

Urbanization and Health Challenges: Need to Fast Track Launch of the National Urban Health Mission

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Introduction

The theme of the World Health Day, 2010, was, 'Urbanization and Health,' with the campaign focusing on 1000 cities – 1000 lives.⁽¹⁾ The world we live in is becoming urbanized at an unprecedented pace. In 2008, for the first time in history, more than half of the world's population, 3.3 billion, will be living in towns and cities. By 2030 this number will swell to almost 5 billion.⁽²⁾ This shift toward urbanization is occurring at a much faster rate in the developing countries of the world. Urban growth has been exponential in India over the last few decades. Although India's rural population has doubled between 1961 and 2001, the urban population has grown 3.6 times.⁽³⁾ The urban population growth in India represents the 2-3-4-5 syndrome: in the last decade India grew at an average annual growth rate of two percent, urban India grew at three percent, mega cities at four percent, and the slum population rose by five to six percent.⁽⁴⁾ The population projections by United Nations indicate that by 2030, India's urban population will grow to 590 million, accounting for nearly 40 percent of the total population.⁽⁵⁾ In 2001, there were 35 cities with a million plus population and 393 cities with above 100,000 population. It is now estimated that the number of million plus cities will increase to 75 by 2021 and there will be 500 cities with a population of above 100,000.⁽⁶⁾

Stresses caused by rapid urbanization are interrelated –

lack of sanitation, air pollution, respiratory problems, communicable diseases, accidents, and injuries require holistic solutions. The city is home to both opportunities and obstacles; with better planning we can create safer cities, prevent injuries, and save lives.

There are problems in the delivery of healthcare services in rural areas too and the needs of the rural population are important. To a large extent, the National Rural Health Mission (NRHM) launched in April, 2005, is beginning to contribute toward addressing rural health needs. Unlike rural areas that have a dedicated government healthcare structure, urban areas do not have such a structure. India now talks of 'inclusive growth'. How long can we ignore the needs of the fastest growing segment of India's population, the 300 million urban population, of which 100 million live in slums? When providing health care, a liberal democracy cannot discriminate between rural and urban populations.

Sometimes in order to move forward, we have to retreat. When it comes to the history of urban civilization, let us for a moment go back in time to 6000 years ago, to the ancient urban civilization of India – the Indus valley Civilization and the cities of Mohenjo-Daro and Harappa.

The Indus Valley Civilization was a Bronze Age Civilization, which flourished around the Indus river basin. A sophisticated and technologically advanced culture was evident. The quality of municipal town planning in Harrapa and Mohenjo-Daro suggests the knowledge of urban planning and efficient municipal governments, which placed a high priority on hygiene, drainage, and sanitation. In Harrapa and Mohenjo-Daro, an urban plan included the world's first known urban sanitation systems. The ancient systems of sewage and drainage that were developed and used in cities

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throughout the Indus region were far more advanced than any found in contemporary urban sites in many areas of India. Within the city, individual homes or groups of homes obtained water from wells. From a room that appears to have been set aside for bathing, waste water was directed to covered drains, which lined the major streets. Moreover, huge granaries were built, which took care of food security of the urban dwellers.

The city of Mohenjodaro was rebuilt seven times. With fast forward millennium speed let us now connect with the City of Delhi in 2010, which was also built seven times. When we compare Mohenjodaro with the Delhi of today, where are we with respect to the civic amenities and food security that were provided in Mohenjodaro?

Water is a precious resource that needs to be conserved and also shared equitably. The city of Delhi requires approximately thirty three hundred (3330) million liters of water a day (MLD), but has access to only two thousand (2000) MLD, a shortfall of nearly 40 percent. This shortfall has put a strain on the scarce underwater resources of the city, resulting in a depletion of the groundwater table by 20 – 30 meters across the city.⁽⁷⁾

The existing capacity of the sewerage system in Delhi is grossly inadequate, as only about 55 percent of the population is covered under an organized sewerage system and about 15 percent under on-site sanitation systems.⁽⁸⁾ The rest of the population does not have proper access to sanitation facilities. The sewage treatment facilities in the city are also grossly inadequate. Furthermore, we have only recently started thinking about food security for the urban poor, by expanding the net of the National Food Security Act to include the urban poor. In addition to this, the Delhi government will be introducing a Bill that will make extraction of underground water chargeable.

Urban Health Challenges

The health of the urban poor is considerably worse off than the urban middle and high income groups and is maybe even worse than the rural population. In the National Family Health Survey (NFHS)-3, the under-five mortality rate was 73 for every 1000 live births among the urban poor, compared to the average of 48 among all city dwellers in India.⁽⁹⁾ A re-analysis of the third National Family Health Survey showed that one in 10 children born in the slums did not live to see their fifth birthday; only 40 percent of the slum children received all the recommended vaccinations; of the 2.25 million births each year among the urban poor, more than half were at home; 54 percent of the children under five years were stunted; and 47 per cent were underweight.⁽¹⁰⁾ One in ten children in slums did not live to see their fifth birthday.

