries, urban primary health centers)**

**1. Mandate**

- a. What is the population covered? Is there a geographical area or a number of households allocated to the facility? Or do they provide care only to those who actively seek it?
- b. Which services are provided in the facility; at an outreach point, and which are home based?
- c. What are services provided by this facility and its staff? Which of these are restricted to its “service area” and which are open to anyone who walks in?
- d. For services like ante-natal care and immunization, how do they ensure that no one is left out? Is there a comprehensive register of all families- or do they only treat those who seek their services.
- e. What are the facility timings? When is it open? If it is open on a 24\*7 basis who stays during the night and what services are available then.
- f. Other than preventive care- antenatal and immunization and safe delivery and contraceptive services – what is the quantity and range of out-patient services provided?
- g. Are there any beds? What are they used for day-care? Delivery cases? Stabilization care or regular in-patient care?

**2. RCH services:**

Give a sense of quantity of RCH services in the table below

S. No.	Service	Yes/No	Average No. in a month	Who provides them	Content of Service Provided
<b>Maternal and Child Health Care</b> (if applicable)					
a.	Ante-natal care				
b.	Delivery Services				
c.	Post-natal care				
d.	New born Care				
e.	Child care including				

	immunization				
F	Family Planning				
G	MTP				
H	Management of RTI / STI				

- a. Are there home deliveries taking place? Why is that? Is there an experience of being denied admission at higher facilities or at this facility for any reason?
- b. Are home deliveries attended by a midwife from this facility? Who attends on them?
- c. Are home visits made at least for past partum care?
- d. Which is the site of ante-natal care and immunization- what proportion happens in this facility, and what happens at anganwadi or other outreach center, mobile medical unit and at home?
- e. Is this facility declared a site of institutional delivery for purposes of JSY? What are the out of pocket expenses still present in the facility.
- f. Are there any forms of adolescent health services?

### 3. Disease Control Programmes.

	RNTCP	What RNTCP activities take place- referral for sputum testing, sputum collection, microscopy, DOTS provision, tuberculosis unit? If not happening here which is the nearest facility where these activities take place. How many TB patients in this facility's area or taking drugs from here? What are the problems with follow up?
	HIV	Where is the nearest site for HIV testing? Where for ARV drugs? How much testing happens here? What is the number of HIV patients under care here?
	Leprosy	Same questions as for RNTCP- but in addition number of patients identified with disability and of these those received care and those waiting for surgery.
	Vector Borne Diseases	What are the main vectors borne diseases in this area? What activities happen at the facility (tests, treatment, referrals) and what in the area (testing blood in fever cases, insecticide spraying,

		source reduction etc)? What happens in referral sites?
	Non-Communicable Diseases	Is there any specific NCD programme in place? Does this facility detect hypertension and diabetes, test for it, initiate treatment; are drugs available- how many regulars depending on drugs from this facility? Which would be the site of referral for specialist opinion? Are there cases referred up that have come back and now under the facility's follow up care?
	National Mental Health Program	Same as above>
	Disease surveillance	Does the facility report on S forms or P forms or L forms or a combination of these. Is there any feedback received on the reports. Any action triggered by these reports.
	Water-borne diseases	Are there outbreaks of jaundice or typhoid or diarrhoeas reported in this area? How frequently? What is the response to an outbreak?

#### **4. Other clinical services:**

- a. What are other clinical services available in this facility?
- b. What emergency care is available? Primary management of wounds, minor surgeries, burns?
- c. Are there dental services available?
- d. Are there AYUSH services available?

#### **5. Linkages:**

##### **With higher facilities:**

- a. What is the process of referral?
- b. Are there guidelines on when to refer and when not to? What are the most common causes of referral?
- c. Is there any measure or records of numbers referred?
- d. When do we refer on hospital ambulance and who pays for it.
- e. What is the number/proportion and type of cases referred up who are referred back for follow up?

**With community level institutions:**

- f. Are there facilities or service providers who work under this facility? Is there a reporting relationship to it- like ANMs reporting to the dispensary or to the PHC, or ASHAs reporting to the sub-center etc?
- g. How many ASHAs or other community level workers are there under the leadership of this facility?
- h. Is there outreach sessions conducted- in anganwadis or other sites on a regular basis?
- i. Are there linkages with self help groups or other CBOs?
- j. What if any are the efforts made to identify and interact with and give special attention to the marginalized and their community structures?

