Executive Summary

Reaching Health Care to the Unreached:

Making the Urban Health Mission Work for the Urban Poor

Report of the Technical Resource Group,

Urban Health Mission,

Ministry of Health and Family Welfare,

Government of India

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Mandate

On 1st May 2013, the cabinet approved the National Urban Health Mission as a part of the National Health Mission (NUHM), thus bringing to a conclusion a process which began, along with the National Rural Health Mission (NRHM), as far back as 2006. As per the NUHM framework document, its main objective is "to address the health concerns of urban poor through facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor".

On 25th July, 2013 the Government of India issued an order for formation of a Technical Resource Group (TRG) on the National Urban Health Mission under the Chairpersonship of Mr. Harsh Mander. The terms of reference of the TRG included guiding the NUHM on key issues of reaching of vulnerable sections of the society, examining the main strategies and institutional design of NUHM, and how we may better the organization of urban health service delivery and its governance. Based on a series of consultations with experts and a range of vulnerable urban poor groups, and field visits to 30 cities, the TRG submitted its final report to the Government of India on 26 February, 2014. This Executive Summary outlines its main findings and recommendations.

Overview of Urban Poverty and its Relevance to Issues of Urban Health

Urbanization is one of the most significant demographic trends of the 21st century, expected to significantly boost workforce participation, capital investment, and innovation. The proportion of the urban population in India has increased from 10.8 per cent in 1901 to 31.2 per cent in 2011, and is expected to increase to 50 per cent over the next few decades. There is considerable variation in urbanization rates across states: Maharashtra, Uttar Pradesh, and Tamil Nadu are home to the largest number of urban residents in the country.

Migrants are drawn to urban areas for employment opportunities and to establish a better life for themselves and their families. Lack of land-holdings and viable economic opportunities in rural areas often push the rural poor to urban areas in search of work. However, most Indian cities from mega cities to small towns, lack the necessary infrastructure in terms of housing, water and sanitation, employment opportunities, and basic services such as health care and education to accommodate and meet the needs of migrants. This leads to adverse implications for the health, wellbeing and productivity of the migrants who constitute the major chunk of urban poor. Cities, thus possesses enclaves of prosperity and commerce" alongside clusters of concentrated social, economic, and political disadvantage and exclusion.**Error! Bookmark not defined.**

Individuals, groups, and even communities may experience social exclusion due to caste, class, religion, occupational status, and residence. Further the experience of exclusion can take place at different levels – individual, family, community, societal, institutional, and policy levels. There are also some groups such as the homeless and the mentally ill who experience social isolation across all levels. The urban poor are often employed in the informal sector as seasonal or cyclical migrants who come to cities at certain times of the year for work, have tenuous residential status, live in insalubrious conditions, have financial responsibilities to their families in villages, and lack access to health care, education, financial services, and social capital. These factors individually and together impact their ability to respond to or fulfil basic needs of shelter, security, food and water. Given their itinerant, illegal, unrecognized, and marginalized status, the urban poor may have to pay for basic amenities such as water and toilets that may otherwise be widely available and affordable for the urban non-poor.

Whether in slum dwellings or not, many among the urban poor reside in spaces marked by a lack of one or more of the following: access to an improved water supply; access to improved sanitation; sufficient living area; durability of construction; and security of tenure. Many survive in makeshift, temporary constructions fashioned out of plastic, brick, tin, and other waste materials (that may be unsafe and hazardous) or simply live on the road, under flyovers, railway platforms, and outside shops without shelter and in unsafe conditions.

Each of these "slum" characteristics has differential deleterious implications for the health and wellbeing of the urban poor. Poor access to safe water and basic sanitation (a common problem for most urban poor) has considerable adverse effects on the physical and even cognitive development of children, results in a range of gastrointestinal disorders in adults, and makes it difficult for girls and women to maintain personal and menstrual hygiene. Poor housing confers little or no physical protection against the heat, cold, pollution, traffic, crime, theft, accidents, and physical and sexual abuse. Children, adolescent girls, women living in such tenuous circumstances are particularly at risk for sexual violence, especially when they sleep in the open or in insecure dwellings, collect water, or defecate in the open. Densely populated living conditions in slums places household members at risk for infectious diseases such as tuberculosis, acute respiratory infections, and various skin disorders. Further many urban poor live in poor, disadvantaged parts of a city (e.g., city outskirts, low lying areas, near factories and construction sites) and are at risk for floods and outdoor air pollutants. Lastly, the insecurity of tenure for most urban poor compounds the lack of access to basic amenities and opportunities, which other city dwellers do – especially in terms of education, health care, and employment. Additionally, insecure living conditions cause psycho-social stress. In addition to the harsh physical environment, the social environment of slums is also adverse: high rates of crime can cause physical and emotional trauma as well as financial loss for urban residents.

Reaching Vulnerable Sections

While it is clear that each city has various vulnerable groups who face disproportionate burdens of ill-health, the challenge emerges of identifying and demarcating such groups in every city in terms of their specific health needs. Vulnerabilities are often intersecting, overlapping, and mutually constitutive.

Most commonly, vulnerability is officially seen as coterminous with low incomes or slum dwelling. The heterogeneity of urban populations is not captured in most published data, thereby masking the health conditions of urban poor sub-groups.

The TRG relies on the Hashim Committee (constituted by the Planning Commission to advise it about ways to identify the urban poor) recommendations for the vulnerability-based identification of the urban poor, as follows:

i) Residential or habitat-based vulnerability in urban areas includes urban persons/households who are houseless, living in kutchha/temporary houses, facing insecurity of tenure, and un-served or under-served with basic public services like sanitation, clean drinking water and drainage.

ii) Social vulnerabilities point to gender-based vulnerabilities such as those faced by female-headed households, age-based vulnerabilities such as minor-headed households and the aged, and health vulnerabilities such as disability and illness.

iii)Occupational vulnerability is faced by persons/households who are without access to social security, susceptible to significant periods of unemployment, as well as those who by virtue of no access to skills training and formal education or the stratifications of gender, religion and caste, are 'locked into' certain types of occupation such as informal and casual occupations with uncertain wages/earnings and/or subject to unsanitary, unhealthy and hazardous work conditions, oftentimes bonded/semi-bonded in nature or undignified and oppressive conditions.

