THE CHALLENGES OF URBAN HEALTH

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Challenges of Urbanization in India

- 300 million Indians live in towns and cities
- Another 300 million will be added within 20 to 25 years
- It took 40 years for India’s urban population to raise by 230 million whereas it is expected to raise 250 million in half the time
- India has not paid systematic attention to urbanization so far.
- Urban India today is distributed in shape with a diverse range of large and small cities spread around the nation and it is expected to continue.
- Huge gap between demand and supply of basic services.
Characteristics of Urban Community

- Social heterogeneity - melting point of races and cultures.
- Secondary relations – private interest over common interest
- Anonymity – namelessness
- Secondary social control – law, legislations, police etc.
- Large scale division of labor and specialization
- High social mobility – social position based on achievements than birth
- Individualistic attitude – in choice of career and competition in life
- Voluntary association - to fulfill the varied interests
- Social tolerance – spirit of tolerance gives unity in diversity
- Spatial segregation – functional segregation in the city
- Unstable family – women are employed, family ties are loose (Women PH workers, Street vendors, etc)
Urban health problems are not markedly different from those in rural areas, but their solutions are quite different. Urban health is based on core healthy cities principles of equity, intersectoral cooperation, community involvement and sustainability.

World Bank
Urban Health: Why does it matter?

- Urban health is a major focus of global public health policy due to increasing number of urban population.
- Though urban areas show higher levels of health and increase in accessibility to services, urban population is characterized by health disparities.
- Migration from rural areas and natural population growth put pressure on limited resources in cities.
Much of the natural and migration related growth in urban populations is among the poor.

More than one billion people – one third of urban dwellers – live in slum areas which are often overcrowded with life-threatening conditions.

Disparities increase as the combination of migration, natural growth and scarcity of resources results in cities being unable to provide the services needed by those who come to live there.
Urban Health: Why does it matter?

- There is evidence of poorly planned or unplanned urbanization patterns which have negative consequences for the health and safety of people.
  - This includes increased risk of road traffic injury.
  - Increase of risk factors (such as physical inactivity and unhealthy diets) for heart disease, cancer, diabetes and chronic lung diseases.
  - Overcrowding, lack of proper sanitation lead to increased risk of communicable diseases.
  - Increased exposure to environmental pollution.
  - Unsafe living conditions leading to accidents.
Urban Health Issues

- **Non-communicable diseases** linked to urban lifestyles like heart disease, high blood pressure, diabetes and obesity
- **Communicable diseases** such as diarrhea caused by unsafe food and water or tuberculosis due to overcrowded living conditions
- Increased risk of **road traffic accidents**, injury and violence
- **Mental health disorders** and substance abuse
- Exposure to **air pollution** and second-hand smoke
Urban health issues & problems: Global Scenario
Urban health problems:

- Poor roads, drainage and lack of playing spaces for children

  - Vulnerability: Land rights, Drainage, Waste disposal
  - Open drains $\rightarrow$ Blockage (solid waste)
  - Open waste disposal in vacant spaces, no clearance
  - Lack of proper playing spaces $\rightarrow$ Children play in dumps or near open drains $\rightarrow$ health risks
Urban health problems:

- **Lack of safe water and sanitation.**
  - 83% of urban population of African cities & 55% of people in large cities of Asia lack toilet facilities.
  - Greater problem for women & adolescent females.
  - 4% of all deaths → directly attributable to lack of clean water supply.