**With peer facilities:**

- k. Are there institutional linkages with other government facilities- run by municipality, ESI, public sector undertakings etc?
- l. Are there institutional linkages with private sector facilities?

**6. Governance and Management:**

- a. Who supervises/reviews work of the facility? Who is in charge of facility? Who pays the salary?
- b. Is there an RKS or equivalent structure in place? What is the degree of public participation? What is the area of its supervision and its powers?
- c. Are fees of any sort- formally or informally collected by the facility staff?
- d. Are there grievance redressal systems in place- for the service users and for the providers themselves?

**7. Human Resources at the facility:**

List the staff in the facility. If it has a clear service area assigned to that facility- also provide number of ASHAs, anganwadi centers, health posts etc under this facility.

S. No.	Facility Staff:	Sanctioned	Posted	Remarks
a.	Medical Officer			
b.	Pharmacist			
c.	Nurse-Midwife/Staff Nurse			
d.	Health Worker (Female)			
e.	Health Worker (Male)			
f.	Health Educator			
g.	Health Supervisor			
h.	Clerks			
i.	Laboratory Technician			
j.	Driver			
k.	Group D			
l.	Others (specify)			
	<b>Total</b>			
	<b>Service Area below UPHC</b>			
I	ASHA or other community volunteer or worker			
ii	ANM			
iii	Nurse			
iv	Doctor- ayush or MBBS			
V	Others – specify			

## 8. Infrastructure

S.No.	Physical Feature	Yes/No	Remarks/Observation
a.	Location		
b.	Travel time to reach the facility from the remotest place in the coverage area		
c.	Building		
d.	Is it a designated government building		
e.	If No:		
	Rented premises		

	Other government building		
	Any other specify		
f.	Present condition of the building		
g.	Cleanliness(Observe)		
h.	Charter of services		
i.	Separate toilets for males and females		
j.	Examination room/area with privacy		
k.	Reliable water supply		
l.	Process of Bio-medical Waste Disposal		
m.	Reliable electricity supply		
n.	Reliable communication facilities		
o.	Transport facility including referral transport		
p.	Residential facility for the staff		
q.	Suggestions/Complaint Box/Register		

**9. Equipment Gaps: List those equipment where despite presence of providers, services are denied because of lack of equipment:**

S. No.	Equipment	Not procured, or procured but not functional.	Remarks

**10. Drugs- List drugs which are essential for mandated services - and their presence**

S. No.	Name	Part of facility's essential list - Yes/No	If yes- is it present or stock out	Remarks
a.	Antibiotics ( 2 to 3 at least is essential in most settings			
b.	Paracetamol,			



	antihistamine, dicyclomine, and other basic symptomatic relief drugs.			
c.	Albendazole, Iron, Calcium, ORS			
d.	Drugs relevant to RCH services			
E	Drugs relevant to the main disease control programmes			
f.	Drugs needed for management of chronic diseases – taking diabetes and hypertension as trace indicators			

**Provider Interviews:**

1. Name of Respondent (optional) .....

2. Place of posting .....

3. Post.....

4. Posted since .....

6. What services do you/your institution provide? Which are the most utilized? Which are the least utilized?

7. Who are the most vulnerable groups in your area? How do you identify them and target service delivery?

8. What are their barriers to accessing and utilizing services?
9. What challenges do you face in rendering services to them?
10. What changes do you suggest in providing and improving services for them?
11. Where do you refer patients when required? What are the obstacles for accessing referral services? What are your suggestions to improve referral services?
12. What constraints do you face in delivering the program? [Infrastructure; staff shortages; supply logistics; diagnostics; ancillary services; travel]
13. What are your interactions and experience with private providers and NGOs?
14. What are your experiences regarding user fees/charges and RogiKalyanSamiti [RKS] in the specific context of vulnerable groups?
15. What are your suggestions for priorities for the NUHM, particularly for organization and delivery of primary health care services for the vulnerable sections of your town/city?

## 2.4. Exit Interviews on Cost of Care

Use separate form for OP patients and other for IP. For IP add a column number of days. In both instances a minimum of 10 patients per facility is recommended. Take 10 consecutive consenting patients.