Health Burdens: The health burdens of the urban poor are well known; most are the same as those that affect other urbanites, but more pronounced and more often, co-occurring, such as high prevalence of under-five mortality, underweight, lung disease, and vector-borne diseases like malaria. Immunization rates in these populations are also low. Disease epidemics are strongly correlated to site location and cramped space; vector-borne and respiratory diseases are easily spread, especially under conditions of poor sanitation and exposure to environmental pollution. Mental health distress is pervasive, because of the stressful, lonely, alienating environment, cut off from traditional, emotional and social security support systems, creating ample opportunities for co-morbidity and reinforcing stigma. Diabetes, hypertension and to a lesser extent, asthma, are reported as the most commonly suffered chronic diseases. We also encounter dog-bites, alcoholism, substance abuse and occupational diseases suffered by

sanitary workers, rag-pickers, head-loaders and sex workers. A major burden for homeless persons is trauma, from accidents, attacks, and protracted neglect, for want of spaces for recovery and rehabilitation.

Health-seeking: In terms of health seeking behaviour the Report indicates following barriers faced by the vulnerable:

i) Being invisible and ineligible in the system: Vulnerable groups accessing health services have to confront the esoteric and excluding bureaucratic rituals and requirements of proving one's existence to the system – For example without an identity proof with your father's (not mother's) name, a homestead, and a date of birth, you don't exist.

ii) *Lack of comprehensive primary care services in public facilities*: There are far too few public facilities providing services and even what is provided is limited to a very narrow range of reproductive and child health (RCH) services and at best symptomatic care for other illness- thus pushing most primary care utilization to tertiary care sites.

iii) Ill-timed consultation and waiting hours: Most health centres have morning timings, which excludes all domestic workers and daily wage workers, even self-employed impoverished workers, indeed most of the urban poor populations. In every city, they explained that a visit to a morning OPD at a health centre would cost them a day's wages, and regular visits could entail the loss of a job. Thus despite the high costs, visiting a private practitioner instead in the evening, may be their only option.

iii) Location and distance for appropriate services: Distance and costs of transport are frequent barriers for health-seeking, which is why it is important that primary health services are located within distances which do not require the patient to use public transport.

iv) Disrespectful behaviour: One of the most important reasons for not using public health services by vulnerable groups is disrespectful, and sometimes insulting, behaviour by public health providers.

v) High, hidden costs: Across cities, user fees as well as the requirement that patients purchase most drugs and sometimes even consumables like gloves was uniformly found by vulnerable populations to be excessive for them, and in many cases, a deterrent to health-seeking. Many also report rent-seeking by health providers for offering services.

The consequence for many then is that the first choice is to not seek care, but to self-medicate and to avoid even having to approach the public health system. They often opt instead for more accessible but poorly qualified private practitioners, who often follow irrational practices, or even just the shop-attendant in a pharmacy.

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

There is wide diversity of institutional arrangements for the attainment of better health outcomes and the delivery of health care services in urban India. But for ease of analysis, the Report identifies three broad institutional patterns from the perspective of which government takes primary responsibility for organising health care in the city.

- In the first, health care facilities are entirely provided by the state departments of health, with no involvement of the urban local body (ULB).
- In the second, a minority of care provision is by the ULB and this role is usually receding. Typically, it is a maternity hospital and a few urban health dispensaries or health posts. For the main part it is the district hospital or medical college hospital that provides the health care services.
- In the third pattern, the majority of health care facilities are under the ULB which looks after medical and non-medical public health functions in an integrated manner.

The ideal organization of health care services could be described as a health care pyramid, with the bottom of the pyramid constituting community and outreach processes and primary health centres; at the next level secondary hospitals act as the first referral site, offering hospitalisation and a larger range of diagnostics; such that only 5 per cent of care and illness requires tertiary levels of care, with a majority of this being for complex illnesses. But the Report notes an *inverse pyramid* phenomenon. The major proportion of curative primary care provision is occurring at the medical college and the district hospitals, with the UHC and maternity homes catering to a much smaller proportion, and almost no care occurring at the outreach of community level for a major part of the population. In rural settings, distances disallow, to a degree, such a pattern. But in urban areas, geographical distance is not a major barrier- and since services are more assured at the higher site, the poor prefer to go there.

Another big issue in the organization of primary care services is that primary health care in the urban setting is not population-based. Typically, the urban peripheral facility- be it health post or health centre - treats those who come to it: there isn't an *a priori* responsibility for the health of the entire population in a defined catchment area. This lack of definition of a catchment area and the connection between the health centre to a given population base has a direct adverse consequence for reaching the vulnerable. Another consequence is that outreach services are limited. This implies that those with latent illness or inadequate health-seeking behaviour are altogether missed.

A third pattern is that primary health services in most cities are restricted mostly to RCH services, and even within this, to family planning, immunization, and a limited quality of antenatal care. This is a major reason for reliance on tertiary hospitals or

private care providers. Vertical health programmes are typically not converged in primary health institutions.

Finally, inadequate attention is given to wellness and promoting healthy lifestyles. This is partly the case because the health system is heavily tertiarised and attention given, correspondingly to drug, diagnostics and care. There are structural requirements for health promotion, including access to information, as well as health-promoting products, activities, and spaces that tie in with other urban governance issues. These have to be duly addressed.

Community Processes: Learning and Options

The most common observation across all states and cities is that there is really no major programme focussed on strengthening urban community processes in place. A further challenge in urban areas is that in settlements of the urban poor, there are fewer organic communities than one may find in villages. A village is also deeply divided by caste and gender inequalities, but at least it is a settled and stable social entity. In cities, by contrast, people are far more socially isolated and uprooted, and live in settlements in which they lack organic, stable bonds with their co-residents. This has many consequences for health including much greater psycho-social stresses and the lack of care-givers for many poor migrants. At the same time, this also has great challenges for organising community processes, as few organic communities of the urban poor exist.

The spectrum of services currently offered by urban ASHAs or other Community Health Workers, to the extent that they are in position, is largely limited to promotion of immunization, antenatal care and family planning. Evidence from the city reports point to the fact that the reach of the ASHA to vulnerable people is limited, since she has not been equipped either by mandate or through her training to focus on the felt health needs of these marginalized groups. The reach of the ASHA to marginalized communities is critical, particularly in view of the fact that the NUHM lays such substantial emphasis on particularly reaching the invisibles- the destitute, the homeless, the marginalized, those with different sexual orientations, etc.

Community based selection of the ASHA is an important tenet of the NHM. But whereas a relatively greater homogeneity in rural areas facilitates this, the selection of urban ASHA poses several challenges due to both the higher heterogeneity and the lack of accepted community leaderships, organisation, and solidarity cutting across the different groups living in close proximity.

Remuneration packages for the community based workers vary with urban local bodies usually paying salaries ranging from Rs. 3000 to Rs. 8000. However in the NHM architecture, payments are incentive-based- which in many urban contexts leads to very low levels of monetary compensation. A fixed basic salary/(a regular income) for ASHAs in urban areas is worth considering, given her larger role including but going beyond RCH.

