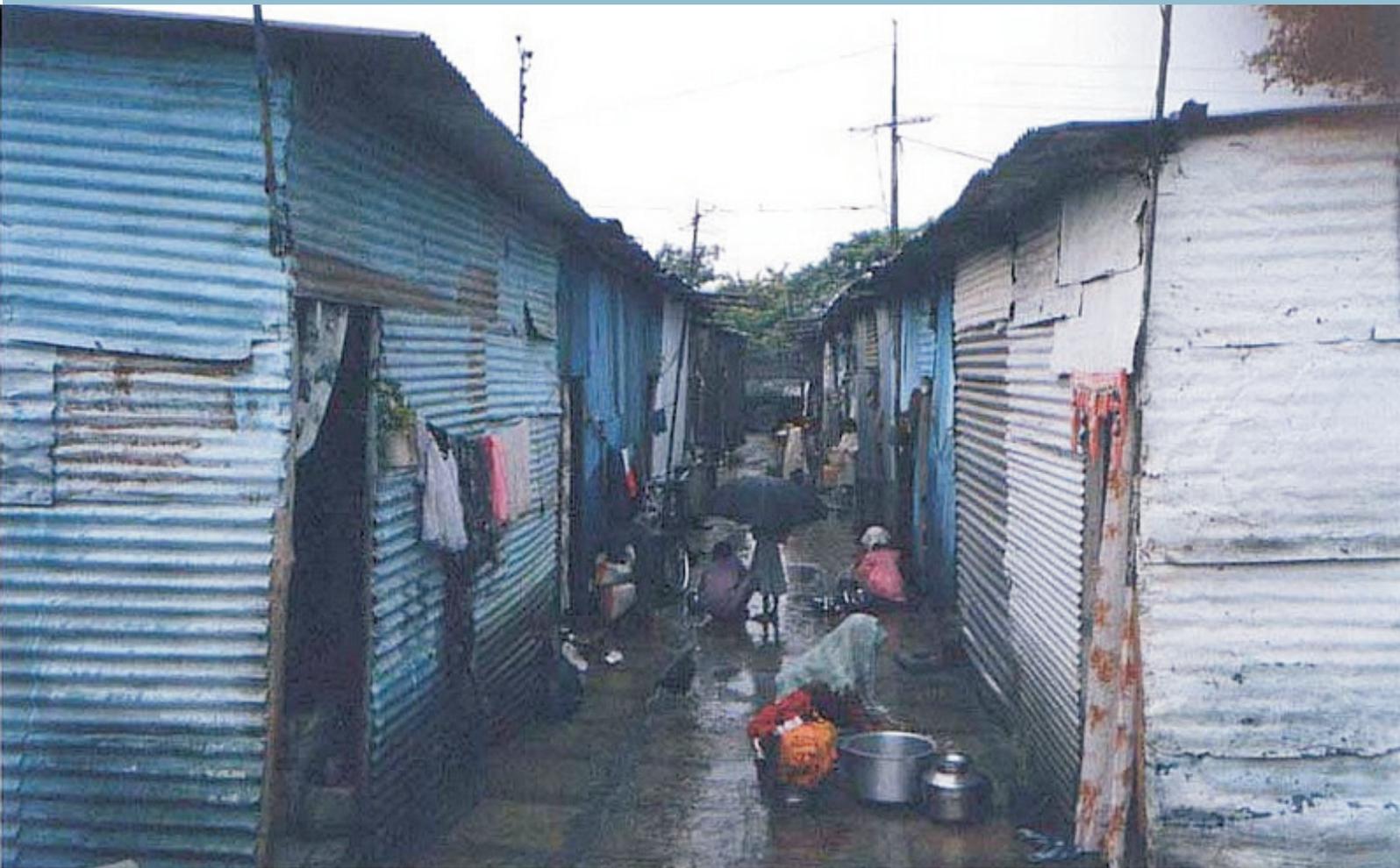




Institute of Health Management Pachod

HEALTH OF URBAN POOR IN MAHARASHTRA IN THE CONTEXT OF NUHM



- Organised by -

Institute of Health Management Pachod in collaboration with

Yashwantrao Chavan Academy of Development Administration and Government of Maharashtra

with technical support from - International Institute of Population Sciences, Mumbai



**WORKSHOP ON THE
HEALTH OF THE URBAN POOR IN
MAHARASHTRA
IN THE CONTEXT OF
NATIONAL URBAN HEALTH MISSION
(NUHM)**

Nov. 4th to 6th, 2008

Executive Summary

- Organized by -

Institute of Health Management, Pachod (Pune Centre)
in collaboration with
Yashwantrao Chavan Academy of Development Administration (YASHADA), Pune
Public Health Department, Government of Maharashtra
and
International Institute of Population Sciences (IIPS), Mumbai

Executive Summary

Workshop on the Health of the Urban Poor in the Context of NUHM

Dr. A. Dyalchand

Objectives of the state level workshop:

- Orientation of NUHM for key stakeholders in Maharashtra
- Take stock of the health status of urban poor
- Take stock of health infrastructure and health systems operating in urban areas
- Review tested innovations that can become a part of the Programme Implementation Plan of urban local bodies (ULBs) in the future
- Discuss the way forward for Maharashtra. The workshop is the first in the country involving government staff and officials on NUHM, and can provide Maharashtra a head start in its implementation

The projected scope of the workshop:

- Orientation of government staff to NUHM policy and strategies
- Trends and projections for urbanisation in Maharashtra
- Overview of the existing health infrastructure in Maharashtra
- Evaluation of the urban health infrastructure
- Health status of urban poor in Maharashtra
- Expenditure on health care by the urban poor and its implications for them
- Dimensions of urban poverty and its implications for health
- Health infrastructure, systems and services provided by urban local bodies
- Strategies innovations in urban health
- NUHM strategies, activities and plans – strengths and weaknesses
- Potential for public - private partnership (PPP)

The following are the highlights of the presentations made at the workshop:

Trends and projections of urbanisation in Maharashtra:

- Maharashtra is the second most urbanised state in India, with a high internal migration to large cities. It has the highest number of slums in the country.

Evaluation of urban health infrastructure in Maharashtra:

- Maharashtra has the largest number of urban health posts in India; however, a considerable number are not functional. Facilities are

deficient and there is shortage of staff, equipment and drugs. Services are not uniform across cities.

- The urban health infrastructure needs to be revamped, with attention given to financing of urban health posts. The role of urban social health activist (USHA) is crucial to ensure universal access to services by the poor.
- There is need for a comprehensive referral system and increased inter-departmental and inter-sectoral co-ordination.

Overview of the existing health infrastructure in Maharashtra

- Reliable and complete data are lacking. This must be rectified immediately if comprehensive planning is to be carried out.
- There must be a demonstrated political will to assume responsibility and accountability for services, arrange for requisite finance, and coordinate with concerned groups, unions, etc. PIPs must also be tailored to meet each area's specific needs and specifications.
- There is need to streamline and integrate personnel across programmes, and introduce innovative methods of increasing motivation. Attention needs to be paid to pay scales, staff diversion for other health promotion activities, and continuous capacity development.
- The poor participation of civil society in urban health services must be reversed. Support for the implementation of national programs must be ensured. Comprehensive management information system (MIS) must be created and put in place, and the excessive focus on RCH must be reconsidered. Greater involvement of the private sector through PPP must be accompanied by greater regulation and accreditation.

Health status in urban areas

- The health status of the poor in urban areas is worse than that of their rural counterparts. Small towns are particularly vulnerable because of a lack of infrastructure, and the poor health of the urban poor. Poor knowledge of available services leads to low usage. A targeted approach to ensure universal access must be initiated.

Expenditure on health care by urban poor and its implications for them

- Use of health services by the urban poor involves large out-of-pocket expenditure by them, causing indebtedness and further poverty. Financing mechanisms for cross subsidization must be set up. Viable funding options and adequate monitoring by civil society must be ensured.

Identification of the urban poor

- NUHM implies a pressing need for identifying the poor in cities and small towns. There is a large variation within each slum population: slums are not synonymous with 'poverty'. The lack of an index for identifying the poor makes the process difficult. New migrant groups and squatters form slum groups with a high degree of mobility. Care must be taken to include all vulnerable and marginalized sections of the urban poor.

Key Recommendations:

- Use mapping and census in urban slums to provide baseline information
- Create an index for identification of urban poor
- Introduce a monthly surveillance system and micro-planning for urban health programs
- Encourage community participation through slum level committees (made up of women and men of different age groups)
- Integrate community monitoring mechanisms with existing groups like school PTAs, self help groups, etc.
- Strengthen CBOs to generate demand
- Increase monitoring of services in order to increase utilization.
- Increase the role of USHA for delivering structured outreach services and focused behaviour change communication (BCC) as opposed to generic messages
- Integrate programs, provide a functional referral system and comprehensive follow up. Collaboration between NGOs and ULBs must be attempted. There is scope for public-private partnerships and outsourcing of services
- Integrate Adolescent Reproductive and Sexual Health (ARSH) programmes with HIV and RCH programmes
- Integrate programmes that deal with communicable diseases with urban health programmes
- Create community based insurance schemes
- Involve volunteers from slums and the larger society through the creation of committees at the ward level
- Use appreciative enquiry for the better provision of services and for effective implementation of interventions
- Create training manuals for surveillance and need assessment, training of trainers, BCC, and for monitoring coverage and quality of services
- Make provisions for the scaling up of successful interventions for replication within larger settings, like the government. Scaling up requires extensive documentation of interventions, protocols, processes and norms, and the impact of different interventions. For this, the capacity building of NGOs is required
- Establish a **Task Force** to formulate a program implementation plan for Maharashtra

Workshop on the
Health of the Urban Poor in
Maharashtra
in the Context of
National Urban Health Mission
(NUHM)

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Report

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Foreword

Maharashtra is the second largest state in the country, in terms of population, and the second most urbanized state in the country after Tamilnadu. Maharashtra has a higher urban growth rate as compared to other states. Migration contributes to one-third of the urban growth and majority of migrants (70 per cent) come from within Maharashtra.

Several large scale surveys indicate that the health status of people living in urban slums is worse than the rural population in the state. This is particularly true for vulnerable and marginalized sections of urban society. The health indices of this burgeoning urban poor population are much worse than the state average.

In light of the rapid population growth in urban India, the increasing proportion of people living in urban slums, near absence of an effective infrastructure and the poor health indices of this population, the Government of India established a Task force to develop a policy for the health of the urban poor known as the National Urban Health Mission (NUHM)

NUHM aims to improve the health status of urban poor particularly slum dwellers and other disadvantaged sections by facilitating equitable access to quality health care through a revamped public health system, partnerships and 'communitised' risk pooling with the active involvement of ULBs.

Institute of Health Management, Pachod (IHMP) Pune centre, organized a workshop on "Health of the Urban Poor in Maharashtra" from Nov. 4th to 6th, 2008, in collaboration with Yashwantrao Chavan Academy of Development Administration (YASHADA), Pune and the International Institute of Population Sciences (IIPS), Mumbai. The principal objective of the workshop was to identify strategies for effective implementation of health care for the urban poor in the context of the National Urban Health Mission (NUHM) in Maharashtra.

In sharp contrast to rural areas, absence of reliable data and information on health for urban areas is of immediate concern, as it makes health planning for urban areas an impossible task. The workshop on "Health of the Urban Poor in Maharashtra" enabled us to collect an anthology of information from the Ministry of Health, Government of Maharashtra, urban local bodies, research and training institutions, and non government organizations in the State, which policy makers and administrators will find valuable in strategic planning for implementing NUHM in their city. This information is presented in this monograph - Health of the Urban Poor in Maharashtra in the context of NUHM.

I would like to acknowledge the vast effort put in by Dr. Anil Paranjape, Dr. Megha Antwal, Dr. Arvind Menon, Ms Kalpana Sanas and other staff of the Institute of Health Management, Pachod (IHMP) Pune centre in organizing the workshop and putting together this monograph.

A. Dyalchand

Director

Institute of Health Management, Pachod (IHMP)

Chapter I

Introduction to State Urban Health Workshop

Dr Ashok Dyalchand

The Institute of Health Management, Pachod (IHMP) Pune Centre, has been providing health care services in the slums of Pune city for the last 12 years, since 1996. The Institute has developed a unique model for primary health care for the urban poor living in slums. This has received attention at the national and international levels. The Institute was invited to be a member of the taskforce formed by the Government of India in 2007-2008 to formulate the urban health policy under the National Urban Health Mission.