		1	2	3	4	5
1	Diagnosis					
2	Cost on drugs					
3	Cost on diagnostics					
4	Cost on fees of any type					
5	Transport costs					
6	Other costs- diet, attenders,					
7	Cost for this episode					
8	Source of funding					
9	Livelihood loss costs					
10	Episode outcome#					
11	Monthly costs- if chronic patient					
12	Is patient registered for insurance costs					
13	Does he/she know what was cost of care bill signed- for insurance to reimburse? If yes mention the amount					
14.	Occupation of the patient- or main earning member in family.					
15	Satisfaction with care:					
a.	The quality of clinical advise					
B	The quality of patient amenities for comfort					
C	The quality of provider- patient interaction and communication					

All costs mentioned in 2 to 7 above are only out of pocket expenditure at time of care.

Outcome for episode- is cured, relieved, no change, worsened.

Satisfaction is poor, fair, good and excellent.

## **Chapter-4**

### **TOOL-KIT SECTION III**

#### **THE ORGANIZATION OF HEALTH AND RELATED SERVICES BY THE URBAN LOCAL BODY**

##### **Objectives:**

1. To understand the roles and responsibilities that urban local bodies currently have in terms of the provision of health related services especially as regards maintenance of environmental health, nutrition and child care services, and the provision of safe drinking water and sanitation.
2. To understand the roles and responsibilities of urban local bodies in provision of health care services.
3. To understand how the above work is organized, what are the gaps in such service provision and the reasons for these gaps.
4. To understand the issues of governance and financing of urban local bodies that have a bearing on health outcomes and health services
5. To understand the organization of public services with reference to nutrition and food security, drinking water and sanitation, child care services, school education, health education- and the role of urban local bodies in provision, monitoring and coordination of these services.
6. To understand the efforts made at convergence and coordination and the successes and gaps in this aspect.

##### **Process:**

- To understand the overall governance issues and the issues of financing and the organization of all health related services under the urban local body, we have to identify three or four key officers. This would include in the least
  1. The generalist IAS cadre officer to whom the municipal health officer/city health officer reports to; this is usually a deputy commissioner health, but in smaller municipalities could be directly to the commissioner.
  2. The city health officer/municipal health officer
  3. The programme officers in charge of ICDS, drinking water and sanitation programmes and school education.

- One may also need to take time with the officer in charge of the accounts and look at the income and expenditure statements of the ULB
- One would also need to discuss with elected leader of the ULB and the commissioner or whoever the leading administrator of the ULB is.
- With reference to the health care services and hospitals under the ULB control, most of the information would have been collected in section 2.1 to 2.3. Here only coordination functions need to be probed.

### **3.1. Interview Schedule for Collecting Information on the roles and responsibilities of Urban Local Bodies towards ensuring Health Outcomes**

#### A. Funds:

1. What is the Municipal budget allocated? What proportion of Municipal budget is allocated to healthcare? What proportion to health related sectors- sanitation including waste disposal, drinking water, and education.
2. What are the priorities of allocations [activities/programs *within* the health sector?
3. What are the sources under which funds are mobilized for health care activities- municipality's own revenues, central grants, state grants, user fees, others:
4. Under what circumstances could more funds be allocated/disbursed from existing budgets?
5. If you need more money from State, Centre, what would you want it for?
6. How could more funds be raised?

#### B. If there are Health Care Facilities UNDER the Municipality (use interview schedules 2.1 to 2.4).

#### C. What is municipality role in each of the following 11 areas?

1. Provision of safe drinking water:
2. Provision of toilets and promotion of their use
3. Management of waste esp. solid waste management
4. Active linkage of above three activities with prevention of water borne disease.
5. Active linkage of above three plus additional activities undertaken for prevention of vector borne disease?
6. School health programmes and School midday meal programmes
7. ICDS programmes
8. Active linkage of above programmes with prevention, identification and management of malnutrition and anemia.
9. adolescent health programmes
10. Occupational health :the relevant occupations and related health issues : enforcement of standards, prevention, promotion and management
11. Programmes for diagnosis and prevention of TB, HIV, RTI/STIs.

In each of the above areas we seek to understand the following:

- a. How is its implementation organized?
- b. What is the staff strength working in each of this area? How adequate is this
- c. How is it coordinated with health care delivery and outcomes?
- d. Who are partners?
- e. What does the ULB do for access to knowledge resources/technical guidance in this area- internal analytics, knowledge partners, its own resource organizations?