For bottom up planning to occur, a community worker operating in isolation is insufficient. She needs a group of people- a community collective- who can support the process of local planning, given their knowledge of and familiarity with their community and their environments, and their interest in positive outcomes. The proposed Mahila Arogya Samiti (MAS) under NUHM is composed of about 15-20 persons, drawn from a neighbourhood cluster. The *Kudumbashree* model in Kerala has useful lessons on how to make this committee more representatives by a drawing one committee member from each cluster of 10 to 20 houses.

There is however one dilemma that the urban health committees have to resolve: many cities have sizeable populations of single male migrants with unique health concerns- women health workers may not be able to address or perhaps even discuss these. This makes the case for the introduction of a male ASHA equivalent, or at least some men in what are now a Mahila Arogya Samiti.

One finding from across the urban areas, is that there are no public grievance redressal mechanisms in place. Part of the problem seems to be a lack of willingness to invite complaints knowing the poor ability to respond where there is such lack of finances and human resources. But an equally important issue is the administrative space and follow-through to do it, given the key role this could play in building confidence in the public system.

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

One of the major issues that the TRG addresses is effective institutional mechanisms for convergence of urban primary health care services with other government run schemes responsible for health determinants. This is critical considering the massive burden that the poor state of these determinants like sanitation, drinking water, air and water pollution, and housing imposes on the health of our population.

Across cities, towns, states and within states, there are wide variations in governance arrangements for each of these services, the mechanisms and effectiveness of coordination between them. However, what is fundamentally different between rural and urban area, is that in villages most of these functions are not and never were with a health officer in rural areas. But in urban areas, the original institutional design was the complete integration of these functions under a municipal health officer, who was a public health officer with public health qualifications. The challenge in NUHM is how not to lose this element of convergence that may already exist., As health care services are being taken over by the state department in many states, inadvertently as part of turf issues, the municipal health officer post often loses leadership of public health activities. This undermines both convergence and effective responses to outbreaks of diseases.

Apart from the above described services, urban health also requires coordinated and effective service delivery for food security, Integrated Child Development Services

(ICDS), school education, and housing- all four of which are areas which have always been outside the purview of city health officers – but have a direct bearing on health.

Since cities are hubs of development and consumption, they are also centres of massive waste generation. In all cities, almost without exception, solid waste management emerged as one of the main problems facing populations, especially in slum areas, and particularly for ULBs. Many linked challenges were identified, from land availability, to environmental hazards, mechanisation, to carcass disposal. As many of these are addressed inadequately or not at all, all too often, the brunt of the solid waste is borne by the poor, whose localities are specifically chosen for dumping of waste, and simultaneously ignored while clearing it. Further, across cities and towns among the most ignored of issues is the health and safety of sanitation workers themselves, who face among the highest rates of infection, substance abuse, acute and chronic morbidity and premature mortality in the country.

Financing Urban Health

Broadly, financing for urban health is drawn from four sources: 1)the budget for health and related services in urban local bodies, 2) the expenditure incurred from state government budgets, 3) the central budget, and 4) out of pocket expenditure- almost all of it as fee for service and a very small part as pre-payment through insurance mechanisms. The TRG found that in general: a) the major part of total health expenditure is out of pocket; b) except in the large cities the major part of public health expenditure is from state health department budgets; and c) the contribution of other sources of financing of public services- essentially insurance and public private partnerships- is at this point of time very limited. The central government contribution has hitherto been minimal, but this is set to change with the introduction of NUHM.

National Sample Survey Organisation (NSSO) studies indicate that 5 per cent of urban households fell into BPL as a result of total healthcare expenditure in 2004. Of this, around 1.2 per cent of urban households fell into poverty due to expenditure on inpatient care while 3.8 per cent fell due to expenditure on outpatient care. In effect, overall in the country, 79.3 per cent of impoverishment is due to outpatient care and only 20.7 per cent of impoverishment is due to inpatient care. The effect of healthcare related expenses is highest in the second poorest quintile in urban areas.

There are three broad policy approaches for engaging with the private sector to provide financial protection and quality of care: a) regulatory mechanisms, b) public private partnerships (PPP), and c) insurance mechanisms. With regard to regulation, no current regulatory approach has even attempted to look at costs of care. In fact, the first efforts at regulation were so tightly limited to inputs - like infrastructure, human resources and equipment, that their expected effects on costs may be have been adverse.

Strictly defined, a PPP is sharing of investments, risks and rewards. We found no example of an unqualified, successful PPP, particularly in primary health care- though there have been many attempted. One putative "successful" form of PPPs is the outsourcing of urban UPHCs to not for profit NGO agencies. Typically, while the NGO brings in no money, its existing corpus and influence may help cope with delays in payment by the government. Other successful and much needed models of PPPs are management contracts to NGOs for catering to special needs of particularly vulnerable groups. Yet another successful form of PPP is for closing critical gaps in essential clinical services- like for dialysis, and cancer where the complexity is high and public provision difficult due to the problems of attracting and retaining required specialists.

Both the presence and expectations of insurance in the urban context are high. The city visits and group discussions show that in areas of high coverage, most people in slums had been enumerated, but not nearly as many had received cards, and few of those with cards and requiring hospitalization had received their entitlements to cashless services –in both public and private sector. Of greater concern, there are well-documented reports of actual denial of services in the private sector. Further, the community was not aware of the actual list of hospitals, nor of any grievance redressal mechanisms.

It therefore appears that the most promising route to improving access and financial protection, not just for the poor, but also a considerable section of all classes is public provisioning based on adequate and appropriate public financing- and while there should be efforts to improve upon existing insurance mechanisms- these have only a limited contribution to make and also require a viable public sector to fall back upon.

The key questions therefore are: a) what would be adequate public financing, and b) what share of this would come from NUHM, state government, ULB, and OOP/insurance mechanisms, respectively, and c) what needs to be done to improve efficiency and equity in public health expenditure from all the above sources.

The TRG suggests that efforts must continue to increase budgetary financing for NUHM – at least to reach what has been spelt out in the cabinet approval for the scheme and the 12th Plan projections. The importance of this is not only to improve central support, but to catalyze and improve state and municipal contributions. Advocacy is particularly needed to improve municipal contributions. There is a need to protect and expand all activities related to non-medical public health in all towns and cities irrespective of governance arrangements. A minimum set of services under a UPHC should be costed, excluding the costs of drugs and supplies, which would flow separately. The non-negotiable bottom line is that all primary health services should be completely free for users. This should mean and be measured by elimination of out of pocket expenditures and the removal of user fees (for essential drugs and diagnostics).