In light of the developments that have taken place under the National Urban Health Mission, **IHMP** Pune centre, organized a workshop on “**Health of the Urban Poor in Maharashtra**” from Nov. 4th to 6th, 2008, in collaboration with Yashwantrao Chavan Academy of Development Administration (**YASHADA**), Pune and the International Institute of Population Sciences (**IIPS**), Mumbai.

Dr Dyalchand introduced the workshop and outlined the agenda. He highlighted the rapid urbanization in Maharashtra and increase in the number of urban poor living in slums, placing a huge strain on the existing urban health infrastructure. He stressed that the objective of the workshop was to identify strategies for effective implementation of primary health care for the urban poor in Maharashtra, in the context of the National Urban Health Mission (NUHM), and to provide guidelines to local urban bodies.

Dr Dyalchand outlined the following key policy briefs of the National Urban Health Mission (NUHM):

1. Strengthen the existing urban health infrastructure.
2. Focus on urban poor and other vulnerable populations in listed and unlisted slums.
3. Protect the poor from the impoverishing effect of out of pocket expenditure.
4. Strengthen community participation in planning and managing health delivery.
5. Appoint USHA (Urban Social Health Activist).
6. Involve urban local bodies in the planning and management of urban health programs so as to promote transparency and accountability.

He suggested that the immediate implications of these policy objectives on planning are:



Workshop inauguration by Mr Nitin Kareer (IAS) Ex Divisional Commissioner Pune, along with (From left) Dr Ashok Ladda, Dr R.B. Bhagat, Ms Manisha Khale, Dr Ashok Dyalchand, Mr V Ramani



Mr V Ramani (IAS), Director YASHADA

-
- To ensure convergence between government programs dealing with HIV/AIDS, and communicable and non-communicable diseases. This will entail integrated service provision, systems development, and planning at the city level.
 - To increase state funding, increase revenue potential of ULBs, and cross subsidization and regulation of the private sector

Dr Ashok Dyalchand is Director, Institute of Health Management, Pachod.

Inaugural Address - Mr Nitin Kareer

Mr Kareer presented a broad outline of the present urban health system in Maharashtra. He pointed out the gaps in the existing system and made important recommendations for improvement. He stated that it is imperative that the lessons learnt during the implementation of NRHM be applied during the implementation of NUHM. For urban areas, a well-defined, uniform infrastructure should be put in place, as distinct from more “soft” forms of infrastructure development in rural areas.

The key issues raised by Dr Nitin Kareer were the following:

1. In spite of having good hospitals, medical colleges and health facilities, actual health delivery in urban settings is poor. This is mainly because the urban health care system is focused on secondary and tertiary care, and not on primary level services.
2. Overburdening of staff in public health care facilities and the adverse doctor-patient ratio in these institutions is one reason for the low utilization of health services.
3. Over emphasis on public-private partnerships may lead to discrepancies in health care provision.
4. The government must create primary health facilities in urban slums through an infrastructure similar to that existing in rural areas.
5. Lack of support for USHA from the government, will not permit her to work effectively.
6. There is need to identify vulnerable sections of the urban populations and ensure that they receive services, rather than focusing exclusively on the poor as intended beneficiaries.

Mr. Nitin Kareer IAS, former Divisional Commissioner, Revenue Division, Pune Municipal Corporation, is currently posted as Secretary to Chief Minister, Maharashtra.

Inaugural Address - Mr. V. Ramani

Mr. Ramani described the urban health workshop as an “idea whose time has come”. He stressed the necessity of central involvement and support for the issue of urban public health. The key issues raised by Mr. Ramani were:

1. In sharp contrast to rural areas, the absence of reliable data on health for urban areas makes programs aimed at them directionless and inefficient. One solution may be the introduction of a SMART card to track the health status of families.
2. The ultimate responsibility of providing health services in urban areas is not clear. Unlike rural areas where the district administration is in charge of public health, there is still some ambiguity regarding this in urban areas. Mr. Ramani suggested that the responsibility for urban health must lie with the urban local bodies.
3. The unplanned introduction of personnel within the health system often creates problems that may result in barriers to effective implementation. A challenge in implementing urban health would be to integrate and sustain new personnel.
4. The funding modalities for urban programs must be planned in advance so as to offset the twin problems of urban immigration and increasing loads of an aging population. Innovative schemes could include strengthening existing health programs, public-private partnerships and participation of civil society.

Mr. V Ramani, IAS, is Director General, Yashwantrao Chavan Academy for Development Administration.

Chapter II

Pattern and Processes of Urbanization in Maharashtra

Dr. R.B. Bhagat

Dr. Bhagat suggested that urbanization plays a major role in the process of social change and modernization. It is an inevitable fact and should be viewed positively.

Key Findings

- Maharashtra is the second largest state in the country in terms of population and also is the second most urbanized state after Tamilnadu.
- Migration contributes to one-third of the urban growth in Maharashtra and the majority of migrants (about 70 per cent) come from within Maharashtra.
- Maharashtra state has the highest urban growth rate in the country.
- There are basically two definitions of urbanization
 1. Demographic
 2. Sociological
- The demographic definition is important as it deals with number of people, growth, and planning.
- Urbanization within Maharashtra is very lopsided. Western Maharashtra is more urbanized as compared to extreme parts of Vidharbha and Marathwada, which have the lowest level of urbanization in the state.
- Mumbai, Thane, Pune and Nagpur are the most urbanized cities in Maharashtra.
- There are 7 million cities in Maharashtra in which almost 51% of the State's population resides.
- The decadal growth rate is going to slow down in the future, but the urban population will increase.
- The Census in 2001 collected data on slum population for the first time.
- The slum population of urban Maharashtra is 27% of the total. The contribution of Mumbai alone is 54% of the total slum population.
- In the context of the health of the urban poor, the percentage distribution of the SC and ST population is important. The SC and ST population in Maharashtra is 10% and 9% respectively.
- There are 127 non-municipal towns (one-third of total urban centers), which are mostly governed by rural local bodies. There is a need to grant them Nagar Panchayat status as per the provision of the 74th Amendment of the Constitution.
- A few cities in Maharashtra have a very high level of slum population and also a high proportion of SC and ST communities.

-
- The large proportion of SC and ST communities living in the slums are more vulnerable, and should be given priority while implementing NUHM in Maharashtra.
 - Issues of social exclusion and marginalization should be immediately addressed.
 - The Muslim community should be given special attention as it constitutes one-sixth of the urban population in Maharashtra, and it is spatially segregated. There is high unmet need of reproductive health care among Muslim women.

Dr R. B. Bhagat is Professor, Department of Migration and Urban Studies, International Institute for Population Sciences, Mumbai.

Chapter III

Maternal and Neonatal Health Status in Urban Slums of Maharashtra

Dr Benazir Patil

The Sure Start project is being implemented in urban slums in 7 cities of Maharashtra. A baseline survey was conducted in the slums of Mumbai, Navi Mumbai, Pune, Nagpur, Malegaon, Sholapur and Nanded. A structured questionnaire was used, covering 3284 mothers who had delivered a live birth during the calendar year 2007.

Key Findings

Profile of the respondents

- 20% were illiterate
- 91% mother were not working
- 99% of the spouses of respondents were working
- 41% were using public toilets and 33 percent had their private toilet facility
- 82% had their own electricity connection
- 71% had their own house
- Only 15% owned agricultural land
- 7% households had a monthly income of less than Rs. 1000
- 80% households had a monthly income of Rs. 1000 to 5000
- Urban health facilities were not affordable for the slum dwellers

Knowledge about safety measures during antenatal period

- 47.7% were aware of the need for regular AN checkups
- 40.5% were aware of the need for immunization with Tetanus Toxoid
- 40.3% felt the need for taking iron folic acid during the AN period
- 27.6% believed in taking extra rest during the antenatal period

Antenatal care - service utilization

- 43% got registered for ANC in the first trimester, 37% in the second trimester and 19% in the third trimester.
- 49% received antenatal care from a private hospital
- 25% received fewer than 3 ANC checkups

Knowledge about danger signs during pregnancy

- Knowledge about fifteen key danger signs during pregnancy ranged from 2% to 20%

Knowledge about birth preparedness

- Knowledge of fourteen key issues that require preparedness before delivery ranged from a mere 2% to 30%.

Intra-natal care - place of delivery

- 78% had an institutional delivery
- 22% deliveries, even in urban slums, are conducted at home

Knowledge about potential complications during delivery

- Knowledge of 6 key potential complications during delivery ranged from 5% to 20%

Out of pocket expenditure for delivery

- 72% of the respondents, on an average, paid a fee of Rs. 500 to 1000 for delivery. The range of fees paid was Rs. 100 to 10,000.

Janani Suraksha Yojana (JSY)

- Only 9% respondents knew about Janani Suraksha Yojana (JSY). Of those who knew about JSY only 36% received JSY money, and of those, 25% received the money before or at the time of discharge, 41% a week after discharge, 17% within one month, and 13% received JSY money more than a month after delivery.

Knowledge about danger signs during postnatal period

- Awareness levels about the 12 potential complications during the postnatal period ranged from 2% to 20%

Knowledge about essentials of new born care

- Awareness about the six essentials of new born care ranged from 10% to 30%

Knowledge about neonatal danger signs

- Awareness levels in this regard ranged from 5% to 20%

Newborn care and postpartum period

- 81% of the newborns were weighed after birth
- 91% of these newborns were weighed within one hour of birth
- Of those who were weighed, 44% weighed less than 2.5 kg

Initiation of breast feeding and prelacteal feeds

- 20% reported that they had initiated breastfeeding 1 to 5 days after delivery
- 30% gave pre-lacteal feeds such as honey, sugar and water, top milk, etc.

Exclusive breast feeding

- Merely 39% mothers reported exclusive breast feeding for 6 months

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- The main reasons for not practicing exclusive breast feeding were custom, failure of lactation, problems with the breast, and poor health of mother or new born.

Conclusions:

Maternal health

- Late or no registration for ANC
- Specific beliefs / misconceptions about diet
- Prevalence of home deliveries

Neonatal health

- Delay / lack of early and exclusive breast feeding
- Bathing immediately after birth

Other findings

- Negative attitude towards public health facilities
- Lack of quality of care
- Lack of financial resources
- Poor urban outreach services
- Restrictions on decision making by women

Dr Benazir Patil is the State Manager, Sure Start Project, PATH Mumbai. This presentation was prepared in collaboration with Dr. Rashmi Asif, PATH

Chapter IV

Variation in Reproductive and Child Health Status in Urban Maharashtra by size of Towns and Cities - NFHS III

Dr. Madhuree Talwalkar

Based on the NFHS III data, Dr. Madhuree Talwalkar described the variations in health status in urban areas, by population of urban setting. Urban settings compared were:

- **Mega city:** Fifty lakhs and above
- **Large city:** Ten to fifty lakhs
- **Small city:** One to ten lakhs
- **Small Towns:** Less than one lakh

Key Findings

Antenatal care and T.T. immunization

The percentage of pregnant woman receiving 3 or more ANC visits was least in small towns (73%).

The percentage of pregnant woman that had received 2 tetanus toxoid injections was lowest in small towns (84%).

Place of delivery

The percentage of home deliveries was highest in small towns (30%). The proportion of institutional deliveries was lowest in small towns. The share of private deliveries was high in small towns, probably because of non-availability of health infrastructure.

Immunization coverage

Immunization coverage for children 12 to 23 months was lowest in small towns (55.8% complete immunization), even lower than that of slum populations in large cities.

Completed family size

The mean number of children born to women aged 40 to 49 years was 3.78 in small towns as compared to 2.89 in mega cities.

Mean number of children born to women aged 15 - 49 years

Mean number of living children born to women aged 14 - 49 years, in small towns was 2.02 compared to 1.50 in mega cities. Child loss (as percent of children ever born) was 6.5 percent in small towns as compared to 5.1 in mega cities.

Married girls and teenage fertility (adolescent girls between 15 - 19 years)

Incidence of married adolescent girls and teenage fertility rate was highest in small towns as compared to the other cities. Percentage of adolescent girls 15 to 19 years who have had a live birth was 12.2 in small towns as compared to 5.3 in mega cities.

Contraception: currently married women (15 - 49)

The percentage of women aged 15 - 40 years who had undergone sterilization was higher in small towns, 49.3% as compared to 39.3% in mega cities. But the percentage of women maintaining requisite spacing between two children was lower in small towns.

Post natal complications

Percentage of women reporting postnatal complications was higher in large cities (12.6%) followed by small towns (11.0%).

Birth weight

The percentage of newborn babies not weighed was highest in small towns (25%) compared to 11% in mega cities. The proportion of low birth weight babies was higher in mega cities (22%) as compared to small towns (21%)

Childhood diseases

The reported prevalence of fever, ARI and diarrhea was significantly higher in small towns and small cities compared to large and mega cities. However, the use of ORS after diarrhea was much higher in mega cities 50% as compared to 22% in small towns.

