“The future of India lies in its villages”. This famous quote of Mahatma Gandhi clearly focuses the commitment and concern of our leaders towards the rural India. Even though this has been aptly quoted by Mahatma, before the independence when more than three fourth of our populace lived in the rural areas, 66 years after independence a lot of transitions have taken place in the demographic characteristics of India. Rapid growth of industries, lack of job and educational opportunities, craving for better living conditions, economic security have attracted the rural population to urban areas leading to unprecedented urbanization with burgeoning urban slums. Population of India residing in urban areas has increased to its ever highest figure of 37.7 crore as per 2011 census compared to 28.6 crore in 2001. There is an interesting observation in relation to population growth in urban India, which follows a peculiar 2-3-4-5 syndrome: in the last decade India grew at an average annual growth rate of two percent, urban India grew at three percent, mega cities at four percent, and the slum population rose by five to six percent. As per Census 2001, 4.26 crore people lived in slums spread over 640 towns/cities having population of fifty thousand or above.1,2

The problems of urban India are much more complex and multifactorial, in addition to age old burden of communicable diseases, urban populace also suffer from considerable lifestyle diseases (non-communicable diseases), mental illness and substance abuse. Indicators related to the maternal and child health in few slums in our country are worse than some of the underserved rural areas. There is no homogeneity of population as evidenced by, considerable amount of migration, instability of slums, varied culture, fewer extended family connections, and more women engaging in work. There is a separate group of highly vulnerable group of people unique to urban localities such as homeless, rag pickers, street children, rickshaw pullers, sex workers, construction, brick and lime kiln workers, other temporary migrants who are less accessible to the health and welfare services. Keeping these observations in mind we need to rethink and restructure Mahatma’s quote to the current scenario.1,3,4

The Government of India in the First Five Year Plan established 126 urban clinics of four types to strengthen the delivery of Family Welfare services in urban areas. In 1976 these were reorganized into three types based on different population parameters and named as Urban Family Welfare Centers. On the recommendations of the Krishnan Committee, under the Revamping scheme in 1983, the Government established four types of Urban Health Posts (UHP) in 10 States and Union Territories with a precondition of locating them in slums or in the vicinity of slums. Even in spite of these efforts, urban health remained largely under addressed and that lead to uninterrupted growth of private sector, which largely provides curative health care, by selectively isolating urban poor from its facilities due to unaffordable cost for care.2,3

Successfully crossing the casualty of bureaucratic logjam and inter-ministry turf issues, a much awaited flagship programme of central government National Urban Health Mission (NUHM) has become a reality on 20th of January 2014, as a sub-mission of National Health Mission (NHM) in order to ensure quality health care to the urban poor. The mission is implemented in 779 cities and towns with more than 50,000 populations and in all the district head quarters irrespective of their population size. NUHM is expected to cater a population of over 220 million, of which an estimated 77.5 million are poor and vulnerable across the country.2,3

Goal

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

Core strategies

1. Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing existing government
primary urban health structure and designated referral facilities

As described in the initial section of the article, there are already few public health facilities available in the urban areas like urban family welfare centres, urban health posts, which are largely poor in staffing pattern, infrastructure, drugs, instruments etc., under NUHM, these structures are revamped and renewed in order to provide efficient services.

Urban Primary Health Centre: with outreach and referral facilities, to be functional for every 50,000 population on an average. However, depending on the spatial distribution of the slum population, the population covered by a U-PHC may vary from 5000 for cities with sparse slum population to 75,000 for highly concentrated slums. The U-PHC may cater to a slum population between 25000-30000, providing preventive, promotive, and non-domiciliary curative care (including consultation, basic lab diagnosis and dispensing).

Urban Community Health Centre (U-CHC) and Referral Hospitals: 30-50 bedded U-CHC providing inpatient care in cities with population of above five lakhs, wherever required and 75-100 bedded U-CHC facilities in metros. Existing maternity homes, hospitals managed by the state government/ULB could be de; In towns/cities, where some sort of public health institutions like Urban Family Welfare Centres, Maternity Homes etc., exist effort will be made to strengthen them on the lines of U-PHC and U-CHC. Based on GIS mapping, the cities would identify existing public sector health facilities to act as referral points for different types of healthcare services like maternal health, child health, diabetes, trauma care, orthopaedic complications, dental surgeries, mental health, critical illness, deafness control, cancer management, tobacco counselling / cessation, critical illness, surgical cases.

Outreach: Creation of Sub Centres has not been envisaged under NUHM. Outreach services will be provided through Female Health Workers (FHWs)/ Auxiliary Nursing Midwives (ANMs) headquartered at the UPHCs. ANMs would provide preventive and promotive health care services to households through routine outreach sessions. Expansion of services will be carried out through outreach to children by covering at least all government schools and Anganwadi Centres. Other schools located in the slums would also be covered. During such sessions, screening for birth defects, diseases, disability and deficiency (4 Ds) would be carried out and follow-up actions would be initiated.

2. Promotion of access to improved health care at household level through community based groups: Mahila Arogya Samitis

Link Worker / ASHA - One frontline community worker (ASHA) would serve as an effective and demand–generating link between the health facility and the urban slum population. Each link worker/ASHA would have a well-defined service area of about 1000-2500 beneficiaries/ between 200-500 households based on spatial consideration.