Urban health problems:

Housing, Land tenancy & Unrecognized slums:

- Located on marginal land (near railway tracks, river banks, near garbage dumps, etc) or illegally on Govt. or Private owned lands. → Prone to accidents, disasters, eviction
- Not counted → No official records → No services
- 48% of slums in Indian cities are unrecognized
- In Nairobi, 60% of the urban population is in unrecognized slums

National Sample Survey, India, 2008-09

Urban health problems:

- **Child under-nutrition:**
  - Poor diet, repeated morbidity, unhygienic living conditions lead to malnutrition

- **Low access to health services:**
  - Proximity to quality health services
  - Barriers – economic, social

- **Uncertain livelihoods:**
  - The level of livelihood stability is closely linked to health
  - Stability mitigates fear of uncertain livelihood →
    - Sense of responsibility for health and surrounding
    - Improved healthcare & education of children
    - Greater community participation as well as urge to improve local conditions
Urban health problems:

- **Injuries: Road traffic accidents** -
  - Unplanned development
  - Improper road & traffic infrastructure
  - Mixed nature of vehicles & pedestrians
  - Overuse and overloading of 2-wheelers

- **Injuries: Occupational & Residential** –
  - Living near construction sites, railway tracks, etc
  - Unsafe, poorly constructed housing, overcrowding
  - Waste & garbage – within slums or in children’s play areas.

- **Injuries: Intentional/ Violence/ Crime** –
  - Need to work & commute late (for women)
  - Improper lighting, inadequate policing.
  - Stress → Alcohol/ Drug abuse → Domestic violence
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Urban health problems:

- **Communicable diseases:**
  - HIV & Sexually transmitted diseases
  - Vector borne diseases – Malaria, Dengue, Chikungunya
  - Tuberculosis

- Factors –
  - Poverty in slums
  - Overcrowding, Migration, Floating population
  - Poor water management
  - Unhygienic living conditions – sanitation, solid waste, drainage
  - Increased unsafe sex
  - Low knowledge & awareness of healthy practices
  - Weak public health system + low access to available services
  - Lack of preventive measures, Fragmented response
Impact of poverty is more than financial — e.g. lost opportunities to develop essential human capabilities; lost time, labour, income, and the burden of health care costs.

Illiteracy, ill health, malnourishment, environmental risks and lack of choices contribute to the perpetual cycle of poverty and ill health.
Foundational Concepts – The 4 ‘F’s

- Fingers, Fluids, Flies and Fields and Floor, are the basic routes for Fecal-oral contamination
- Escherichia Coli (E. coli), or other worms, like tapeworms, roundworms, pinworms, etc. that live in the human digestive system and are ingested into the human digestive system through unsanitary practices related to defecation.
COMMON SIGHTS IN URBAN AREAS
Common sights in urban areas
Common sights in urban areas
Common sights in urban areas
GOAL

- To improve the health status of the urban population but particularly of the poor and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system. capacity of urban local bodies.
NUHM would have high focus on:

- Urban Poor Population living in listed and unlisted slums
- All other vulnerable population such as
  - Homeless,
  - Rag-pickers
  - Street children
  - Rickshaw pullers
  - Construction and brick and lime kiln workers
  - Sex workers
  - Other temporary migrants.
- Public health thrust on sanitation, clean drinking water, vector control, etc.
- Strengthening public health capacity of urban local bodies.
Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing existing government primary urban health structure and designated referral facilities

Promotion of access to improved health care at household level through community based groups: Mahila Arogya Samitis
- Strengthening public health through innovative preventive and promotive action
- Increased access to health care through creation of revolving fund
- IT enabled services (ITES) and e-governance for improving access improved surveillance.
- Capacity building of stakeholders
- Prioritizing the most vulnerable amongst the poor
- Ensuring quality health care services
Institutional framework

- The NUHM institutional structures..... at the National, State and District level for operation
- The Mission Steering Group under the Union Health Minister
- At the State level, the State Health Mission under the Chief Minister
  - The State Health Society under the Chief Secretary and...
  - The State Mission Directorate
At the City level, the States may either decide to constitute a separate:

- City Urban Health Missions/ Societies or....
- Use the existing structure of the National health Mission

The Mission provides flexibility to the states to choose the best suited model
Every ULB will become a unit of planning with its own approved broad norms for setting of health facilities.

These separate plans can be part drawn from NRHM.