Anemia in women:

Prevalence of anaemia and poor nutritional status (BMI < 17.5) was significantly higher in small towns and small cities as compared to large and mega cities.

Literacy and poverty

The proportion of women, with no literacy, SC / ST, the proportion with the poorest wealth index and the proportion having no toilet facilities was a great deal higher in small towns compared to all the other cities.

Conclusions

- The health status of small towns and small cities is much lower as compared to large and mega cities, small towns being the worst affected.
- The poor health status of small towns is partly due to near-rural socio-economic characteristics of the population and the lack of a well-established health infrastructure.
- Disadvantaged groups among urban population should be given priority while implementing NUHM in Maharashtra.

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- Not only big cities but also small towns and small cities should be included under NUHM to improve the health status of the urban poor.

Dr Madhuree Talwalkar was the State Demographer for Maharashtra. Currently she is working as Consultant, Institute of Health Management Pachod.



Dr Ashok Ladda, Joint Director (TB & Leprosy) Public Health Department



Dr. Sulabha V. Akarte, Prof and Head, Dept of Community Medicine
Grant Medical College and JJ Group of Hospitals, Mumbai

Chapter V

Key elements of the Urban Health Infrastructure in Maharashtra

Dr. Ashok Ladda

Dr Ashok Ladda provided an overview of the existing urban health infrastructure in Maharashtra and also identified gaps in the system.

Key Issues:

Demographics of Maharashtra

- Maharashtra is the second largest state with 9.42% of the national population and having 42.3% urban population (2001 Census)
- About 30% of the urban population lives in authorized slums. Information about non-authorized slums and pavement dwellers is not available.

Administrative infrastructure

- There are 22 corporations, 222 Municipal Councils and 7 Cantonment Boards.
- The population of Mumbai is 11.91 million and that of Thane is 4.75 million with six corporations.
- Mumbai and Thane District Corporations account for 58% of the total population under the jurisdiction of corporations in Maharashtra
- Maharashtra State Urban Scenario (2001 census)
There are three types of Municipal Corporations.

○ 'A' Type municipal councils	-	18	(30.63 lakh population)
○ 'B' Type municipal councils	-	62	(37.96 lakh population)
○ 'C' Type municipal councils	-	142	(33.20 lakh population)
		Total	- 222 (10.24 million

population)

The health indicators of Municipal Councils of B and C types are poor.

Public health department structure in Maharashtra

- Dr. Ladda presented the organogram of the Public Health Department and the city health services. He also presented organograms for urban health posts and UFWCs.

GOI funded Health Institutions in the State are as follows:

Urban Family Welfare Centers (UFWC):

- Type I - 21 (11 functional)
- Type II - 10 (10 functional) - 1 run by NGO
- Type III - 50 (40 functional) - 22 run by NGOs
- Total - 81 (61 functional) in 13 Corporations and 42 Municipal Councils

Urban Health Posts (UHP)

- Type A and Type B municipal councils have 13 UHPs, all are functional.
- Type C municipal councils have 43 UHPs, 41 are functional; four are run by NGOs.
- Type D municipal councils have 216 UHPs, 193 are functional, 30 are run by NGOs.
- Total 285 UHPs (260 are functional) in 20 Corporations and 9 Municipal Councils.

Urban infrastructure under RCH - II

- Urban Health Posts
 - 379 in Corporations
 - 55 in Municipal CouncilsTotal - 434
- ANMs employed on a contractual basis in Municipal Councils - 1015 ANMs

Human Resource

- UHPs are facing a serious problem regarding shortage of staff
- Additional health posts and staff will be proposed after considering the current population and NUHM norms.

National health programs

The administrative structure and staffing patterns of the National Vector Borne Disease Control Programme (NVBDCP), the Revised National Tuberculosis Control Programme (RNTCP), and the National Leprosy Eradication Programme (NLEP) were described in detail by respective programme officers (refer presentation).

Funding for Urban Health Programmes

- Only a few Corporations like Mumbai, Pune, PCMC, Navi Mumbai, and Nagpur have the administrative and financial capacity to provide Urban Health Services
- Other Corporations need to demarcate separate and sufficient budgets.

Funding sources:

- Central Govt.:
 - RCH, FW, JSY & RI activities
 - UHP & UFWC
 - Drugs & chemicals for RNTCP, NLEP & NVBDCP
 - Staff for RNTCP (except 15 CTBs),
- State Govt.:
 - Staff under NLEP & NVBDCP
 - Local bodies: for Hospitals and Dispensaries.

Referral:

- **Corporations:**
Referral services are available in Corporation hospitals / District hospitals / Medical college hospitals
Good number of private hospitals are available
- **Councils:**
 - Few Councils have their own hospitals
 - Majority of Councils get referral services from nearby headquarter Rural hospitals and District hospitals

Gaps in the Urban Health System:

1. Infrastructure:
 - Except for Mumbai and PCMC, all Corporations / Councils need additional Health Posts and FRUs as per NUHM guidelines.
2. Funding:
 - Only a few corporations such as Mumbai, Pune, PCMC, Navi Mumbai, and Nagpur have the administrative and financial capacity to provide Health Services.
 - All councils should have a separate budget for Urban Health Services.
3. Transport:
 - All Corporations have their own ambulances in addition to private / NGO ambulance services.
 - A few councils have their own ambulances such as councils at district headquarters and councils at headquarters of PHC/RH.
4. Manpower:
 - A few corporations have the requisite manpower to provide and monitor health care services, but for the remaining corporations there are substantial gaps.
 - Councils usually lack capacities.
5. Access to the poor:
 - NFHS III provides desegregated data for urban poor only for Mumbai and Nagpur, which indicate very poor health status of this population. There is paucity of data on urban poor living in slums of other cities.

Recommendations:

- Undertake a city wise analysis of health indicators for urban poor.
- Facilitate survey and study of utilization rates for urban health services.
- Implement aggressive planning of NUHM initiatives.
- Implement public / private initiatives wherever feasible.
- Implement cashless insurance services in accredited private / public hospitals.

Steps taken by the State for NUHM:

- Joint secretary (H) identified as State Nodal Officer.
- NUHM cell, under Joint Director established.
- Organogram for NUHM in the State finalized.
- Sensitization of MOH, corporations to be conducted.
- Coordination meeting of Department of Public Health, Urban development and JNNURM officers to be conducted.
- Uniform structure for collecting baseline information for NUHM developed, circulated and information being compiled.
- Study tour of MOH and corporation to Indore and of MOs and the councils to Agra organized in October 2008.
- GOI has been requested for additional support for GIS mapping.

Dr Ashok Ladda is Joint Director, Leprosy and Tuberculosis, Department of Health Services, Government of Maharashtra.

Chapter VI

National Report on Evaluation of Functioning of Urban Health Posts/ Urban Family Centers in India

Dr Chander Shekhar, Dr Faujdar Ram

Introduction

The National Report on the evaluation of the functioning of urban health posts / urban family centers in India was sponsored by the Ministry of Health and Family Welfare, Government of India, New Delhi. The population centers in the various states conducted the evaluation. Dr Chander Sekhar presented the overview of this report.

Urban Family Welfare Centers (UFWCs) have been functioning since India's family planning programmes were launched in 1951.

In the eighties, as a result of the recommendations of the 'Krishnan Committee Report', 1982, Urban Health Posts (UHPs) were opened to provide primary health care for urban slums and the urban poor. The major responsibilities of these posts are to work as channels for providing integrated service delivery including antenatal, natal and postnatal care, child immunization, treatment of minor ailments, and advice and services to family planning acceptors.

The urban health posts were initiated under the 'Urban Revamping Scheme' sponsored by the Central Government. The Ministry of Health and Family Welfare, Government of India provides an annual grant for urban family welfare centers and urban health posts.

According to the 2001 census, 28% of the country's population lives in urban areas. However, the decadal growth rate in urban areas has almost doubled from 1951-60 to 1991-00. The decennial growth rate of urban population has gone up from 18 percent during 1951-61 to 30 percent during 1991-2001. This increase caused both by natural increase as well as by rural to urban migration, has created pockets of low socio-economic status in urban areas that suffer from a high unmet need for health care.

The number of million cities in India swelled from 23 to 35 from 1991 to 2001, thus creating an additional demand for basic necessities of life including health care services. The lower socio-economic populations of urban slums tend to have higher unmet health care needs. Since slum populations are composed of migrants, it is more challenging to make adequate health services available to them. The Government of India adheres to the National Population Policy (2000) that puts urban slums among under-served population groups in health care.

Key findings:

1. 740 Urban Health Posts (UHPs) and 789 Urban Family Welfare Centers (UFWCs) are currently functioning in the country. The average catchment area is 48557 persons for an urban family welfare centre and 62603 persons for an urban health post. This ranges from 110,000 (Bihar) to 5535 (Rajasthan)
2. The states of Haryana, Punjab, Tamil Nadu, Andhra Pradesh, and West Bengal serve a smaller population per health facility. In Maharashtra, more than half of urban health and family welfare centers are in the city of Mumbai alone.
3. About 43% of all urban health care centers are more than 30 years old, and more than half of those are older than 50 years.
4. 55% of the total urban health posts in India have their own building provided by the government; one in five centers is attached to either a hospital or an urban health centre. Only 4% facilities have a car or jeep.
5. About 90% of all urban health bodies are controlled by DHMO/ CHMO/ CHO/ DFW/ DHO, or by local bodies such as municipal bodies, etc. Among these, the former accounts for two-thirds of the facilities. Of all urban health centers, 64% have medical officers, and about 84% have public health nurses.
6. Analysis of the training status of staff in urban health posts / family welfare centers reveals that training is inadequate in the topics of acute respiratory infections, immunization and diarrhoea.
7. For efficient service provision, at least 29% facilities should recruit a male or female medical officer on an urgent basis, and 16% should recruit a public health nurse
8. 21% of the personnel require comprehensive training in Reproductive and Child Health.
9. The availability of equipment is mostly satisfactory, but the proportion of equipment in working condition is low. Haemoglobinometers, weighing machines and medicine chests are in short supply. The disproportionately large amount of money spent on registers could be diverted to other supplies and innovative schemes, e.g. SMART cards could be used for tracking the health status of the people.
10. Urban health facilities in Maharashtra have served the maximum number of clients (about 8,700) in 2007. Across the country, the number of patients attending outpatient departments in urban facilities has shown a steady increase in the past three years.
11. Exit interviews with clients point to the need for regular supply of medicines, additional paramedical staff, improved laboratories for better quality services at urban health centers/posts, and use of public address system and IEC material for demand generation in the community as essential measures to improve quality of services.
12. Grading of urban health facilities across India on the basis of availability of staff, equipment in working condition and regular supply of drugs and materials puts 497 urban health facilities (UHPs and UHFWCs) in the

“good” category, and 540 in the “average”, out of a total of 1529 such facilities. In Maharashtra, 57 UHPs were rated as good and 139 as average, out of a total of 303 centers.

13. There is urgent need to improve 99 facilities that have been graded as ‘poor’, most of them from Haryana, Maharashtra and Tamil Nadu.
14. Exit interviews with beneficiaries revealed that most respondents received services within half an hour, the majority felt that the behaviour of the doctor and staff was good, and that the location of the centre was convenient. About 63% reported that they were visited by a health worker at home in the previous month.
15. Around one-fourth of the total beneficiaries reported that no health worker had visited their community or home during the last one month. It may be inferred that outreach and follow-up services need improvement.

Dr Faujdar Ram is Director, International Institute of Population Sciences, Mumbai.

Dr Chander Shekhar is Reader, International Institute of Population Sciences, Mumbai.

Chapter VII

Evaluation of Functioning of Urban Health Posts and Urban Family Welfare Centers in Maharashtra

Dr. Sanjeevani Mulaye

Objectives of the Evaluation

- To find out the present status of functioning of UFWCs and UHPs in the state.
- To find out whether outreach, preventive and referral services are being provided.
- To assess the medical and paramedical manpower, infrastructure and equipment available in the centers.
- To recommend the extension of the programs/schemes to the needy areas.
- To identify gaps for strengthening and reorganization of the centers for better utilization and provision of improved facilities.

Introduction

There are 846 urban health posts (UHPs) in India, of which 281 UHPs are in Maharashtra.

Urban health posts are divided into 4 types, type A (less than 5,000 population), type B (5,000 to 10,000 population), type C (10,000 to 25,000 populations) and type D (population above 25,000). Almost 75 percent UHPs are of type D.