Governance for Urban Health- including the Governance for Urban Health Care Services

A well governed and managed urban health system should be able to deliver the health care services and achieve health care outcomes effectively, efficiently, and the services should be responsible to the needs of the people and accountable to them who are ultimately the owners of public services.

There are two major institutional frameworks of governance in the urban context. The first is the elected urban local body and its executive. The second is the state government and its department of health. The latter's actions could be further mediated through the directorate or the state and district health societies.

India's constitutional position, especially after the introduction of the 73rd and 74th amendment of the constitution makes health services a part of the mandate of local bodies. Potentially, services under local bodies are both more accountable and more responsive. This remains an important principle. However, there are concerns about capacity, the ability to govern increasingly complex technical services at decentralised levels, and political will.

Given the complexity of these factors, the NUHM framework rightly leaves this decision to be made by the state government. The TRG considers this issue and while agreeing that states should make the final call, emphasize the following guidelines: a) In all large metros- all urban health services – involving both health care delivery and non-medical services remain under the urban local body and should be strengthened. b) In all cities above ten lakh where urban local bodies are able and willing to contribute to financing- up to a possible cut off, 5 per cent of the total municipal budget for health- there is a strong need to preserve the same architecture as in the metros. c) In cities and town where health care services are being handed over to the state department of health, the participation of the elected urban local body and its executive at all appropriate levels should be maintained. d) In all the above three situations, a clear memorandum of understanding between the ULB and the state health society should guide the funding from NUHM clarifying the expectations as regards deliverables and the roles of respective organisations.

National Urban Health Mission

Summary of TRG Recommendations

1. City Level Vulnerability, Facility and Service Mapping

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

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

It would be useful for the survey to involve not just the local body and health department of the state government, but also trade unions and collectives of urban poor groups – such as of rickshaw pullers, construction workers, rag-pickers, sex workers, homeless people, single women, disabled peoples collectives, organisations of the aged, homeless and street children – youth groups, and colleges of social work, social sciences, and urban planning. It is not only health, management or IT technical expertise, but the insights and contributions of social scientists and community based organizations that would help develop good mapping outputs.

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

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

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

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

When concentrations of vulnerable are over-laid with and carefully co-related with existing health infrastructure available and the access audit, gaps, needs, imbalances and mismatches are made visible. The purpose of mapping is to draw up city health plans under UHM that would be able to correct these multiple imbalances and gaps, and address vulnerability more comprehensively.

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

2. Nursing Stations-cum-Health Sub-Centres

The NUHM Framework for Implementation provides for a female health worker/ANM in urban areas for a population of 10,000 to 12,000. Such a population cluster would also have approximately 5 ASHAs. Given the existing constraint in funds and the very low baselines in health posts and ANMs, this is understandable. However the TRG makes a case for phase-wise upgrading this lone female health worker per 10,000 populations with 5 ASHAs to a three person Nursing Station cum Health Sub-Centre – which we refer to further as "nursing station." This facility should ideally have two female health workers and one male health worker- all with equal remuneration. The location should be as close as possible to where the catchment population lives or works

The nursing station will **provide all primary health care that does not require the intervention of doctors; this includes health and nutrition counselling, health literacy activities, preventive and promotional health activities, vaccination and ante-natal care services. Most importantly it is the point of supply of drugs initiated by doctors and followed up by nurses with tests, counselling, free medication, and prescription refills.** Coverage should include Tuberculosis (TB), mental health distress, leprosy, hypertension, diabetes, epilepsy, asthma and other high burden NCDs, as well as dressing of wounds. These could also be sites for initial counselling and referral for substance abuse, and for disability, geriatric and palliative

health care, including domiciliary care. They would also be able to support and help coordinate vector control activities- and organise with the ASHAs to understand and ensure preventive and promotional health care provisioning.

Most nursing stations would be open at certain fixed hours, mainly in the evening but if required, also in the mornings - as finalised in discussion with local communities. If there are three health workers per nursing station, it should be possible to combine this requirement with a schedule of home visits so that every vulnerable household is regularly visited by one or other member of the health team.

3. Urban Accredited Social Health Activists (ASHAs)

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

The basic Female Health Worker qualification is Auxiliary Nurse/Midwife (ANM) certification, and where available, General Nurse/Midwife (GNM) certification is preferred. Similarly, for ASHA, there is a case for preferring 12th class pass women, since they could later get trained and upgraded into full time community health nurses. However, if the community finds a lesser qualified woman more suitable, education alone should not be a barrier. All categories of workers would require appropriate in-service training for them to handle this task.

As in rural areas, ASHAs are a major component of the community processes. Their selection must be based on the decision of a cluster of Mahila Arogya Samitis, helped by a facilitator, with endorsement of a ward committee.

Unlike in rural areas, from the outset there may be greater expectations of the urban ASHA in facilitating access to a wider range of services. RCH services are to be a priority. Other emerging roles include assisting patients to navigate the secondary and tertiary care hospital and safeguarding the interests of those enrolled in an insurance programmes – in terms of securing cashless health care services as an entitlement, without unnecessary care.

Given the increasing range of work expected from the ASHA, if the work load approaches 25 to 30 hours per week, then a regular adequate compensation becomes essential -NUHM needs to provide for it.

The Supreme Court has directed that all slum populations must be fully served by ICDS centres. Since each ICDS centre serves a population of 1000 persons, 10 slum-based ICDS centres will be linked to each slum-based sub-health centre. There should be a strong organic linkage between ICDS centres, ASHAs, Multi-Purpose Workers and UPHC,

especially in matters of nutrition and health of infants, young children, as well as expectant and nursing mothers; and also in the implementation of all national programmes for TB, leprosy, mental health and blindness prevention, among others.

4. Community Health Volunteers

In addition to the above the TRG recommends a programme to encourage community health volunteers of diverse backgrounds for diverse roles who would be entirely unpaid and voluntary, and actively mobilised like the literacy activists during the literacy campaigns under the National Literacy Campaign in the 1990s. The major part of these would be peer educators belonging to specific vulnerable groups, for example rag-pickers, sanitation workers, and commercial sex workers. Another set could be community volunteers who work in adolescent friendly clinics located in adolescent hang-out locations or amongst unorganised workers. A third set would be young volunteers who extend domiciliary support to aged and disabled people, as well as support to take them to health services. They could be given names like Jan Swasthya Sevaks to provide inspiration and some recognition, but recognising that these are entirely voluntary entities, with no financial compensation of any sort.