Municipal corporations will have separate plan of action as per broad norms for urban areas.
For every 2.5 lakh population (5 lakh for metros)

**U-CHC**
Inpatient facility, 30 - 50 bedded (100 bedded in metros)
*Only for cities with a population of above 5 lakh

**U-PHC**
MO I/C - 1
2nd MO (part time) - 1
Nurse - 3
LHV - 1
Pharmacist - 1
ANMs - 3-5
Public Health Manager/ Mobilization Officer – 1
Support Staff - 3
M & E Unit - 1

For every 50,000 population

For every 10,000 population

200- 500 HHs (1000-2500 population)

50-100 HHs (250-500 population)

1 ANM
Outreach sessions in area of every ANM on weekly basis

Community Health Volunteer (USHA / LHW)

Mahila Arogya Samiti
Urban & Rural health care delivery

- **District Hospital**
  - **Block**
    - 1 village = 1500 pop
    - 3000-5000 pop
    - 20,000-30,000 pop
    - 80,000-1.2 lakh pop

- **Municipality**
  - 200-500 HH; 1000-2500 pop
  - 10,000 pop
  - 50,000 pop
  - 5 Lakh pop

- **Centres**
  - PHC
  - UPHC
  - SHC
  - ANM
  - USHA
  - ASHA

- **Roles**
  - ANMs
  - SHC
  - UCHC
  - FRU
  - CHC
The urban health delivery model would basically comprise of an Urban Primary Health Centre for provision of primary health care with outreach and referral linkages.
1. URBAN- COMMUNITY HEALTH CENTRE (U-CHC)

Population Norms and Location

- May act as a satellite hospital for every 4-5 U-PHCs
- The U-CHC would cater to a population of 2,50,000

Services

- It would provide in patient services and would be a 30-50 bedded facility
- It would provide medical care, minor surgical facilities and facilities for institutional delivery.
Support Staff

- Two doctors (one regular and one on a part time basis)
- There will be 2 multi skilled paramedics (lab technician and pharmacist)
- 2 multi-skilled nurse, 1 LHV, 4-5 ANMs (depending upon the population covered)
- Clerical and support staff and one Programme Manager for supporting community mobilization, behavior change communication, capacity building efforts and strengthening referrals
2. URBAN PRIMARY HEALTH CENTRE (U-PHC)

Population Norms and Location

- Functional for a population of around approximately 50,000-60,000
- It may be located preferably within a slum or near a slum within half a kilometer radius catering to a slum population of approximately 25,000-30,000, with provision for OPD from 12 noon to 8 pm in the evening
- The cities based upon the local situation may establish a U-PHC for 75,000 for areas with very high density
Services

- OPD (consultation); Basic lab diagnosis, drug/contraceptive dispensing; Distribution of health education; Material and counseling for all communicable and non-communicable diseases

- It will not include in-patient care
Support Staff

- Two doctors (one regular and one on a part time basis)
- There will be 2 multi skilled paramedics (lab technician and pharmacist)
- 2 multi-skilled nurse, 1 LHV, 4-5 ANMs (depending upon the population covered)
- Clerical and support staff and one Programme Manager for supporting community mobilization, behavior change communication, capacity building efforts and strengthening referrals
3. COMMUNITY LEVEL

A. Urban Social Health Activist (USHA)

- A Frontline community worker for each slum/community similar to USHA under NRHM
- The USHA would be a woman resident of the slum, preferably in the age group of 25 to 45 years
- She would be covering about 1000 - 2500 community level beneficiaries.
- She would be covering between 200-500 households based on spatial consideration preferably co-located at the Anganwadi Centre functional at the slum level the door steps
She would serve as an effective demand-generating link between the health facility (Urban Primary Health Centre) and the urban slum populations.

She would maintain interpersonal communication with the beneficiary families and individuals to promote the desired health seeking behavior.

She would help the ANM in delivering outreach services in the vicinity of the doorsteps of the beneficiaries.