Key Findings

Distribution of UHP/ UFWC in Maharashtra:

Broadly, the locations of the centers conform to the basic criterion set for UHPs, which is that they must be for the low-income strata. However, this is not true for Mumbai, which has 37% of the slum population in the state, but the population under UHP/UFWCs in Mumbai accounts for only 26% of this population.

The UHP/UFWCs are located mainly in big towns. Small towns are deprived of any government health facilities.

Overall, large numbers of UHPs/UFWCs are full-fledged health centers and can provide a variety of services. However, there are districts like Latur and Parbhani, which do not have a single full-fledged centre.

Some of the UHPs and UFWCs are non functional. Out of 281 UHPs 244 are functional and of 72 UFWCs 59 are functional.

Staffing Pattern:

Small towns with a population of 10,000 to 20,000 do not have a Primary Health Centre (PHC) or a Rural Hospital (RH). These towns have urban

health posts of type A and B, which do not work efficiently; hence these small towns are deprived of public health services. As compared with PHCs, the staff available at these UHPs consists of only one nurse midwife in Type A and B UHPs and two nurse midwives in type C UHPs, despite the fact that the activities expected to be carried out are similar to a PHC. The norm for sanctioned staff is inadequate and sanctioned posts are not filled.

There were no male medical officers sanctioned but 44 doctors were actually working in the centers. In some places where UHPs are attached to hospitals, they were being used as additional ancillary resources.

Infrastructural facilities in UHP/UFWC

Broadly speaking, facilities such as water, electricity and toilet were adequate. However, some UHPs of type A/ B/ C have some problems regarding these facilities. About half the centers lack transport facilities. UFWCs of type I and II are worst in this respect. There was inadequate supply of instruments, furniture, material supply, and drugs.

Supply of medicines and equipment

The smaller centers (UHPs of type A, B, or C and UFWCs of type I and II) have inadequate supplies of materials such as ORS packets, reagent strips, syringes, IFA tablets, TT injections and cotrimoxazole tablets. In these smaller facilities there is also shortage of hemoglobinometers, infant weighing machines and medicines. Only in case of contraceptives, there are no shortages even at small centers.

Expected activities of UHP and UFWC

Services expected to be provided by the UHPs and UFWCs include ANC, PNC, intra-natal care, immunization, and treatment for RTI/STI and diarrhea. However, the only satisfactory services available at these facilities are sterilization and family planning.

Activities of UHP/UFWCs are designed on the lines of PHCs and Sub-Centers. However, the sanctioned staff-strength is inadequate. For example, a sub-centre with 5000 population has one ANM and one MPW, whereas a type A - UHP has only one ANM.

For centers that are attached to hospitals, performance related data are not available. Although a number of activities are stipulated, only ANC, immunization, and family planning services are provided at these centers. There is a large demand for services by the urban poor, but centers of type A, B and C do not have sufficient infrastructure and staff. If all the existing centers were to work efficiently a considerably large population could be served.

Recommendations

- The staffing pattern of UHPs and UHSCs needs to be reconsidered.
- There is need for effective supervision and monitoring to ensure that these facilities function efficiently.
- Continuation of smaller centers (UHPs of type A, B and C and UFWCs of type I and II), particularly those not attached to any hospital need to be seriously reconsidered.
- The centers need to be better equipped, provided with necessary drugs and supplies.
- In case of centers attached to hospitals, the facilities must have the staff and infrastructure earmarked for them.

Dr Sanjeevani Mulaye is Retired Reader, Gokhale Institute of Politics and Economics.



Ms. Nasrin Siddiqui, Director, CESJHD, YASHADA



Presenters interacting with the audience (From Left) Mr Ravi Duggal, Ms Aparna Sharma, Ms Madhuree Talwalkar, Ms Benazir Patil

Chapter VIII

Issues in Urban Poverty

Ms. Nasrin Siddiqui

Ms. Siddiqui gave a historical overview of the evolving perspectives of poverty. Development theory now universally classifies poverty as extreme or absolute poverty, defined as the lack of income necessary to satisfy basic food needs, and overall or relative poverty, defined as a lack of income necessary to satisfy non-food needs. The definition of poverty includes sophisticated indices such as the human development index. India, however, still uses income as the means to measure poverty. The vast disparity between income levels in Indian society has important implications for urban policy formulation.

Key Issues:

1. Classifying poverty in absolute and relative terms has two advantages in that it makes global comparisons possible, and provides a single quantitative criterion of Below Poverty Limit (BPL) to identify beneficiaries for schemes.
2. The Human Poverty Index (HPI), captures 3 dimensions:
 - Deprivation of a long and healthy life
 - Deprivation in knowledge.
 - Deprivation in economic provisioning, from private and public income as measured by the percentage of people lacking access to health services, the percentage of people lacking access to safe water, and the percentage of children under five who are moderately or severely underweight.
3. Analysis of India's poor reveals that the poor are mainly in rural areas, and predominantly belong to 4 states (Bihar, Orissa, Madhya Pradesh and Uttar Pradesh) and among scheduled castes and tribes. Here, poverty indicates both limited resources as well as access to services such as education and health.
4. Although poverty often traces its origins to historical inequalities and oppression, its perpetuation has been contributed by unimaginative poverty alleviation policies that were inefficiently implemented.
5. One of the crucial phenomena that are seen in the migration of poor is the urbanisation of poverty. The poor migrate to cities, thus increasing the load and the pressures on urban centres.
6. An analysis of the relative values of human development across states in India reveals two important issues: rural bodies are performing better than urban bodies, and there is an accumulation of poor people in cities.

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7. There are thus, four important implications for urban policy:
 - Money spent for rural development must create sustainable means of livelihood other than agriculture.
 - Efforts must be made to formalise the growing informal sectors of the economy.
 - There must be systemic and institutional reform of urban India.
 - Market forces and financial institutions should work towards providing affordable housing for the poor in urban areas.
 8. The World Bank has set out five dimensions of urban poverty: income poverty, health poverty, education poverty, personal and tenure insecurity and disempowerment. Housing poverty was also added to this as another dimension. The interactions between these aspects create a vicious cycle for the perpetuation of the problem.
 9. Urban development policies have perpetuated the state of poverty by maintaining slum populations at the same levels and by equating urban renewal with poverty alleviation. Key issues of access, security of tenure, and affordability have been neglected. The ability of the urban poor to pay for services has been overestimated.

Ms. Nasrin Siddiqui is Director, Center for Equity, Social Justice and Human Development, Yashwant Rao Chavan Academy of Development Administration, Pune and Additional Director, State Institute of Urban Development.

Chapter IX

Financing of Urban Healthcare

Mr. Ravi Duggal

Mr. Ravi Duggal gave a general overview of the state of health care financing, and analysed the deficiencies in the existing system.

Key Issues:

1. Financing of health services is critical to reorganizing the health care system. The current use of resources involves a lot of waste in both public and private sectors.
2. The public health sector accounts for less than 1% (Rs. 450 billion) of the GDP and private expenditure about 5% (Rs. 2600 billion) of GDP. This comes to Rs. 2200 per capita, which is a very large sum in India's economic context.
3. Urban areas account for 70% of this resource utilization and an estimated 50% of this, especially out of pocket resources, is wasteful spending.
4. All this needs to be changed through creating an organized system of healthcare
5. Public financing of health care, which had touched a peak of 1.5% of GDP and 4% of total government spending in the latter part of the nineteen eighties, began its downward trajectory at the turn of the nineteen nineties and has stagnated since then. Private expenditure, which was a little over twice the public spending, got boosted post-SAP and is now over five times that of public spending. This is a debilitating burden on households because over 80% of it is out-of-pocket. This makes India the most privatised health economy in the world.
6. In 2007 the total estimated health expenditure in India was over Rs. 3000 billion, of which the public sector accounted for only 19%, including social insurance. Out of pocket expenditure was 80% at over Rs. 2500 billion. Private insurance, mostly in urban areas, is small, but increasing at 40% per year, with the middle classes rapidly shifting to private insurance so that they can access hi-tech corporate hospitals.
7. Out-of-pocket spending in India is the main mode of financing health care whether for OPD or inpatient care, and this often includes taking on debt or selling assets. Over the last three decades, out-of-pocket spending has been increasing due to the decline of the public health system, and more so in urban areas which had reasonably well functioning public health facilities until recently.
8. Urban areas account for three-fourths of healthcare resource distribution - doctors, hospital beds and expenditures. Resources are not grossly inadequate in the country but the distribution is. Urban areas have healthcare resources on par with developed country averages and definitely within the framework defined by WHO.

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9. Since independence, the share of health resources across rural and urban areas has not changed substantially. Urban areas continue to have a disproportionately large share of healthcare resources but all this does not necessarily lead to better health care or an improved health care status of the urban population.
 10. Urban health resources are largely in the nature of medical care. The public health situation is poor in most urban areas, despite the volume of public and private health resources committed to urban areas.
 11. Public health resources in urban areas are reasonably adequate. This is reflected in the fact that out of pocket expenses in urban areas are about four times higher than what the state spends on healthcare in urban areas and ten times higher than what it spends in rural areas.
 12. Mumbai alone corners about half the public health resources of the state and also about 40% of private health resources
 13. The issue in urban health financing is not inadequacy of resources but inefficiencies in the way resources are organized and used.
 14. Inadequate resources are allocated to primary care and, as a result, hospitals share the burden of dealing with primary care issues. Further, there is no referral system.
 15. Since SAP, investment in the public health sector has been declining and, together with increased salaries, has created additional inefficiencies in allocation.
 16. Lack of regulation and standard protocols for care lead to a wide range of irregularities like unnecessary prescriptions, procedures and diagnostic tests, unnecessary surgeries, cross practice and other forms of malpractice. All these have financial consequences for the user in terms of increased costs of healthcare.
 17. These issues can only be sorted out by radical restructuring in the way resources are organized and used to provide health care to people.
 18. The challenge lies in creating an organized system of healthcare provision. This would involve strengthening primary healthcare services and allocating more resources to it. Setting up an appropriate referral system is critical for rationalizing resource use at secondary and tertiary levels.
 19. A major breakthrough will be needed in designing innovative financing mechanisms that, apart from rationalizing use of resources, also helps in raising new resources. User charges are regressive and promote inequity. In urban areas, with a larger workforce in the organized sector, it is easier to organize resources in a collectivized way, and people can contribute on the basis of capacity to pay, through some form of social insurance.
 20. To support this reorganization, regulation of the health sector is most essential. Minimum quality standards of good practice have to be evolved. Standard treatment protocols have to be put in place and an accreditation system needs to be created. The best route to this is self-regulation and ethics in medical practice. Thus the onus lies on the medical profession to bring about this change, which will benefit not only the patient but also the professional.

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21. All resources invested in urban healthcare deal primarily with curative services. Public health measures are grossly inadequate, resulting in poor hygiene and environmental health. Filth, pollution, epidemics, and unsanitary living conditions cause preventable health problems, leading to avoidable medical care expenditures.
 22. A declining public healthcare system adds to the problems, especially for the poor. The decline is due to falling investments and declining expenditures in public health spending, largely a post-SAP phenomena. For instance Mumbai's health budget, which was close to 30% of the municipal budget in the eighties, has declined to less than 15% presently.
 23. Within the public health system there is pressure for privatization because of accumulating debt burdens. The private health sector is expanding rapidly and the corporate sector is also getting increasingly involved in providing healthcare. This has raised the cost of healthcare substantially. Even in public health institutions user charges have been raised substantially. This makes access to healthcare more difficult not only for the poor but also for the middle classes.
 24. The private health sector is plagued by large-scale malpractice, unnecessary interventions and negligence, which has made private health care more risky and hence more unaffordable. The complete lack of ethics and self-regulation within the profession makes matters worse and has affected the status of the medical profession.
 25. In urban areas, there is an increasing tendency to directly access specialty services, and primary care is ignored. Even public health services give inadequate resources for primary care. For instance dispensaries and health posts in the BMC health budget get only 6% of the allocations. Dispensaries average 80 patients per day, which is a reasonable number, and shows that there is need to expand the dispensary infrastructure (surveys show that only 10-15% of OPD care is dealt with by the public system). Demand surveys show that people prefer public services provided they become more accessible. Setting up an appropriate referral system is critical for rationalizing resource use at secondary and tertiary levels.
 26. Public health measures and environmental health issues need immediate attention and increased investments because they cause a large proportion of the ill health. In the long run such investments are more cost-effective.
 27. Regulation of the health sector and quality standards in medical practice needs priority attention, under an accreditation system. While NRHM has evolved this for the public health system, the private sector is completely unregulated. Regulation can become a route for reining in the private health sector under a public domain through a financing mechanism based on pooled resources.
 28. NUHM falls into the trap of selective and targeted approach, which, history tells us does not work. Anything designed separately for the poor never does. Health financing for universal access and equity requires cross

subsidy and hence can only work if everyone is part of the health scheme, and all resources for healthcare are pooled. NUHM requires a fresh strategic thinking.