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

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

The NUHM Framework for Implementation provides for one UPHC for every 50,000 population. This will be achieved by both adapting/upgrading existing facilities and adding new ones. The geographical and social distribution of UPHCs within the city must maximise access for the urban poor, following certain guidelines:

i. **At least 50 per cent of all Urban Primary Health Centres (UPHCs) must be located within or near (at a maximum distance of 0.5 kilometres) settlements and habitations of urban poor persons and unorganised workers**, including slums(both notified and non-notified); slum-like habitations of areas of sub-standard housing stock with very high density characterised by housing with *kutcha* roofs and walls; areas with lack of piped water supply, underground sewerage and drainage, and extreme over-crowding; or in slum resettlement colonies; urban villages; land-fills, and red-light areas; factory worker and scavenger colonies; leprosy colonies; construction workers' camps; and impoverished inner-city areas. Only in cases where all efforts to find land *within* these habitations for UPHCs fail, these can be located at a maximum distance of

0.5 kilometres from the boundary of these settlements. For ensuring that at least 50 per cent of all UPHCs are located in or near settlements of the urban poor, a UPHC would be considered serving settlements of urban poor neighbourhoods if at least two-thirds of the catchment population are residents of what this note has designated to be urban poor habitations[1].

ii. About 5 to 10 per cent of all UPHCs will have special additional services meant for homeless populations and street children, as well as temporary and circular migrants. Services include mobile clinics as well as recovery shelters. Mobile units, whose package of services would be similar to nursing stations, would provide fixed time services to unreached areas, such as remote slums, temporary migrant populations, and scattered homeless persons.

iii. **The UPHCs in the remaining parts of the city, areas which are not slums and in which the majority of residents belong to the middle classes with decent housing and civic infrastructure could be about 30 per cent of the whole**. Active utilization of at least these UPHCs would have its own challenges, but such utilization would bring popular support to strengthening UPHCs and also provide considerable relief and financial savings to the non-poor sections as well, apart from serving domestic help populations who live in upmarket areas. Whereas services for dedicated urban poor UPHCs will be intensive, those serving the better-off parts of the city can be more extensive- serve larger populations, even up to two lakhs. For these UPHCs, existing public health centres such as CGHS and ESIC dispensaries should also be incorporated and upgraded.

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

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

exclusions- and the state would in consultation with them decide on how much of this can be provided, where and how.

6. Special UPHCs for Homeless Populations and Street Children

A rough estimate of homeless persons in any city is about 1 per cent of the total population of the city, of which 0.5 per cent would be street children. This estimate could be used to check whether the mapping process has been rigorous and sensitive enough.

Further, UPHCs which are tasked with affirmative action to reach homeless groups, street children, temporary and single migrants, must be equipped with additional facilities, including a) mobile clinics for dispersed homeless populations, and b) **recovery shelters of at least 30 beds each enabling care for those without homes and carers discharged after treatment for serious ailments like TB, accidents, cancer and others, requiring bed-rest and special nutrition**. The detailed design of a homeless recovery shelter is given in the annexure of the TRG Report.

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

7. Measures to Ensure Inclusion

i) It will be the explicit mandate of the UPHC to provide priority services to urban poor people, especially those in most difficult circumstances such as street and slum children, the aged, disabled, single women, unorganised workers in unsafe occupations, and survivors of violence (domestic violence, sexual assault, caste and communal violence).

ii) There will be **no requirement of any document to prove identity, address or citizenship for a person accessing a UPHC for primary health care. No persons shall be turned away from any UPHC on any ground for a service which is on the assured services list of the facility, including lack of documents, lack of caregivers, location, homelessness, disability, gender, sexual orientation, or nature of ailment. This in turn requires a process of actively listing and enrolling every individual in the catchment area, and providing them with an individual health record as part of a family health folder, as a way of having this information to ensure continuum of care as well as updated, responsible, and inter-operable record-keeping and information management. Identity cards and documents are thus never a gate-keeping requirement, but an optional enabling device for facilitating quality and continuity of care.**

iii) Sensitivity needs to be built on problems of identity with respect to standard formats. For example children of sex workers and single mothers would find a form

with only mothers name very friendly and one with only a father's name as hostile. In particular, **all forms under the UHM should ask for mother's name only, instead of father's or husband's name**. A transgender person, who the hospital does not want to record as a woman or man, would require to be identified as trans-gender. Formats design should have the flexibility for these concerns.

v) **End-to-end computerisation will ensure that patients will not have to preserve their medical records**. For patients who are street children, homeless, migrant, nomadic or residents of non-notified slums, it is difficult to preserve paper records. Copies of these will be available in hard form wherever a patient demands, to cater to mobile circular migrant populations. Identity codes or bio-metrics are useful for this, but UHM should provide a choice from multiple codes and do not make it mandatory for receiving care.

vi) Since the majority of unorganised workers are unable to access health facilities during morning hours (this involves loss of a day's wages), **all UPHCs and Nursing Stations should be open preferably 24 hours, but if not possible then surely from 3pm to 9 pm daily**. The exception will be UPHCs catering to red-light areas, which will operate in morning hours. Women staff will be ensured security protection to enable them to work in evening and night hours. Where shift outpatient wards are very crowded, a second shift with its own complement of staff would provide better services and would optimise use of the infrastructure.

vii) **UPHCs should have a special focus on geriatric and disabled persons' care. All UPHCs must have a special help-desk for the aged and disabled, and also fast-track counters for them**. Staff in sub-centres should provide domiciliary services to home-bound old and disabled persons. There could be Sunday Clinics especially for the aged, in which local youth volunteers could assist ASHAs in bringing the aged to the clinic and help them within the UPHC. In hospitals in one evening a week, the UHM could also run special poly-clinics for the aged and disabled.

viii) All UHM staff, especially front-line staff in nursing stations and UPHCs should be specially trained in health challenges of persons with disabilities. In particular, they must be trained to remember both that disabled people have health problems just like other non-disabled populations (an obvious fact which is often forgotten because caregivers and health provides often focus so much on the disability that they forget that the disable person is also a person like any other); and that specific disabilities often have high chances of specific co-morbidities.