Mahila Arogya Samiti acts as community group, involved in community awareness, interpersonal communication, community based monitoring and linkages with the services and referral. The MAS may cover around 50-100 households (HHs) with an elected Chairperson and a Treasurer, supported by an ASHA. This group would focus on preventive and promotive health care, facilitating access to identified facilities and management of revolving fund.

3. Strengthening public health through innovative preventive and promotive action.

The ASHA, in coordination with the members of the MAS would promote proactive community action in partnership with the urban local bodies for improved water and environmental sanitation, nutrition and other aspects having a bearing on health.

4. Increased access to health care through creation of revolving fund.

The urban poor incur high out-of-pocket expenditure often leading to indebtedness and impoverishment. To mitigate this risk, it is proposed to encourage Mahila Arogya Samitis to “save for a rainy day” for meeting urgent health needs.

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

The availability of ITES in the urban areas makes it a useful tool for effective tracking, monitoring and timely intervention for the urban poor. The NUHM would provide software and hardware support for developing web based HMS for quick transfer of data and required action. Mobile telephony will be used for data gathering and follow-ups. It is envisioned that the GIS system envisioned would be integrated into a disease surveillance and reporting system on a regular basis. This system would also be synchronized with the IDSP surveillance system.

6. Capacity building of stakeholders.

NUHM proposes to build managerial, technical and public health competencies among Urban Local
Bodies/ Medical and Paramedical staff/ Private Providers/ Community level structures and functionaries of other related departments. The NUHM would promote active participation of the ULBs in the planning and management of the urban health programmes. In the seven mega cities, namely Delhi, Mumbai, Kolkata, Chennai, Bengaluru, Hyderabad, and Ahmedabad, the NUHM would be implemented through the City Urban Health Mission/Society. In other cities/ towns, NUHM will be implemented through the District Health Society except the large cities where in the view of the State Government, implementation of NUHM can be handed over to the City Urban Health Mission.

7. Prioritizing the most vulnerable amongst the poor.

Under the NUHM special emphasis would be on improving the reach of health care services to 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.

8. Ensuring quality health care services.

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

Public Private Partnership

In view of presence of larger number of private (for profit and not for profit) health service providers in urban areas, public – private partnerships particularly with not for profit service providers will be encouraged. NUHM will also support innovations in public health to address city and population specific needs. However, clear and monitorable Service Level Agreements (SLAs) need to be developed for engagement with Private Sector.

Issues and Challenges

1. National Urban Health Mission has emerged as a silver lining in the lives of millions of urban poor living across the country. However, there was no systematic exercise conducted to assess the health needs of urban poor before implementing the mission. Even though mission document quotes few studies to assess the health problems of urban poor, they were conducted in diverse geographic locations and are patchy in their sampling.

2. Urban areas have very complex administrative structures unlike rural areas where there is a well defined uniform system across the country. Administrative structures of urban areas are largely categorized into town panchayats, municipalities, municipal corporations, urban local bodies etc. Thus planning and implementation of services should also have to be different. This makes, designing and delivering services to urban areas operationally more complicated.

3. The entire framework of the mission does not mention anything regarding health insurance services. As people residing in urban areas have a highest out of pocket expenditure, health insurance coverage stands out as a unique solution to the problem. Thus, it has to be made as an integral part of NUHM service package.

4. Mission tends to be more skewed towards female participation. All the grass route level workers like ASHA/link workers, Mahila Arogya Samitis, and ANMs are exclusively females. Some of the common health and social problems like, alcoholism, substance abuse, and male participation in family planning services necessitate presence of male health workers/activists in the programme. This has to be adequately addressed.

5. Even though mission framework enlists all the vulnerable sections in urban areas like, rag pickers, rickshaw pullers etc., this does not describe the way to approach them and ensuring their access to health care. Outreach sessions of ANM itself cannot solve the puzzle unless some institutional framework is developed.

6. There is much emphasis on public private partnerships and NGO involvement through bipartite MOUs but, the mission should also consider the quality issues on service provision through these NGOs and faith based organizations.

7. Poverty line in India can be considered as a “magic rope”, political and administrative bodies either pull of push this rope in either of the directions to inflate or deflate the burden of poverty. Mission authorities should first decide on the beneficiaries based on a
well defined poverty measure and design their strategy accordingly.

8. Non-communicable diseases, mental illnesses, substance abuse, lifestyle interventions need specific strategies, which are to be addressed with special attention. NUHM again should not restrict itself to family welfare services.

9. There is no provision for sub centres under the mission. ANM and ASHAs will not have specific institutional arrangements in their catchment areas. All the illnesses need to be referred to UPHCs that will be quite away from these areas. Referred patients and especially those belonging to vulnerable groups may not visit the health centre.

10. Involvement of the private practitioners should be given utmost priority, as recruitment of doctors in government sector itself is a problematic option. We have seen enough of difficulties with doctors recruitments in rural areas, but the same thing may remain true for urban slums also as qualified persons residing in urban areas tend to go for private practice than, government services unless incentive norms are revised.

Conclusion

Much awaited National Urban Health Mission has been rolled out as a result of consistent efforts for years. This may become answer to most of our problems related to achievement of much ambitious millennium development goals. Achievements of NRHM have given much more strength and confidence for our health care policy makers towards implementation of this flagship programme. Let us hope that this programme brings about the equity in health services that the world of public health is starving achieve since centuries.

References