Mr. Ravi Duggal is an independent consultant, currently working in Nagpur, Maharashtra.



Lt Col Dr Anil Paranjape Programme Director and Administrator IHMP



(From Left) Dr P P Doke, Dr Ashok Ladda, Dr Prakash Bhatlawande,
Dr A N Joshi

Chapter X

Health Infrastructure, Systems and Services by Urban Local Bodies

One of the objectives of the “State Level Workshop on the Health of the Urban Poor in Maharashtra” was to identify the Key Elements in the health infrastructure, health systems and services established by urban local bodies. The presenters were from the Health Departments of Bombay Municipal Corporation, Navi Mumbai Municipal Corporation and Pune Municipal Corporation.

Health Infrastructure, Systems and Services Provided by BMC

Dr. Jairaj Thanekar

Dr Jairaj Thanekar presented a profile of Mumbai city in terms of health services currently available, services that need to be strengthened, challenges associated with urban health programmes, and the role of NUHM in improving urban health care.

Gaps and Constraints:

1. A high population density, a floating population, population growth and rapid urbanization, and temporary settlers are major issues.
2. There is a major relocation of the slum population towards the western suburbs.
3. Slum and non-slum populations often co-exist.
4. The 1st and 2nd levels of referral services need to be strengthened. The workload for health care services increases during the period June – October.
5. Poor sanitation is often at the heart of all health problems.
6. The major thrust in establishing urban health posts is in the suburban areas.
7. The focus on pulse polio immunization has put an immense pressure on regular primary health activities.
8. Inadequate civic amenities, new diseases, resurgence of old diseases are problems.
9. Lack is of inter-departmental coordination, interference, and utilization of staff for other programmes.
10. Other constraints include unsuitable working hours, lack of space to establish new urban health posts, and the poor commitment of contractual staff.

Key Elements of the Health Infrastructure and Health Systems:

1. Urban health posts mainly provide three types of services: Regular (including preventive, curative, IEC activities and training), seasonal (pre-monsoon and monsoon related activities) and disaster management.
2. A link worker or community health volunteer has been appointed for every 2000 slum population in Mumbai; the main role of the link worker is family welfare, maternal and child health, immunization, health education and awareness generation.
3. The media plays an important role in the publicity of various schemes that are initiated by the government.
4. In the formulation of the state PIP, strengthening of the first referral units should focus on staff, furniture and equipments, repairs and maintenance and skill up gradation of staff.

Dr Jairaj Thanekar is Chief Executive Health Officer, Brihan Mumbai Municipal Corporation. He would like to acknowledge the contribution of Dr. Anil Bandiwadekar in formulating this presentation.

Health Infrastructure, Systems and Services Provided by NMMC

Dr. Sanjay V. Pattiwar

Dr Sanjay Pattiwar explained the general profile of Navi Mumbai, and historical features of the Navi Mumbai Corporation. He explained the health infrastructure, and gave an overview of the various programmes associated with the National Urban Health Mission.

Gaps and Constraints:

1. Since no public health expert was involved in the planning of Navi Mumbai, it lacks basic facilities such as public toilets, hospitals and landfill sites. Since the city's average height is below sea level, water drains become breeding grounds for mosquitoes

Key Elements of the Health Infrastructure:

1. Navi Mumbai was converted from a Gram Panchayat to a Municipal Corporation. The corporation has instituted many innovative measures such as ownership of a dam for water supply, scientific solid waste disposal, underground sewerage system, contractual civil services, and decentralization of work at the ward level.
2. Innovations in health infrastructure in 1992, led to the formation of a 5-tier health system consisting of mobile clinics, 20 health posts, 4 maternity and child health hospitals (50 bedded), a general hospital and a proposed super specialty hospital.
3. Earlier, 500-bedded hospitals for maternal and child health (MCH) used to be the norm. However, analysis of bed occupancy rates of these hospitals

prompted a shift to 50-bedded MCH hospitals with public-private partnerships.

4. There has been constant scaling up of primary, secondary and tertiary health centers with externally funded projects and through the NMMC's own initiatives. Starting with just one primary health centre for a population of 350,000, there are now more than 25 urban health posts (UHPs) for the same population. Similar growth has been seen in the secondary and tertiary centers.
5. The key features of the resource development are:
 - Integration of Sure Start, MNH and NMMC programs.
 - Preventive and curative services are being provided by UHPs.
 - Deputation of medical officers and public health nurses for public health courses.
 - Blood banks in maternity hospitals.

Key Elements of Health Systems:

6. The RCH programme consists of services such as antenatal, postnatal and neonatal care, routine immunization, family planning, school health, routine deworming, Janani Suraksha Yojana, school health programmes and forty plus clinics.
7. Antenatal care provision in the NMMC area is undertaken, based on surveillance by a community based link worker, which leads to early detection and registration.
8. Routine checkups, identification of high-risk cases, referral and follow-up are carried out by the ANM and the community based worker through outreach clinics.
9. A doctor in the UHP or a specialist at the maternal and child health hospital provides ANC checkup for high-risk cases.
10. At the secondary and tertiary levels, a variety of steps such as enhanced diagnostic methods, identification and management of complicated antenatal cases, labour room and theatre services, neonatal care services and baby-friendly hospitals have increased the coverage and efficiency.
11. The method of identifying children for immunization is through a combination of house-to-house surveillance, link worker's records, and private practitioners' records.
12. Referral systems have been strengthened in the NMMC's area through identification of high-risk cases, strengthening transport systems and ambulance services and the installation of telephones in all health care facilities.
13. The MIS is generated through a variety of sources such as baseline surveys, eligible couple registers, field visits by ANM, and daily diary and clinic register. It is necessary, however, to bring private doctors also under the ambit of the MIS systems because a large number of patients go to private doctors for services.
14. A five day training on behaviour change communication (BCC) is to be conducted for the lady health visitor at the urban health post level. BCC

inputs will include use of flip charts and flash cards for inter personal communication, mother-in-law/women's meetings, mass media measures for advocacy and communications.

15. The key recommendations to ensure quality care for patients are: development of adequate infrastructure, effective outreach, standard protocol for antenatal, intra-natal, postnatal and neonatal care, maternal and neonatal death audit, performance-based review of link workers, co-ordination meetings at general hospital and community hospital levels, baby friendly hospitals, and standardized MIS implemented with the help of private facilities.
16. Public-private partnerships have a great scope for creating positive change in delivery of healthcare. The different types of PPP arrangements include service agreements, contracting out services, leasing out facilities for operation by private players, concessions offered to private partners, privatization and NGO participation.
17. PPP arrangements by the NMMC include MCH services, malaria control activities, hospital management, MIS computerization, solid waste management, dog sterilization, public toilets, cattle ponds and rat control activities. In addition, the NMMC has annual maintenance contracts that deal with facilities that are not directly related to health like gardens, streetlights, etc.

Dr Sanjay Pattiwari is Additional Commissioner, Navi Mumbai Municipal Corporation. He would like to acknowledge Dr. Vidya Kshirsagar's help in preparing this presentation.

Integrated Health & Family Welfare Society for PMC

Dr. Anjali Sabne

Dr Anjali Sabne's presentation dealt with a general profile of Pune city followed by a description of the health infrastructure and health services provided to the community.

Gaps and Constraints:

1. There is paucity of data for planning urban health services.
2. Currently available urban data are not being utilized fully.
3. There is a limited focus for outreach services under the present system.
4. Motivation of link workers and rewarding staff for good performance is lacking.
5. Most hospitals and dispensaries are situated in the middle of the city, and the peripheries are left out. This creates a skewed pattern of service distribution.

Key Elements of the Health Infrastructure and Health Systems:

1. Pune Municipal Corporation provides health care services through 30 family welfare centers, 14 type D urban health posts, 5 type-3 urban

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- family welfare centers, 11 health posts under RCH III, 1 general hospital, 1 infectious diseases hospital, 15 maternity hospitals and 44 dispensaries.
2. The Pune Municipal Corporation has been implementing the RCH-II since 2005. A key achievement has been the establishment of 11 new health posts in the city.
 3. The PMC has introduced outreach activities based on surveillance and monitoring undertaken by anganwadi workers. Outreach activity is carried out 4 days in a week. In addition, a yearly survey of beneficiaries is conducted by ANMs.
 4. Anaemia prevention through IFA supplementation is carried out on a regular basis.
 5. Measures adopted for child health include mass media campaigns for child health, haemogram of all girl students, and examination of school students up to 7th standard.
 6. Large scale community mobilization and sensitization activities have been adopted for family planning activities, and a mix of community mobilization and advocacy efforts have been undertaken for sensitization regarding the PNMT act.
 7. Institutional up gradation is undertaken by training of doctors and nurses through NGOs, and training of anganwadi workers in life skills education, etc.
 8. Behaviour change communication is organized to motivate the community, and generate demand.
 9. There is effective implementation of the Janani Suraksha Yojana, by liaising with private nursing homes and hospitals for this purpose.
 10. The NUHM is a positive initiative to integrate different vertical programmes in the health sector, which include outreach in health care delivery, increased community mobilization and provision of specialized services like mobile crèches.
 11. The core strategies planned by the PMC under the NUHM include:
 - An emphasis on outreach in delivery of primary health services.
 - Training of ANMs to provide quality ANC/PNC services at the slum level in collaboration with IHMP.
 - Partnership with NGOs for addressing health delivery gaps. Partners currently include IHMP, PATH, and Dalvi hospital.
 - Promotion of access to improved health care at the household level through community based groups like Shejar Samuha Gats.
 - Strengthening public health through preventive and promotional action, especially to the most vulnerable groups among the urban poor.

Dr Anjali Sabne is Medical Officer for Pune Municipal Corporation. She would like to acknowledge Dr S. T. Pardeshi's contribution in preparing this presentation.

Chapter XI

Effective Innovations in Urban Health by NGOs

The State level workshop on the “Health of the Urban Poor in Maharashtra” served as a platform for NGOs to present field-tested key innovations in urban health to policy makers. Six NGOs presented innovations that can be replicated under NUHM.

Institute of Health Management Pachod (IHMP), Pune Centre

Lt. Col. Dr. Anil Paranjape

IHMP is implementing a health program in 29 slums of Pune City, with a population of 30,000. The objectives of the urban health program are to demonstrate a model for health-post based outreach services, provide quality RCH services, and mobilize communities to participate in health management, integrate HIV and ARSH with RCH-II, and demonstrate policy options and alternative strategies.

Key Innovations in Effective Implementation of Urban Health Care

Community Participation

Slum (Vasti) Health and Development Committees (VHDC) have been established in each slum with specific roles and responsibilities, which include - facilitating monthly needs assessment by the link worker, reviewing monthly micro-plans for the vasti, monitoring the work of health providers, generating demand for services, providing community support to marginalized households, identifying problems in the community, and problem solving.

Community Based Link Workers

Community based link workers, similar to the ASHA proposed under NRHM, have been appointed in each slum for conducting monthly needs assessment, preparing monthly work plans for the ANMs, assisting ANMs in conducting outreach clinics, accompanying clients to FRUs and tertiary health facilities, growth monitoring, providing primary level care, imparting need specific BCC, and ensuring timely referrals and their follow up.

Surveillance and Monitoring System

The community based link worker (USHA) has become the ears and eyes of the VHDC. She assesses the health needs of her community on a monthly basis (400 houses @ 20 houses a day). She gives her need assessment (the list of individuals in need of services) to the ANM, who then provides primary level services on its basis. USHA reports to the VHDC on a monthly basis whether the health needs assessed by her were addressed by the ANM or the UHP, including institutional deliveries and referrals. ANMs get their Monthly



Dr. Anjali Sabne, Medical Officer, PMC, Dr. Sanjay Pattiwar, Additional Commissioner, NMMC, Dr. Jayaraj Thanekar, Chief Executive Health Officer, MCGM



Chairperson: Dr. Sumati Kulkarni, Discussant: Dr. A N Joshi

Progress Reports (MPRs) certified by the VHDC. Certification of MPRs prepared by the ANM, on the basis of the needs assessment conducted by USHA, ensures high coverage of primary level services, and ensures triangulation of data. Surveillance and monitoring by USHA identifies health needs, facilitates monthly planning, monitor's utilization of services, and confirms the outcome of service provision.

Outreach Services

Link workers provide outreach services regularly at the household level. The ANM visits each USHA's slum area on a monthly basis and holds monthly MCH clinics. At the slum level clinics, primary health care and BCC are provided by the ANM. The medical officer conducts monthly cluster level clinics for every 3 - 4 adjoining slums.