8. Design of UPHCs: Service Package, Human Resources, Referral Linkages and Infrastructure.

i) The revised NHM Framework of implementation provides a comprehensive list of primary health care services. There must be an effort to establish all these services from the very outset. We note that most urban dispensaries and urban PHCs visited - whether run through PPPs or run directly by state governments, tend to focus exclusively on a limited spectrum of RCH care. **UPHCs will not only need to integrate all vertical disease control programmes, it must also cover at least the preventive, promotional and curative services given in the NHM framework document.**

ii) The NUHM Framework of Implementation provides for one regular and one part-time medical officer for an UPHC. While this is acceptable as a starting position given resource constraints, there must be the flexibility to add on one more medical officer is the regular outpatient clinic is over 50 patients per day (not counting those coming for immunization, or just to collect medication). Thus, most UPHCs that are even moderately functional will over time have at least three medical officers, of whom at least one will be male and one female, with minimum qualifications of MBBS. There would also be one medical officer trained in Indian Systems of Medicine, in states where co-location is the accepted strategy.

iv) **Each UPHC will also have a Help Desk and Counselling Centre run by a trained social worker, preferably a medical social worker.** Her/his duties will include to advise and support the patient, offer advice about preventive and promotional health such as clean water and sanitation, breast-feeding, child rearing practices, life-style issues and occupational health. She/he would also organise the training of the staff of nursing stations, the ASHAs, the members of the MAS and the peer educators on all these essential non-medical dimensions. The social worker will have special duties to support survivors of violence, children without adult protection, old and disabled persons. This position will be filled by social workers placed on deputation from urban poor collectives, organisations which are part of Jan Swasthaya Abhiyan network (a health rights network), or other reputed health rights NGOs.

v) **Each UPHC will be equipped with basic diagnostics, and for the rest it could be site for collecting samples and conveying results confidentially**.

vi) The NUHM framework does not currently envisage any beds at the UPHC level. Though this could be the starting norm for the present, the TRG recommends that for certain situations and services (especially where secondary services are not there or are overcrowded), the UPHCs should be "Upgraded" over time. Upgraded UPHCs could have twelve bed facilities, for short term hospitalisation, uncomplicated deliveries, recuperation, drug de-addiction, and possibly also for special referral services,

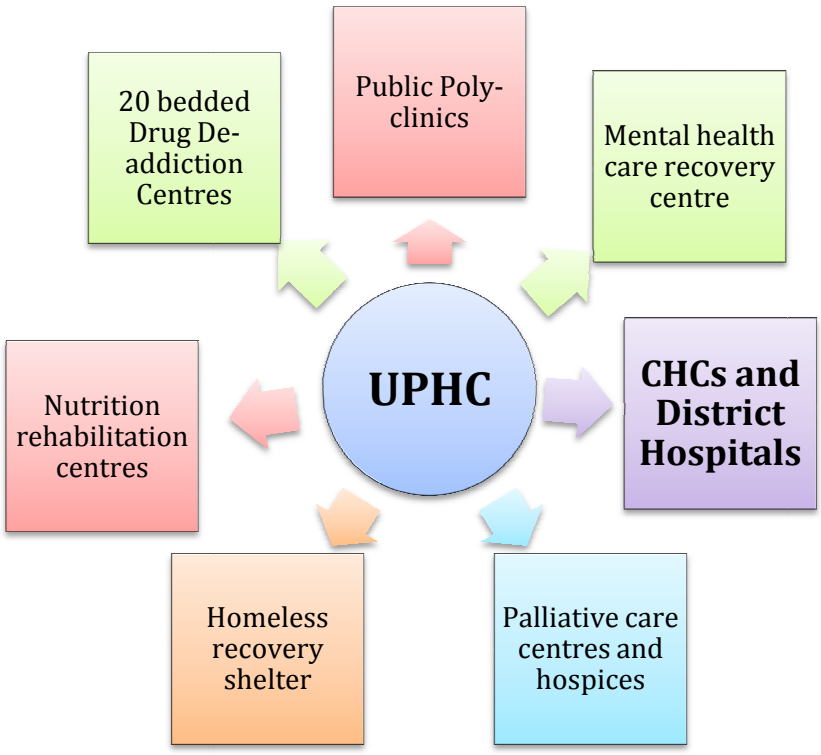
viii) Referral mechanisms from UPHCs to secondary and tertiary health care centres need more systems in place. Patients so referred should receive facilitation at the higher

facility. For example, referred patients could have a green card which ensures that a help desk attends to them, helping them navigate the complex hospital terrain for meeting the right doctor and getting diagnostics done on a fast track basis. An amber card could allow them access to collect their regular medication or get a more complex dressing done, without going through the queue and so on. Another important component of referral is computerised or routine feedback from secondary and tertiary care facility to the primary care provider so that follow up in the primary care centre is enabled.

ix) To enable such continuity of care and to assure quality of care, the development and dissemination and use of standard treatment protocols for all major ailments affecting urban populations should be strictly adhered to. Here it is important that critical areas like mental health are not ignored. Correspondingly, generic medicines should be listed and purchased for all these ailments, and sufficient stocks of these medicines should be available at all UPHCs at all times.

x) **Other than referrals to higher facilities (i.e. the Community Health Centre (CHC)), UPHCs should have two way referral linkages with a number of supportive health care facilities. These may include a) designated Public Poly-clinics or specialised diagnostic clinics; b) Free residential and out-patient 20 bedded Drug De-addiction Centres, c) Free residential 20 bedded mental health care recovery centre, d) Nutrition rehabilitation centres, e) Homeless recovery shelters, and f) Palliative care centres and hospices,** as indicated in Figure 1, below.

Figure. 1 Comprehensive Referral Alternatives from UPHCs



xi) Attempts must be made as far as possible to redeploy, extend and refurbish existing infrastructures: new infrastructure should be created only where none exists. Facility mapping could indicate available public health institutions, including state government and ULB dispensaries and hospitals, CGHS clinics and ESIC hospitals. There should be clear central government guidelines that all these health institutions should be regarded as a common pool to progressively ensure universal primary health coverage in urban areas. Since a great number of these existing facilities would be located in non-poor areas, UHM can invest in additional rooms, staff, equipment and drugs in these institutions to provide UPHCs in these non-poor areas at relatively low levels of initial investment.

xii) Imaginative use can be made of the existing physical health infrastructure for the UHM. **Most of the above facilities as well as out-patient premises of medical colleges are usually vacant in the evenings, which is the most useful time for health-seeking by urban poor populations. These spaces should be used for running poly-clinic OPDs as a first referral from UPHCs. These could also be deployed on Sundays such as for special geriatric clinics.** Where UPHCs and secondary hospitals are crowded and busy a second shift OPD from 3 pm to 9 pm, with a separate contingent of health personnel, may be able to reach the poor much more effectively.

xii) Unless an existing building is available in the slum, typically each slum UPHC will be a prefabricated strong and secure structure, which has the additional quality of being rapidly constructed and easily dismantled and relocated, as necessary. Moreover, no slum relocation will be permissible without the prior creation of a fully functioning UPHC in the relocation site.