5. In each of the above areas of municipal roles, what is the situation with regard to vulnerable sections? What are the affirmative or additional measures in place to ensure that these sections are reached?

D. What does ULB do to respond to information of outbreaks? Who responds? Where do they get the information from- IDSP, journalists, word of mouth etc? What is the system of disease surveillance and of notifying diseases and how effective is this currently. How is information used for action?

E. What are non-clinical legal and regulatory services under municipality: To what extent and how does municipality manage these roles?

1. food safety including hotel hygiene
2. regulation of health trades;
3. Registration of vital events; especially births and deaths.
4. cremation and burial grounds;
5. hearse vans;
6. slaughter house hygiene
7. Monitoring air pollution and initiating action to safeguard health.
8. Any others:

In each of the above areas we seek to understand the following:

- a. Whether the ULB has the mandate and is seized of it.
- b. How is its governance and implementation organized?
- c. What is the staff strength working in each of this area? How adequate is this?
- d. How is it coordinated with health care delivery and outcomes?
- e. Who are partners?

- f. What does the ULB do for access to knowledge resources/technical guidance in this area- internal analytics, knowledge partners, its own resource organizations?

F. Partnerships:

- a. Linkages with and role of NGOs- what is currently functional? Any major past efforts which are not sustained?
- b. Describe the different forms of Linkages with and role of private [for-profit] sector
- c. History and experience of Public Private Partnerships [PPP] in urban health care services so far: What has been tried? Is it still functional? What are its strengths and its weaknesses? If not functional, why did it fail to sustain?

G. Perceptions of Officers and elected members of ULB

- a. Opinion about service provisioning by public health care facilities
- b. Strengths and weaknesses in municipal bye-laws related to public health
- c. Perceptions and issues on utilization of health services by:
  - a. the urban poor and vulnerable groups [e.g. homeless people, sex workers, street children]
  - b. those with special needs [e.g. adolescents, elderly]
- d. Suggestions for strengthening public health services and primary health care in your town/city.

**VI. Governance Issues:**

1. What is the organizational structure for all the above functions (both of governance and of management)? An illustrative organogram would be useful and it could indicate the number of managers deployed for these functions? Also indicate the role of elected members of the ULB. How is their contribution?
2. Planning process – what is currently in place? What is proposed?
3. Interactions and coordination between state and ULB. How the Chairman is represented on the District Health Society? Do you have any say in the meetings, minutes, agenda etc.?



4. Is there any strategy for peri-urban locations; geographically distant, unauthorized settlements including non-notified slums?
5. Is there any Health Management Information Systems [HMIS]? What is the level of its completion and quality of reporting and use of information?
6. What are the other technical support agencies at work for this ULB? What areas of expertise and involvement do they have? These could be academic agencies or NGOs, or development partners or private consultancies?

**3.2. Interview Schedules for collecting information from the officers in charge of the following:**

**a. Solid waste management and sewage and the provision of toilets.**

1. What is the institutional arrangement for waste management in the city? Is there any public-private partnership in waste management?
2. Please tell us the role of public health department in waste management.
3. What is the quantity of waste produced in the city?
4. Does the corporation have a waste treatment facility like compost plant and incineration facility? How is the final disposal of waste carried out? Do you have a sanitary landfill for final disposal?
5. Do you provide waste collection service to both notified and non notified slums?
6. What is the total number of sanitary workers in the city? Please provide a break up of permanent and contract sanitary workers. Are they provided with equipment that protect from occupational hazards on a regular basis? Have you conducted a morbidity study of the sanitary workers?
7. Have the ULB been able to provide toilet facilities to all the notified and non-notified slums in the city? Is there any community involvement or PPP model followed in the provision of toilet facilities?

**b. Drinking water management.**

1. What is the institutional arrangement for water supply in the city?
2. Is the water connection in the city metered? What is the total amount of water supplied in the city? What is the average time of water supply in the city per day? Do you supply water for non domestic purposes?
3. Please provide a list of both notified and non notified slums having piped water connections and not.
4. What are the major challenges to adequate water supply in the city?

**c. School Health.**

1. What are the activities that are covered in the school health programme?
2. How often are the medical camps conducted in the schools?
3. How are the involvement of parents and teachers ensured in improving the child health?
4. What is the mechanism for monitoring of school health activities?
5. Are the children provided with mid day meal? What are the nutrient supplements given to children?
6. What are the challenges faced to effectively implement the school health programme?