Need and Behaviour Specific, Behaviour Change Communication (BCC)

During monthly surveillance, USHA identifies the BCC needs of each household or beneficiary. Using tools like checklists and flash cards, she provides 'Need Specific BCC' till she is able to demonstrate behavior change.

Referral System

Functional referral linkages have been established with private practitioners, nursing homes, maternity homes, surgical facilities and charitable hospitals. Depending on the need of the client, USHA and ANM refer cases to the appropriate level where the required service is available, without wasting time on referral to UHPs and FRUs, if the service is not available at that level. Referral cards are developed for identification, tracking and follow up of referral cases.

Impact of the Program

Because of the above interventions there was a decrease in the prevalence of low birth weight babies, malnutrition, mortality and morbidity rates RTIs and STIs. There was an increase in health care seeking behaviors like utilization of MCH, RH, and HIV testing.

Lt. Col. Dr. Anil Paranjape is currently working as Administrator and Programme Director, Institute of Health Management Pachod, Pune Centre.

Society for Nutrition, Education and Health Action (SNEHA)

Dr. Wasundhara Joshi

Dr Wasundhara Joshi gave an overview of the various activities of SNEHA in the field of urban health. SNEHA is implementing 14 projects such as maternal and child health, domestic violence, nutrition, and services for senior citizen. Its mission is to look for innovative solutions for problems in

nutrition, education and health. SNEHA works with women and children, senior citizens, toddlers, adolescent girls and slum communities.

The two main objectives of SNEHA are:

- To change the health care seeking behavior in the community
- To institutionalize quality care at the facility level

Key Innovations in Effective Implementation of Urban Health Care

Appreciative inquiry:

Appreciative Inquiry focuses on generating and applying knowledge that comes from inquiry into areas of excellence. The process makes people recognize their strengths and achievements and encourages them to scale up positive elements to address the gaps in the system. It has also been used effectively to improve health facilities.

The Sakhi model has been developed to bring about change in the community through group participation. A local woman is identified from the community, who is trained in MNH care issues to change behaviours through Appreciative Inquiry.

Public private partnership

In keeping with a key strategy of NUHM, SNEHA has formed partnerships with organizations like MCGM, IHD and ICCHN. These partnerships have resulted in a synergistic initiative to improve the delivery of services and quality of care.

Surveillance of vital events through female identifiers

SNEHA conducts surveillance of vital events in 3.5 lakh population, divided into 48 clusters. Each cluster covers around 1200 households. A local identifier identifies an event and informs the interviewer. The interviewer confirms the event and reports it to the supervisor, who in turn crosschecks the events, conducts verbal autopsies and forwards a report to the data entry officer.

Dr. Wasundhara Joshi is Executive Director, Society for Nutrition Education and Health Action, Mumbai. She would like to acknowledge Dr. Armida Fernandez and the SNEHA team for their help and support in making this presentation.

Urban Health Resource Center (UHRC), New Delhi

Sidharth Agarwal, Prabhat Jha, Anuj Shrivastava

Urban health resource center works in collaboration with 5 NGOs in Indore city. Dr Anuj Shrivastava from UHRC presented three strategies used by UHRC.

1. Strategy I - community and health system partnership

Nine community care teams have been formed and 90 community-based organizations have been trained, each with 7-9 members. UHRC provided the necessary technical support, capacity building and supervision. This structure was developed by UHRC with a view to build a sustainable community health system in poor urban communities in the city of Indore. Community partnerships helped in improving access to government entitlements. There is an increase in the proportion of complete immunized infants. The proportion of exclusively breastfed children has also increased.

2. Strategy II - outreach services into the slums through private doctors

Socially committed private doctors were identified. Each doctor covers around 4-5 slums. About 30 pregnant women are examined per camp. Each slum is covered on alternate months. The doctors provide services like ANC, referral for delivery, high-risk cases and diagnostics. Honoraria for the doctors are collected by the community.

3. Strategy III - Convergence among civic agencies, community and CSOs at ward level for accountable health services

This strategy resulted in the improvement in child health indicators. The percentage of completely immunized children has been doubled to 64 percent at midline assessment from 32 percent at the time of the baseline.

Delhi. Dr. Siddharth Agarwal is the Executive Director of the Urban Health Resource Centre, Delhi Dr. Prabhat Jha is Urban Health Partnership Officer, Urban Health Resource Centre. Dr. Anuj Srivastava is Regional coordinator, Urban Health Resource Centre,

PATH, Sure Start

Dr. Kranti Raymane

Dr Kranti Raymane presented Sure Start, a Maternal and Neonatal Health Care project, being implemented in seven cities of Maharashtra, namely Mumbai Navi Mumbai, Pune Nagpur, Malegaon, Sholapur and Nanded. Sure Start works on a need based approach, using the surveillance and monitoring system designed by the Institute of Health Management Pachod (IHMP). Sure Start is also using the tools designed by IHMP for imparting need specific behavior change communication (BCC). Four city specific models have been developed under the Sure Start project:

Health financing scheme through SHGs

The concept of health financing was initiated in Amhi Amchya Arogya Sathi (Nagpur) and Shri. Swami Samarth Shikshan Prasarak Mandal (Nanded). For health financing, SHG groups have been formed and they contribute funds that can be used by pregnant women for emergency care.

Model of volunteerism

Halo Medical Foundation (Sholapur) has adopted the model of 'Volunteerism', which consists of MSW students, senior citizens and NSS groups. Several SHGs have been involved in the programme. Each SHG adopts around 8 to 10 pregnant women in their area and provides them with MNH related information and ensures that the women avail themselves of MNH related services.

Public private partnership

Navi Mumbai Municipal Corporation is the partner involved in demonstrating effective public, private partnership.

Quality of care

SNEHA is working extensively to increase the quality of care. It has collaborated with the nearby maternity homes and enhances their MNH service and quality of care.

Convergence model

PCI in Pune is developing a convergence model. This is a single window program for convergence of MNH and HIV / AIDS services. It entails incorporation of HIV / AIDS with the reproductive and child health program. Each mother is screened for HIV and, if required, given treatment. PCI has also developed birth preparedness and complication readiness cards.

Dr. Kranti Raymane is currently employed as Maternal and Newborn Health Specialist, PATH Mumbai. He would like to acknowledge Dr. Benazir Patil for her help with the presentation.

Community Participation in Enhancing Adolescent Health in Urban Slums

Mr. Shivaji Kare

Family planning association of India, Mumbai branch is working in five slums of Mumbai with the objective of enhancing adolescent health initiatives through community participation. The key program strategies implemented by FPAI are:

1. Behavior change communication:

BCC is given at all levels.

2. Peer educators:

Peer educators are identified from the target group i.e. 10-24 year olds. These peer educators are trained by FPAI. They help in the identification of STI clients and refer them to FPAI Clinics for treatment.

3. Community volunteers

Community Volunteers are self-motivated individuals. They are trained in SRH. They help in creating an enabling environment, planning events, referrals and resource mobilization. They also work as community based condom depot holders.

4. Enabling environment:

The following strategies are being used for creating an enabling environment:

- Networking & Linkages
- Advocacy
- Kishor Sabha (Assembly of Adolescents)
- Health Advisory Committee
- Parent Teacher Association
- Adolescent Friendly Information Hubs
- Support Groups for PLHIV

Outcome of the interventions by FPAI

- 129 Peer Educators and 160 Community Volunteers were trained
- The project reached out to a 27,616 target population through BCC
- 32 Kishor Groups and 5 Kishor committees were established
- Through Kishor Sabha interventions, the project succeeded in networking with schools and coaching classes and reached 7,369 adolescents
- 83 PLHIVs were identified and referred to NMP+
- 766 persons were treated for STI

Mr. Shivaji Kare is presently the Assistant Branch Manager, Family Planning Association of India, Mumbai Chapter. He would like to acknowledge Dr. Janaki Desai for her contribution to the presentation

Intervention for the Reproductive health of Married Adolescents in Maharashtra

Ms. Manisha Khale

This pilot project was undertaken in 29 slums of Pune city. The objectives of the pilot study were to test the efficacy of an intervention to improve sexual and reproductive health of married adolescent girls. The innovative strategies tested in the pilot project are:

1. Community based surveillance
2. BCC for couples, parents and community
3. Delivery of primary level services;
4. Formation of "Vasti Arogya Vikas Samitis" to encourage delayed marriage and conception as a social norm.

Results of the pilot interventions are as follows:

- The median age at marriage increased to 17 years at end line survey, compared to 16 years at baseline.
- The median age at first conception increased to 17.7 years at end line, compared to 16.2 years at baseline.
- Contraceptive use at end line was 30.4 percent, compared to 8.0 percent at baseline.
- Prevalence of self reported RTIs was 21.8 percent at end line, compared to 26.1 percent during baseline
- Treatment seeking behavior for RTIs increased from 41.3 percent at end line compared to 35.4 percent during baseline.
- The proportion of young women receiving minimum postnatal care by ANMs, after delivery, increased dramatically to 75.0 percent at end line, compared to only 27.7 during baseline.
- There was a significant reduction in self-reported postnatal complications at end line compared to the baseline prevalence.

Ms. Manisha Khale is Managing Trustee and Associate Director, Institute of Health Management Pachod.

**Innovative Strategies for Urban Health,
Niramaya Health Foundation**

Dr. Shubalakshmi Iyer

Niramaya Health Foundation is implementing projects in the fields of anemia prevention, adolescent education in the field of reproductive and sexual health, community health centers and outreach work, HIV / AIDS programmes for migrant workers, and health programmes for rag pickers.

Key innovations instituted by Niramaya through its health programmes:

Anemia / Malnutrition Prevention and Control Programme (APCP)

1. Awareness generation through focus group discussions and interviews on health, nutrition and anemia with teachers and parents in balwadis / primary schools.
2. Haemoglobin level check up camps and interventions with iron folic acid tablets and de-worming, along with follow up/counseling through home visits.
3. Cooking demonstrations and audio visual use for IEC

Impact of APCP

- The project reached out to 375 balwadis (run by NGOs), and targeted 5911 children ages 3-6 years.
- There was a 20% improvement in grades of malnutrition among the children.
- Haemoglobin estimation was done for 1,417 mothers and iron supplementation given to them; there was a 20% improvement in mild and moderate anemia.
- A recipe book that was developed was widely accepted by the community.

Sensitization Program for Adolescents in Reproductive & Sexual Health (SPARSH)

1. Adolescent health workshops and need based counseling in government, municipality and unaided slum schools.
2. Haemoglobin estimation camps to identify anaemic adolescents. Anaemic children were given iron and de-worming tablets.
3. Participatory learning method was initiated using case studies, role-plays, essays, etc.

Impact of SPARSH

- The programme reached 8,976 adolescents in schools, shelters and the community. More than 500 adolescent girls were sensitized in the Kishori Melava held by BMC.
- The project outcome was the publication of a book on adolescent issues.
- Participants reported a 60-80 % gain in knowledge at the end of the project
- There was a 56% improvement from moderate anaemia to normal haemoglobin levels.

Outreach Action towards Health Care (OATH)

1. OATH is an initiative for street and homeless children involving sensitization of staff and children in shelters.
2. Quarterly medical camps, regular health talks and counseling sessions
3. Special diagnostic camps for haemoglobin estimation, ophthalmic and dental care.
4. Behaviour change communication for adolescents, and participation in sports / ghar angan activities.

Impact of OATH

- The programme reached out to 1,311 beneficiaries.
- The key outcome was a change in behaviours (addictions, hygiene, and safe sexual practices). Street children living on railway platforms were rescued and entrusted to childhood shelters.

Clinic / Community impact

- Reached out to 5,140 beneficiaries
- Increase in number of women motivated for FP and ANC registration
- Increase in the number of children immunized at UHC
- Increase in the referral for TB (DOTs centre)

Dr. Shubalakshmi Iyer is the Programme Director, Niramaya Health Foundation. She would like to acknowledge the valuable contributions of Dr Janaki Desai.



Ms Manisha Khale, Managing Trustee, IHMP



Dr Dileep Mavlankar, Professor IIM – Ahmedabad

Chapter XII

Public Private Partnership: Corporate Involvement in Urban Health

Dr. Dileep Mavlankar

Dr. Mavlankar outlined the historical context of public-private partnerships (PPP) in health care, and noted that they have been in existence for more than 30 years. However, the private component in PPP has evolved over the years to involve corporate actors, as opposed to only non-governmental organizations. He stressed the need to monitor PPP models to ensure that common shortcomings are avoided and that the system works efficiently.