xiii) In designing the UPHC and other health infrastructure, care should be taken from the start to make these disability-accessible. It is always more costly to try and make facilities accessible after they are constructed fully, particularly given that disability access is more than just ramps and rails. Standard designs for UPHCs require some relooking at from the point of view of accessibility (including safety and maximal utilization of all services within the facility). Simple things like good visual, colour coded signage, rails at important places, height of counters, grab handles in toilets etc. will actually be useful for all people and not just children and persons with disabilities. Universal Design Guidelines prepared by the International NGO Partnership Agreement Programme are appropriate and should be referred to for this purpose

xiv) All urban medical colleges are required to have urban health centres as a field practice site, administered under their public health, social medicine, or related programme. Centres should not duplicate coverage by existing urban PHCs; rather they should demonstrate how services are delivered efficiently and effectively. These are to be used for training of medical graduates and postgraduates on primary health care and its organization. Effective and willing medical colleges could be incentivised and given

administrative control of cluster of urban PHCs. The urban PHCs along with one of the secondary health centre should be community outreach programme of the medical college as a whole with rotation of doctors from all departments and not community medicine alone.

xv) In addition, UPHCs in partnership with local medical colleges located in urban area should be required to conduct a survey of special occupational health problems of urban populations in the specific catchment of each UPHC. It may be found, for instance, that head-loaders suffer from particular spinal and orthopaedic problems; workers in stone quarries from respiratory problems, and so on. Such attention should also be given to mental health conditions, which are often co-morbid with other health challenges. Medical colleges will train the doctors in these health problems again in compulsory 3 month modules. Specialists in medical colleges will also be available for visits to the UPHC, or referral clinics in the medical colleges or weekly tele-medical conferences with all PHC doctors for any complicated cases for which they wish for guidance.

xvi) To ensure adequate quality of care in all public health facilities ranging from the UPHC to the medical college hospital, a number of system strengthening measures are required. These have been detailed in section 4 of the TRG Report and cover human resources, quality assurance systems, drugs and supplies logistics and the architecture of public health information systems.

xvii) Each of the major national health programmes- especially the Revised National Tuberculosis Control Programme (RNTCP) and National Vector-Borne Disease Control Programme (NVBDCP), HIV and leprosy control programmes as well as the National Mental Health Programme (NMHP) have urban specificities and on these also some recommendations have emerged. (See sections 4.12 to 4.16 in the TRG Report)

xvii) While staffing UPHCs, care will have to be taken to not further starve Rural PHCs of trained health personnel. **The salaries of Urban PHCs should not be higher than those of Rural PHCs. There should be a ban on all forms of private practice by doctors serving in public health facilities – along with non practicing allowances and assurance of a reasonable pay package**.

9. Community Processes, Transparency and Convergence

i) At the level of each UPHC, there should be a Empowered Local Health Committee called the Jan Arogya Samiti (JAS), with a local elected ward member, and representative of each of the occupational group living or working in the catchment of the UPHC, and of the chairpersons/representatives of the Mahila Arogya Samitis (MAS) of the area. If there are a large number of MAS under a UPHC catchment area, then the JAS could take one representative from each cluster of 3 to 4 MAS. The majority would be women, but because the UPHC provides comprehensive health services to the entire population, including large and vulnerable single male populations, there could be a maximum of 25 per cent men represented in the JAS. Other than this, we should ensure

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

ii) The Mahila Arogya Samiti would be established at the neighbourhood level- as envisaged in the NUHM Framework. The selection would be in the pattern of Kerala's *Kudumbashree*, beginning with a neighbourhood area being constituted out of compact groups of 10 households each, who would each select a member. There would usually be one MAS for every 500 population- which means about 10 members. In the few instances where the majority of households in a neighbourhood are of single men, then the representative would be a man. The ASHA is the convenor and the FHW or MHW of the nursing station would be an observer.

iii) In areas currently not served by UPHCs, the option is to construct these as Ward Arogya Samitis that link or federate the MAS in that ward area.

iv) The stated objectives of the JAS would include 'optimising use of the existing health services and suggesting ways of improving them' as well as 'addressing the social determinants of health'. Wide experience, including of the Mitanin experience in Chhattisgarh has shown that community involvement *before* the implementation of the medical initiative is not only their right, but also crucial for community ownership. Developing a social worker/health counsellor-NUHM interface may be the way to go for this component, to be created *as the first step* of implementation of the NUHM. (Even with current fund allocations, it is possible to undertake this.)

v) Each Jan Arogya Samiti will prepare a UPHC Community Health Plan, based on an assessment of the social and economic profile of the catchment area, and their specific health burdens, needs, and non-curative health determinants of health. They would also conduct yearly social audits of the services extended by the UPHC, and it will be the duty of the City and State Urban Health Mission to study and introduce correctives in response to these social audit reports, and place their action-taken reports in the public domain.

vi) The stated objective of a MAS is mobilisational, providing support to the ASHA in her work and also being an institutional mechanism to help people reach the ASHA and receive her services, and through her all other primary care services.

vii) Each Jan Arogya Samiti will work closely with the MAS and ASHAs in that area also recruit Community Health Volunteers and peer educators from young women and men as well as recent retirees in settlements. They will not be paid, but will volunteer special services, such as accompanying and home care for the aged and disabled, health counselling, preventive work for vector diseases and NCDs, and so on. They can also be trained for morbidity mapping, and extending voluntary or modestly paid home-based services for the aged or disabled.

viii) There will be a major role of community health volunteers, peer educators, ASHAs, nurses, MPWs and staff of UPHCs in promoting health literacy, following the guidelines of the World Health Organisation. We expand on this in our TRG Report.

ix) Successful establishment of community processes and their institutionalisation requires good support structures and mechanisms and close linkages and support from NGOs, which the TRG recommends. Accredited training institutions and trainers could also be enjoined to ensure quality of training. NUHM must include in its design mechanisms to absorb existing community health workers, re-assigning them appropriate levels and functions and providing them with new skills, where required.

x) The UHM will disseminate routinely necessary and de-identified/unlinked information on websites and notice boards about the functioning of the UPHC, including guaranteed services, patient load, disease patterns, drug availability and distribution, staff availability and attendance, and disease and mortality patterns. An institutionalised process of community monitoring would also contribute to increasing transparency and accountability of health care facilities and their functioning and will provide the data and information as well as the institutional processes to safeguard system accountability.

xi) There should be a clear budget line for grievance redressal systems, along with standards and operational guidelines to ensure that these are established and functional in the early stages of NUHM roll out. A great deal of feedback may be generated by this system, serving to improve it and also help generate demand for services.

10. The Challenges of Convergence

There are large numbers of public services and duties which have a direct and immediate bearing on urban health. In each of these areas- whether immediately under the control of the municipal health officer or not, the health department has an important role to ensure the health of populations. An indicative list of these functions is given in Table 1.