She will be responsible to the Mahila Arogya Samitis (community groups) for which they are designated.
Selection Process

- The USHA will be selected through a community driven process led by the Urban Local Body.

- To facilitate the selection process the District/ City level Mission would constitute a City Level USHA Selection Committee headed by the member of the urban local body. The CMO/CDMO; DPOICDS; and PO of JnNURM; DUDA; SJSRY would be the members.

- The District/ City level health mission can also decide to induct more members from the NGO/ Civil society based on the local need.
Mentoring System

- Involving dedicated community level volunteers/professionals preferably through the local NGO at the U-PHC level for supporting and coordinating the activities of the USHA.

- The states may also consider the option of 1 Community Organizer for 10 USHAs for more effective coordination and mentoring.
Essential services to be rendered by the USHA

- Active promoter of good health practices and enjoying community support
- Facilitate awareness on essential RCH services, sexuality, gender equality, age at marriage/pregnancy; motivation on contraception adoption, medical termination of pregnancy, sterilization, spacing methods
- Early registration of pregnancies, pregnancy care, clean and safe delivery, nutritional care during pregnancy, identification of danger signs during pregnancy; counseling on immunization, ANC, PNC etc. act as a depot holder for essential provisions like Oral Re-hydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Oral Pills & Condoms, etc.
- Facilitate access to health related services available at the Anganwadi/Primary Urban Health Centres/ULBs, and other services being provided by the ULB/State/Central Government
- Formation and promotion of Mahila Arogya Samitis in her community
- Arrange escort/accompany pregnant women and children requiring treatment to the nearest Urban Primary Health Centre, secondary/tertiary level health care facility
- Reinforcement of community action for immunization, prevention of water borne and other communicable diseases like TB (DOTS), Malaria, Chikungunya and Japanese Encephalitis
- Carrying out preventive and promotive health activities with AWW/ Mahila Arogya Samiti.
- Maintenance of necessary information and records about births & deaths, immunization, antenatal services in her assigned locality as also about any unusual health problem or disease outbreak in the slum and share it with the ANM in charge of the area.
B. MAHILA AROGYA SAMITI (MAS)

- It acts as a community group involved in community awareness, interpersonal communication, community based monitoring and linkages with the services and referral.

- The MAS may cover around 50-100 households (HHs) with an elected Chairperson and a Treasurer supported by an USHA Link worker.
Activity

- Preventive and promotive health care
- Facilitating access to identified facilities
- Management of revolving fund

Constitution of Mahila Arogya Samiti

- ASHA
- Group of socially committed females from the community itself
- Women’s/SHG groups
C. AUXILIARY NURSE MID-WIFE: OUTREACH SESSION

- Each ANM will organize a minimum of one outreach session in the area of the MAS every month.
- Outreach Medical Camps – Once in a week the ANMs would organize one Outreach Medical Camp in partnership with other health professionals (doctors/pharmacist/technicians/nurses – government or private.
- 4-5 ANMs will be posted in each U-PHC depending upon the population
- Outreach sessions will be planned to focus special attention for reaching out to the vulnerable sections like slum population, rag pickers, sex workers, brick kiln workers, street children and rickshaw pullers
Urban Health Delivery System

- All the services delivered under the mission will be based on identification of the target groups.

- Provision of primary health care in Urban health delivery mode is basically through:
  - U-ASHA (At community Level) - USHA
  - Urban Primary Health Centre
  - Referral Units
All existing CHCs to have wage component paid on monthly basis. Other recurrent costs may be reimbursed for services rendered from District Health Fund. Over the Mission period, the CHC may move towards all costs, including wages reimbursed for services rendered.

A district health accounting system, and an ombudsman to be created to monitor the District Health Fund Management, and take corrective action.
Adequate technical managerial and accounting support to be provided to DHM in managing risk-pooling and health security.

The Central government will provide subsidies to cover a part of the premiums for the poor, and monitor the schemes.

The IRDA will be approached to promote such CBHIs, which will be periodically evaluated for effective delivery.