A summary of the key points:

1. The benefits of PPP include increased access to areas not reached by the government. There is more flexibility because of fewer bureaucratic hurdles, better service delivery because of focused local interventions, and less utilization of government resources and greater use of private ones. Individuals in the private sector may demonstrate more commitment and efficiency, and may be seen to be more democratic than the government sector. At the same time, the services can be discontinued when their utility is over.
2. The disadvantages of PPP include non-uniformity in service delivery, lack of universal availability of private sector services, preoccupation with self-interest by private individuals due to lack of effective government regulation, leading to increased political patronage and a tendency to serve vested personal interests. It is important to guard against exploitation of the state and government by private agencies, as also to ensure that the organization does not give up work in the area because of poor relations with the government.
3. Corporate agencies may enter PPP initiatives in public health for a variety of reasons: philanthropic considerations, creating brand equity, tax benefits, as a diversion for spouses and relatives, and to receive favours in return from the government. Through partnerships, the corporate sector can contribute money, time, volunteers, goods, services (including management and technical support) and help in IEC activities like community mobilization, purchase of services / products, and training of workers.
4. The dangers of corporate PPP could be a gradually decreasing sense of government responsibility due to the work being conducted by private

agencies exclusively. Also, a tendency to project the achievements of PPP may result in de-motivation of regular government staff.

5. The way forward in operationalizing PPP is to engage corporates through strategic partnerships to address the gaps in health care delivery, while simultaneously exposing them to actual public need. One preliminary step is to map out interested partners, using an intermediary liaison person. A clear process, documentation and a contract with clear program objectives are needed. The partnerships should be with the goal of mutual understanding, hence while the government must not absolve its responsibility and must be willing to treat partners on an equal footing, it must also be aware of the specific deliverables that the corporate partner would bring to the project.

Dr. Dileep Maolankar is Associate Professor, Public Systems Group, Indian Institute of Management, Ahmedabad

Chapter XIII

National Urban Health Mission

Ms. Aparna Sharma

NUHM aims to improve the health status of the urban poor, particularly slum dwellers and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships and communitised risk pooling with the active involvement of urban local bodies.

The core strategies of the NUHM are:

- Strengthening and rationalizing the extant systems
- Promotion of access to improved public health through MAS & USHA
- Innovations for improving public health
- Community risk pooling
- Capacity building of key stakeholders
- IT enabled services and e-governance
- Prioritizing the most vulnerable
- Ensuring quality of health care services through norms (IPHS etc)

Phasing of NUHM

All cities with population above 1 lakh and state capitals would be covered under NUHM during phase I and district headquarter towns with population less than one lakh would be covered under Phase II of the mission, which would last for the duration of the 11th five-year plan (2008-2012).

There would be a high focus on the urban poor in listed and unlisted slums and un-authorized colonies. All other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction site workers, sex workers, etc. would be given extra focus. Towns with less than one lakh population are covered under NRHM. The programme would be launched in 100 cities to begin with.

Four basic steps in the operationalisation of NUHM	
Stage I	Setting of institutional arrangements
Stage II	City Specific GIS mapping of slums and health facilities and the development of city level urban health plans
Stage III	Rationalization and strengthening
Stage IV	Filling gaps and scaling up

One of the important features of NUHM is the flexibility in planning that is allowed at the city level. The reasons for this flexibility in the plan are as follows:

- To address diversity of cities and ensure rationalization and optimal utilization of existing infrastructure and manpower.
- To ensure that all urban poor clusters of the city are mapped and reached.
- To ensure convergence with other departments right from the planning stage
 - Involve program managers of National Health Programs /JNNURM /ICDS
 - Ensure effective integration and rationalization of manpower/resources of various national programs/institutions
- To facilitate involvement of all stakeholders right from the planning stage

Ms. Aparna Sharma is currently the Deputy Secretary of Health, Ministry of Health and Family Welfare, Government of India. She would like to acknowledge the role of the Urban Health Division, Ministry of Health and Family Welfare, Government of India in putting together this presentation.

Urban Health Resource Center

Mr Anuj Shrivastava

NUHM provides an opportunity to create an urban health care system. The diverse health facilities in urban areas are one of the biggest challenges to NUHM.

Key Features for successful implementation of NUHM

- Provision of health care services to unlisted slums and the most marginalized populations.
- Standardization of protocols
- Qualitative change in the PIPs of the district
- Strengthening and empowering of the people at the grassroots level.
- Effective utilization of ANMs and AWWs since these are the sources most closely connected to the community.
- NUHM is a stepping-stone for the process of systematic programming and planning.

Mr. Anuj Srivastava is currently the Regional Coordinator, Urban Health Resource Centre

Dr Nandita Kapadia-Kundu

Consultant, IHMP

Dr. Nandita Kapadia-Kundu presented three key issues related to NUHM

a) Key features of NUHM:

- The core accomplishment of NUHM is making health services available to everyone irrespective of slum or non-slum population.
- NUHM comprises of all the national programmes, therefore depicts a wider view as compared to the RCH programme.

b) Concerns regarding NUHM:

- Lack of uniformity and norms.
- Lack of information for planning an effective programme.

c) Implementation of the programme:

- The roles and responsibility of the state government in the implementation of the programme should be reviewed.
- More options in financing mechanisms should be explored.
- There should be a forum for discussion of ideas by corporations.
- Special consideration should be given to smaller towns with no health care infrastructure.
- Maharashtra can take a leading step towards these issues as it has a good infrastructure as well as services.

Dr Nandita Kapadia-Kundu served as Additional Director, Institute of Health Management Pachod, and is currently working as an independent researcher.

Dr Abhay Shukla

Consultant, Sathi Cehat

Dr. Shukla critically reviewed NUHM and focused on the lacunae in the NRHM policy, with special reference to the guarantees made by NUHM which are:

1. Universal access to quality health care as a right
2. Financial status should not be a barrier to accessing care
3. Focus on strengthening existing capacity of health delivery i.e. public health services in urban areas

Key Issues

- Small-scale insurance schemes suggested by NUHM as a financing option cannot solve problems of health care financing. Tax-based

provision, with modified social insurance for the organized sector (reformed versions of CGHS, ESI) and social security with tax-based subsidy for the unorganized sector should be the direction forward.

- Occupation-based group insurance strategies will play an important role in achieving universal coverage of health services.
- NUHM puts great emphasis on public-private partnership for financing. However, no definite guidelines have been laid down for regulation of the private sector. Regulation, especially rationality of care, is important if NUHM is looking to PPP in order to solve the issue of financing.
- The funds allotted for NUHM are not adequate for the purpose of carrying out the planned activities. One way out of this could be to allot funds on a performance-based fashion, for cities that have a comprehensive plan in place.
- One of the main challenges of NUHM is to reorganize existing health care systems in India. The opportunity is ripe to consider feasible methods of universal health care access, especially in urban areas.

Dr Abhay Shukla is currently working as a Consultant to Sathi Cehat.



(From Left) Mr Anuj Shrivastava, Dr Abhay Shukal, Dr Nandita Kapadia- Kundu



Ms. Chandra Iyengar Additional Chief Secretary Govt Of Maharashtra

Chapter XIV

Valedictory Address - Ms. Chandra Iyengar

Ms. Chandra Iyengar observed that the National Urban Health Mission would be brought into focus following this workshop. Ms. Iyengar said that one of the key issues is to implement NUHM by building upon what we have learnt and achieved through NRHM. The principal achievement of NRHM has been:

“Communitisation” of health services. The “community” is distinct from community based organizations and non-governmental organizations. NRHM seeks to involve persons who are locally affected by the programs. These persons may not have an overarching will or commitment to better the health of the area, yet as they are directly influenced by these measures, they form a concerned group. Under NRHM, it is the community that monitors and ultimately controls the delivery of health care services. The mission has succeeded in funding and facilitating this process of making health providers answerable and responsible for health services in the area. The challenge of communitisation in urban areas, however, unlike rural areas, is the heterogeneity and unstructured nature of society. This makes the process more difficult.

NRHM has succeeded in introducing trained management personnel within the health care delivery system. It envisages creating a parallel structure of financial and management services within the system to aid in the process of health care delivery. This was a task that was formerly being done by doctors in a dual role along with their public health role. The appointment of management experts in NRHM has been one of the most hopeful and exciting new measures in the mission, as their perspective would help to create more efficient health systems.

Another encouraging feature has been the improvement in the health care infrastructure as a direct consequence of NRHM. The major outcome of the mission has been to ensure that health care delivery is more universal, thus increasing availability, access and quality of services.

For the past year, the government has actively pursued outsourcing of support services such as food and canteen facilities, cleaning of health facilities and transport for referral. Self help groups have been involved in the outsourcing of transport of patients to referral services, to the extent that taxis used for referral are paid on the spot at the referral destination.

Key Issues in the process of implementation of NUHM:

- There should be standardization of different municipal corporations/councils and local bodies for effective delivery of services. Thus, the development of a modality for standardization would be a potential area of participation between the participants of this workshop and the government.
- Population size has always been the yardstick for allocating health services. This approach, though, may be seen to be inadequate in towns and larger urban centers. In addition to population, geographical location must be adopted as a norm for service delivery. Access to services must be such that people can avail of health care facilities easily. They should be situated at a manageable distance from their place of residence. This would necessitate a restructuring of the manner in which facilities are allocated in the urban context. Local resources must be taken into consideration.
- One of the major differences in the implementation process of NRHM and NUHM is that rural areas have limited institutional support from capable local private sector bodies. For example the availability of small-scale nursing and maternity homes in small towns and cities, greatly increases the proportion of institutional deliveries in these areas as compared to rural areas where such services are limited or non-existent. However, such support organizations, when available, are very often not consistent in quality of services and institutional competence.

Reproductive and child health were given much importance, particularly issues emphasized by the World Health Organization such as infant mortality rate, maternal mortality rate, etc. In addition, child health is seen as being of paramount importance for the future health of the individual, and hence assumes more importance from a programmatic perspective.

- Another major issue that clouds the process of service delivery is the lack of comparable administrative facilities in an urban setting as compared to rural areas. In rural Maharashtra, the district administration is responsible for public health and the system is well in place with little ambiguity as to individual roles and responsibilities. The same cannot be said of urban local bodies which are understaffed and over-burdened, and whose role in public health is not clearly defined.
- With regard to public private partnership (PPP), it is a myth that private organisations would automatically usher in better management as compared to the public sector. PPP with individual parties who work in co-ordination with the public sector has already begun to create a problem for the government.

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- The main contribution that can be made by partnership in the private sector would be time dedicated for services and support. Also, civil society should be responsible for creating easier access to new technology relevant to health service delivery.
 - Volunteerism is not what is required. Civil society participation must ensure consistent and sustained support. Health work in the public sector is often one of drudgery and monotony, because it requires the same functions day after day. While there is a great value of volunteerism born out of goodwill during disaster situations, for the day-to-day functioning of the health systems, there needs to be a sustained will and commitment.
 - Due to its unique position as a primary health care provider, the government often finds itself in a situation of having to offer healthcare to people who may not want or express a need for it. The government often has to motivate people to avail of primary and secondary health care services, often when these people are reluctant, or unconcerned. The role of private organizations is often in the field of tertiary level health care, while it is the government that shoulders the major responsibility of primary and secondary care. Tertiary care is usually sought by choice, but secondary and primary care is a necessity, though often not seen as such by the citizens. It is the government's job to ensure that the health of the people is taken care of, and this translates into a different guiding imperative compared to the private sector.
 - While the government is concerned about the issue of health care of the poor and non-poor, it also recognizes that the non-poor, assumed to possess some basic level of education and awareness, would be able to demand and avail of better health care facilities. The poor, presumably unaware of their health needs as well as available facilities, require a more targeted focus in health service delivery. NUHM must ensure targeted interventions for vulnerable groups within the urban population, like poorer sections of society, residents of slums and chawls, and persons living in highly polluted areas of cities.

Ms. Chandra Iyengar, IAS is Additional Chief Secretary, Government of Maharashtra and Principal Secretary, Public Health Department, Government of Maharashtra.

Chapter XV

Recommendations

Policy Issues in Urban Health

- Implementation of NUHM must incorporate lessons learnt through NRHM.
- Policy decisions need to be taken to address:
 - The overt focus on curative services
 - Poor public health and hygiene
 - Problems of pollution
 - Collapsing public healthcare facilities
 - Unregulated private sector expansion in health care, and
 - The lack of ethics and self-regulation amongst medical professionals.
- Policy documents must clarify who is the responsible authority for urban health, after reorganising the public health administration in urban local bodies.
- Most of the resources under NUHM should be allocated for out reach work.
- Some of the challenges in improving the urban health delivery system include:
 - Strengthening primary care services - allocating more resources to it
 - Creating a well defined referral system for secondary and tertiary care
 - Creating a public-private mix

Policy Issues Indirectly Related to Health

- There should to be an emphasis on shelter and basic services. This implying effective inter-sectoral coordination.
- Sanitation in slums should be a high priority.
- Market forces and financial institutions should provide affordable housing for the poor in urban areas.
- Policy makers should address key issues of access, security of tenure, and affordability.
- The growing informal sectors of the economy should be formalised through systemic and institutional reform of urban India.