Table 1. Distribution of Public Services and Duties as Observed in TRG Fieldwork

Under Municipal Health Officer	***Under municipal health officer in some cities- but separate departments in the others***	***Under other departments always- but health department having important roles to play***
• Disease surveillance & Epidemic control • Vector control • Dangerous and offensive trade, licensing (in particular slaughter house	• Treatment and disposal of sewage • Solid waste management including carcass disposal • Biomedical waste management	• Integrated Child Development Services • School Health • Implementation of welfare schemes for vulnerable populations – especially the

Under Municipal Health Officer	***Under municipal health officer in some cities- but separate departments in the others***	***Under other departments always- but health department having important roles to play***
management , health safety in cinemas, restaurants etc) • Food safety. • Birth and death registration. • Management of cremation, burial grounds	• Drinking Water supply • Sanitation and Prevention of public health nuisance • Control of stray dogs- rabies control. • Air Pollution Control (often under pollution control board)	homeless. • Implementation of special schemes for disabled and marginalized communities. • Housing schemes. • Road Safety. • Food security programmes

Even where municipal health officers are not directly in charge of a service, they should monitor its provision - and correlate it to disease incidence/prevalence. They could also use disease outbreaks as feedback to the providers of these services and thus close critical gaps- for example attributing the source of a hepatitis outbreak, or a dengue outbreak to vector breeding.

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

User fees for public amenities with bearing on health– such as public toilets and baths - needs to be withdrawn, and alternative institutional mechanisms of maintaining this be found. There is considerable demand for public toilets now (as compared to a decade or two earlier) and a major programme to expand is essential.

Convergence with ministry of social welfare, urban development, education and other relevant departments at primary level is essential, and mechanisms for this will need to be developed both at city municipal and state levels. Services such as drug de-addiction services, homeless shelters, drop-in shelters and residential hostels for homeless street children, short-stay homes for survivors of domestic violence, and many other such social infrastructure, are critical components of a comprehensive health response system.

Growing of medicinal plants and herbal gardens in all public parks and open spaces in urban areas should be encouraged. Studies indicate that the poor are using medicinal plants for their health needs even in urban areas. There is continuing wide use of herbal home remedies, especially by the migrants who retain links with rural areas, and a

revival among the middle class. However, the poor are losing the free access to plants that they did have in urban areas as the natural green areas are disappearing and only ornamental parks are being created instead. This must form a part of the primary level health care that is being assured to the poor.

Public spaces for wellness, exercise, recreation should be considered a public health priority. This includes, inter alia, sufficient places for children in slums to play, as they are being squeezed out of most public parks. Synergy across departments and ministries, including sports and youth development, women and child development, urban development as well as AYUSH, can help to ensure that such spaces are available, appropriately maintained, accessible and optimally used by the urban poor.

Health impact assessments need to be included as part of all large scale urban health development efforts. The capacity for conduct of such assessments needs to be built up. Also large scale urban projects must go along with measures that ensure occupational safety and healthy working and living conditions for the huge inflows of labour they create.

11. Governance and Financing

i. The NUHM framework for implementation and the 12th Five Year Plan envisaged certain minimum public health expenditure. The single most important requirement is to make this level of funding available to the urban areas.

ii. There is a need for a carefully planned advocacy to improve both municipal and state government financing for the scheme. ULBs must be encouraged to spend 10 % of their budget and state governments 5% of their budgets on health- and proportionately urban health would benefit.

iii. In metropolises, both the medical and non-medical aspects of public health will be managed by Municipal Corporations. In others, the medical services will be managed by state governments, but non-medical services in the main would continue to remain under the city health officer and the urban local body.

iv. There is a need to provide for adequately staffed and technically supported programme management units to all city health societies- both for the organisation of health care services and for non-medical aspects of public health.

v. State departments of health and urban local bodies must both take active interest in the role of the city health officer and its multiple roles. There is a need to ensure that a person with good public health experience and qualifications, backed by a robust technical support mechanism, leads this office.

vi. All primary care services and curative care services from public hospitals, including essential drugs and diagnostics will be entirely free and cashless. No

user fees of any kind will be chargeable. The immediate step forward would be a clear policy articulation in this regard.

vii. A clear commitment to employ in a sustainable and well supported manner the minimum public health workforce needed to deliver all primary health care services is a must. However the deployment of human resources must match requirements – as assessed by actual case loads and nature of services needed- so that there is no under-utilisation of human resources at any level.

viii. All UPHCs will be ordinarily managed by public authorities. The only exception will be where the state government decides to allocate responsibilities for these to urban poor collectives and unions, youth and women collectives, and reputed not-for-profit NGOs.

ix. If the NUHM resource envelop provided is much less than the 12th Plan or NUHM framework projections, then there is a need to phase inputs. This could be done in terms of number of UPHCs sanctioned. When a UPHC is sanctioned it should imply the funds required for not only the UPHCs, but the nursing stations, and ASHAs and JAS and MAS that go along with it. This would include the special services required by vulnerable groups, including, crucially, mental health services and disability and geriatric health services. Most cities already have some experience of it when they outsource UPHCs to NGOs. The challenge now is to greatly increase the package of services delivered in line with the NHM framework as well as learn to spend and account for resources allocated on these lines to public facilities.

x. Financing to tertiary care facilities from NUHM would be largely limited to improving and facilitating access as part of continuity of care from the primary care centre- especially for the vulnerable.

xi. Funding to secondary care hospitals from NUHM budget should be proportionate to the case loads being managed. Within this maternity hospitals would have a priority and hospitals that are known to cater to large numbers of poor population must also be prioritised. Without such case load-based additional financial support, these hospitals will be unable to limit out of pocket expenditure on drugs, supplies and even fail to manage hygiene and safety.

xii. In order to institute effective checks on over-medicalisation (a likely outcome of the availability of free drugs), a strong regulatory mechanism needs to be in place. This must include steps to promote rational and ethical practice by all doctors--public and private—and must be initiated *before* the NUHM is implemented. The experience of the NRHM itself shows that the pre-existing private sector and its malpractices act as barriers to strengthening rational public services. In urban areas, this influence is likely to be even greater, and therefore must be checked.

xiii. Engaging the private sector (clinics that provide primary health care to poor) is a major goal- and one must recognise that the many of these clinics are providing primary care to the poor. Involving them in quality circles, providing access to free drugs from the nursing stations and free diagnostics and referral support at polyclinics and urban public secondary hospitals, training inputs, their participation in disease surveillance measures- would all help to use their efforts towards achieving public sector goals. Implementation of the 'clinical establishments act' to improve quality care is also an essential part of engaging with the private sector, while taking caution against escalation of costs, decreasing access to services and keep a check on the quacks.

xiv. Insurance currently covers only secondary and tertiary level hospitalization and here there is a need to protect the poor from unnecessary care or denial of services. Insurance currently plays no role in primary health care and we do not envisage such a role for it in the immediate future as well.

Conclusion

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

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