Infrastructure, Human and Material Resources

- Urban health centers must be built in adequate numbers ensuring universal access to slum populations.
- There should be uniformity in basic structure and services such as sanitation, electricity, waiting room and laboratories.

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- Urban health posts must be distributed evenly to avoid concentration of facilities in few cities, or in parts of a city.
 - Staffing norms of urban health facilities need urgent reconsideration and standardization.
 - UHPs of type A, B, C and UFWCs of type I and II need to be restructured, particularly those not attached to any hospitals.
 - Equipment, transportation, laboratory facilities and medical supplies for urban health facilities need to be standardized, and their availability ensured.
 - Corporations should be strongly encouraged to appoint an USHA for every 2000 population. Effective outreach depends primarily on these link workers.

Data Collection and MIS

- With the support of NGOs, SHGs, Ganesh Mandals, etc., undertake mapping of the city to locate vulnerable populations.
- Undertake a social assessment in recognized and unrecognized slums to assess health status, needs, health utilization behaviours and vulnerability.
- Utilise Appreciative Inquiry as a tool for social assessment to make people recognize their strengths and achievements and encourage them to scale up the positive elements to address gaps in the system.
- Aggregated health indicators be by type of city, type of slum and subgroups of the population.
- Emphasize concurrent data that can be used for micro-planning.

Health Management

- Adequate data needs to be mobilized before PIPs are prepared.
- An outline should be prepared for the development of city specific PIPs. Separate formats are required for corporations and council towns.
- PIPs must take into account natural growth in population and expected migration.
- A surveillance system for monthly need assessment and monitoring of health services needs to be introduced.
- The supervisory cadre for urban health should be strengthened. Alternatively NGOs can be involved in supportive supervision and monitoring of services.
- The first and second levels of referral services need to be strengthened.
- While preparing the State PIP, strengthening of FRUs should focus on staff, furniture and equipments, repairs and maintenance and skill up gradation of staff.
- Enhanced diagnostic methods, identification and management of complicated antenatal cases, labour room and theatre services, baby-friendly hospitals will greatly increase the coverage and efficiency of maternal services.

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- A comprehensive monitoring system and a well-defined management information system must be in place.
 - Standard protocols for antenatal, intranatal, postnatal and neonatal care, maternal and neonatal death audit, performance-based review of link workers, and a standardized MIS implemented with the assistance of NGOs must be prepared
 - Convergence between government programmes dealing with RCH, ARSH, HIV/AIDS, and communicable and non-communicable diseases must be ensured.
 - A high level committee should be responsible for inter-sectoral coordination.
 - The appointment of management experts in NRHM has been one of the most hopeful and exciting new measures in the mission, as their perspective would help to create more efficient health systems. This must be replicated in NUHM. Their primary role should be health management rather than administration
 - Outsourcing and contractual agreements should be considered for malaria control activities, hospital management, MIS computerization, solid waste management, dog sterilization, public toilets, cattle ponds and rat control activities.

Health Service Delivery

- The greatest emphasis should be placed on outreach services (Primary level care) by ANMs with the assistance of USHA.
- Antenatal, post natal and neonatal care services should be provided by ANMs through outreach in the community.
- Anaemia prevention and control must be incorporated into regular work of ANMs and USHA as part of outreach
- The location of health facilities should be evenly distributed in the centre and periphery of cities.
- Urban Health Post's (UHP) should provide both curative and preventive services. Routine diagnostic services must be available at the health posts.
- There must be provision of continuous, adequate & quality drugs, equipments & consumables and computers with Internet connectivity at urban health posts.
- To strengthen referral services, a definite protocol must be followed, and transportation systems must be strengthened.
- Rewards for good performance must be introduced for staff and link workers.
- The focus on pulse polio immunization has compromised primary level services. There should be convergence with routine immunization and other primary care.
- Vacant positions must be urgently filled.

Capacity Building

- Establish new training centers.
- Up grade existing training centers.
- Involve well-established training centers in the NGO sector.
- Initiate training of ANMs for out reach services with the assistance of NGOs
- Initiate training of USHAs with the assistance of NGOs
- Make orientation of Commissioners and Health Officers and existing staff in the corporations an imperative.
- Introduce induction training of new personnel in the government health system.
- Prepare annual plans for on the job training and on going in service training
- Staff in UHPs must be sent for training in public health.
- A detailed course on public health must be included in the medical curriculum.

Targeting of Services under NUHM

- For improving the health status of urban population, slums have to be given special attention.
- There is a need to identify vulnerable populations and ensure that they receive services in addition to focusing on the poor.
- The SC and ST communities form a major proportion of the slums in Maharashtra. These communities are the most vulnerable part of the slums and should be given priority while implementing NUHM in Maharashtra.
- Issues of social exclusion and marginalization need to be resolved.
- The Muslim community, which constitute one-sixth of urban population in Maharashtra and has a high unmet need of reproductive health care, should be given special attention during the implementation of NUHM.
- Urban migrants and aging populations should be targeted.
- The health status of communities in small towns and small cities is worse than slum communities in large cities and needs urgent attention. Small towns should be given special attention, as they have no health infrastructure.

Health Financing

- Measures should be taken to increase state funding and revenue potential of ULBs, and to provide cross subsidisation and regulation of the private sector.
- There must be an attempt to ensure prompt release of funds as well as delegation of monetary powers.

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- Payment according to capacity to pay – social insurance, where people form a co-operative need to be introduced. The contribution should be mainly from the employer.
 - Cashless insurance service in accredited private / public hospitals is essential.
 - Regulation, accreditation and standards for health care services are an imperative

Communitisation – Participation of Civil Society

- “Communitisation” of health services is one of the key features of NRHM. The community monitors and ultimately controls the delivery of health care services. NRHM has succeeded in funding and facilitating this process of making the community answerable and responsible for health services in the area, and this must be replicated in NUHM.
- Existing women’s group like SHG’s, Mahila Mandals, etc. could be considered instead of creating new committees such as the Mahila Arogya Samiti. For example in Pune city there are well established Shejar Samuha Gats that can be given the role of slum committees.
- Slum committees must have access to MIS data and should be involved in monitoring of services.
- The capacity of the Mahila Arogya Samiti should be built through well-planned training. Non-financial incentives must be given to the members.
- Civil society participation must ensure consistent and sustained delivery of support to the government health services.
- Peer Educators and Community Volunteers need to be involved for reporting vital events, as health educators and motivators, and as depot holders.
- The involvement of elected representatives and administrators in health care must be encouraged.

Role of USHA

- USHA should be made responsible for conducting monthly need assessment, preparing monthly work plans for the ANMs, assisting ANMS in conducting outreach clinics, accompanying clients to FRUs and tertiary health facilities, growth monitoring with the AWW, providing primary level care, imparting need specific BCC, and ensuring timely referrals and their follow up.
- The role of the USHA should be evidence-based so that they may be evaluated. Her honorarium should be linked to the outcomes of these activities.
- USHA should ensure birth preparedness and complication readiness of pregnant women in the community.
- USHA must coordinate between ICDS and health

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- She must establish referral linkages between outreach clinics, health posts, FRUs and referral centers.
 - UHSA should confirm the outcome of service provision during monitoring.

Role of Mahila arogya samitis, (MAS) / Jan arogya samitis (JAS)

- The samiti should not be limited only to women. Men should be involved as well and the name could be Jan Arogya Samiti. (JAS)
- Mahila arogya samitis, Jan arogya samitis, must be involved in demand generation.
- The samitis key role should be community based monitoring of health services on a monthly basis.
- USHA should become the eyes and ears of the MAS / JAS. She should assess the health needs of her community on a monthly basis and give her need assessment to the ANM. ANMs should provide primary level services on the basis of the needs assessment done by USHA.
- On a monthly basis, USHA should report to the MAS / JAS if the health needs assessed by her were addressed by the ANM or the UHP, including institutional deliveries and referrals.
- ANMs should get their Monthly Progress Reports (MPRs) certified by the MAS / JAS. Certification of MPRs prepared by the ANM, on basis of the needs assessment conducted by ASHA, will ensure high coverage of primary level services and will promote triangulation of data.

Role of NGOs

- NGOs should be involved in planning, monitoring and evaluation of programmes, providing counseling services, community mobilization, social/health audits and formation of MAS / JAS to make the process more community oriented.
- NGOs should be involved in preparing of IEC manuals for training of USHA and others.

Public Private Partnership

- Public-private partnerships have great potential to improve quality of services, especially in areas of non-clinical services.
- It is necessary to bring private doctors under the ambit of the government MIS systems because a large number of patients go to private doctors for services.
- Corporate partners interested in public-private partnership (PPP) must be engaged through strategic partnerships to address the gaps in health care delivery, while simultaneously exposing them to actual public need.

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- A clear process, i.e. documentation and contracts, along with clear program objectives, need to be put in place through mutual understanding.
 - Corporate PPP should not result in a decreasing sense of government responsibility. At the same time, the regular staff of the government must not be ignored in the attempt to project the achievements of the PPP.
 - NUHM should provide scope for the regulation of the private sector; academic professional bodies should take responsibility for this.
 - Private practitioners should be involved in outreach services and should be able to ensure facilities for investigations at low cost through NUHM schemes.
 - There is scope for the creation of tertiary care services through collaboration with private institutions.

- ABBREVIATIONS -

ANC - Antenatal care
ANM- Auxillary nurse midwife
APCP- Anemia / Malnutrition Prevention and Control Programme
ARI- Acute respiratory infecton
BCC - Behaviour change communication
BMC - Brihan Mumbai Municipal Corporation
BMI- Body mass index
CBO- Community based organization
CHMO-Community Health Medical Officer
CHO-Community Health Officer
CSO- Civil Society orgsnization
CTB- Central Tuberculosis Board
DFW- District family welfare officer
DHMO- District Health Medical Officer
DHO- District Health Officer
FPAI- Family planning association of India
FRU - First referral unit
GDP- Gross development product
GIS- Geographical information system
HPI- Human Poverty Index
ICCHN- ICICI center for health and child nutrition
ICDS- Integrated child development services
IEC- Information Education and Communication
IFA tablets- Iron folic acid tablets
IHD- Institute for Human Development
IHMP- Institute of Health Management, Pachod (Pune Centre)
IIPS- International Institute of Population Sciences
IPHS- Indian public health standard
IT- information technology
JNNURM- Jawaharlal Nehru National Urban Renewal Mission
JSY - Janani Suraksha Yojana
MAS- Mahila arogya samitis
MCGM- Municipal corporation of Greater Mumbai
MIS -Management information system
MNH- Maternal and neonatal health
MO- Medical Officer
MOH - Medical Officer of Health
MPR- Monthly Progress Reports
MPW- Multi purpose worker
MSW- Medical Social Worker
NFHS III- National Family Health Survey III
NGO- Non governmental organization
NLEP- National Leprosy Eradication Programme
NRHM- National Rural Health Mission

NSS- National Social services
NUHM- National Urban Health Mission
NVBDCP- National Vector Borne Disease Control Programme
OATH- Outreach Action towards Health Care
OPD- Out patient department
ORS - Oral Rehydration Salt
PCI- Project concerned international
PCMC - Pimpri Chinchwad Municipal Corporation
PHC - Primary health center
PIP- Program implementation plan
PMC- Pune Municipal Corporation
PNDT act - Prenatal diagnosis and testing act
SAP - Structural adjustment programme
PPP - Public - private partnership
PTA- Parent teacher association
RCH- Reproductive and child health
RH- Rural hospital
RI activities- Regional imbalance activities
RNTCP- Revised National Tuberculosis Control Programme
RTI/STI- Reproductive tract infection / sexually transmitted infection
SHG- Self help group
SNEHA- Society for nutrition education and health action
SPARSH- Sensitization Program for Adolescents in Reproductive & Sexual Health
UFWC- Urban family welfare center
UHP - Urban Health Posts
UHSC-Urban Health Subcenter
ULB- Urban Local Bodies
USHA- Urban Social Health Activist
VHDC- (Vasti) Health and Development Committees
WHO- World Health Organizatio
YASHADA- Yashwantrao Chavan Academy of Development Administration