Malnutrition among the urban poor children was worse than in the rural areas. Only 42 percent of the slum children received all the recommended vaccinations. Over half (56 percent) of the child births occurred at home, in slums, putting the life of both the mother and new born to serious risk.⁽¹¹⁾

There are thousands of easily preventable maternal, child, and adult deaths each year, and millions of days of productivity lost each year. Poor sanitary conditions in slums contribute to the high burden of disease here. Two-thirds of the urban poor households do not have access to toilets and nearly 40 percent do not have piped water supply at home. High concentrations of suspended particulates in the urban areas adversely affect human health, provoking a wide range of respiratory diseases and exacerbating heart disease and other conditions. The urban population suffers a significantly higher burden of non-communicable disease risk factors. As per NFHS 3, 24 percent of the urban women are overweight / obese as compared to only seven percent of the women in rural areas.⁽⁹⁾

The public sector urban health delivery system, especially for the poor, has so far been sporadic, far from adequate, and limited in its reach. Although urban areas have a greater number of doctors per a thousand population as compared to rural areas (80 percent of the doctors serve in urban areas) and do not face the transport bottleneck as compared to rural areas, yet doctors are functionally inaccessible to a majority of the urban poor population.⁽¹²⁾ Cost, timings, distance, attitude of health providers, and other factors put the secondary care and private sector facilities out of reach of most of the poor urban residents. When the urban poor access private facilities, the significant cost incurred leads to severe debt. Other factors contributing to the inadequate reach of services are illegality, social exclusion of slums, hidden slum pockets, weak social fabric, lack of coordination among various stakeholders, and neglected political consciousness. All the above-mentioned factors lead to a rapid proliferation of what is called an 'informal private health sector' in urban slums. This sector is dominated by practitioners who are either untrained in any system of medicine or trained in one system and practice another or those who are less than qualified. The findings of a study conducted by the Center for Community Medicine, All India Institute of Medical Sciences, on the role of private practitioners in urban slums, highlights the grim picture.⁽¹³⁾ (Excerpts in Box 1). With the exponential growth of population, there is pressure on an already unresponsive public sector. Moreover, the undeterred growth of the private sector without appropriate regulations means that the poor and the vulnerable are rendered even more vulnerable. Choices that the urban poor make for health care have implications not only for the individuals

Box 1: Summary of study carried out by centre for community medicine titled**“Health of the urban poor and role of private practitioners: The case of a slum in Delhi”**

In Midanpuri, a settlement of over 25 000 people, unlicensed practitioners were the first point of resort for basic primary care for almost 90% of our respondents. The primary focus for this population, majority daily wage earners, is to get immediate “action” with a purpose to return to work as quickly as possible. These practitioners provide a very effective mix of “quick fix” solutions considered to be very “effective” treatment. Driven entirely by demand, the number of clinics in the settlement during the 2 years of fieldwork increased from 15 to 27. Although government hospitals were invariably cited as the main option in conditions considered to be “serious” or those that require surgical intervention, there was widespread ambivalence toward them—linked to the time-consuming, circuitous procedures, rude behavior of nonmedical staff and bribes that had to be paid to them, and often monosyllabic treatment by attending doctors.

In contrast, positive responses to satisfaction of service received from the private healthcare providers were tied to the proximity of their clinics, clinic-opening times, fees, and accessibility of the practitioners. The cost of consulting a neighborhood practitioner at Rs 35 per visit, compared favorably with not only qualified private practitioners, but even government-run facilities, where transportation and purchase of medicines was found to drive costs to an average of Rs 68 per visit—almost twice that of a less-than-fully-qualified practitioner. Often, additional costs were inflicted when long queues in the hospitals resulted in losing the day’s wages.

treated, but also for disease transmission and the development of drug resistance. With recent outbreaks of dengue, Chikungunya, and H1N1 influenza one cannot and should not ignore the public health challenges of the dismal health status of the urban poor. For these communicable diseases, all the population is at risk, irrespective of the socioeconomic status.

Another factor aggravating the poor health scenario of the urban slum population is lack of intra-sectoral and inter-sectoral coordination. Although there are a number of projects on water and sanitation, nutrition, and maternal and child health that involve various stakeholders, including the government, NGOs, and corporate and private sector organizations, they operate without any coordination and convergence.

The Way Forward

We, the so called urban elites and socioeconomically well-off urban folk, have to realize that it is no longer a question of ‘them’ and ‘us’. In today’s urbanized world, the urban slum population is very much part of our ‘extended family’ and forms an integral part of our daily life, in the form of household and office staff. Urban poor residing in slums are an integral part of our families in the form of ‘drivers’, ‘maids’, and ‘cooks’. No other population is so much part of our lives, whose absence can so affect our lifestyle, and yet is so surprisingly invisible to policy makers (and also to us) as the urban poor. Any ill health of these so called ‘extended families’ directly affects our life in terms of disease transmission and also has a serious psychological impact and cascades a destabilizing effect on ‘us’, the so-called ‘employers’. Thus, it is imperative that all of us together take stock of the situation and try to work toward a solution, because when it comes to urban health issues, there is no ‘I’ or ‘You’, ‘We’ are all in it together.

The National Urban Health Mission (NUHM) was the much awaited initiative, ensuring quality health care to the urban poor, but it has become a casualty of bureaucratic logjam and inter-ministry turf issues.

The NUHM aimed to improve the health status of the urban poor, particularly the slum dwellers and the other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system.⁽¹⁴⁾ The main features of the mission included city-specific planning based on the spatial mapping of the slums and slum-like habitations as well as the existing health facilities, to reach out to all the urban poor clusters; rationalizing the available manpower and resources and partnering with private providers and NGOs, for filling gaps and improving access and quality health services, by regular outreach camps and referral services. The Urban Social Health Activist (USHA) and Mahila Arogya Samitis (MAS) are envisaged to facilitate improved access to public and private health services at the community level and to instigate community risk pooling, linked where feasible, to an insurance mechanism, as also to provide smart cards to the family, to ensure access to quality health care.

We do understand the constraints of the government and the policy makers, with their contention that NUHM will be launched only once the eleventh five-year plan has ended and consolidation of gains made under NRHM is completed. However, the need of the hour is to implement NUHM immediately. The year 2012 may be the framework of planners, but not of the common man. The need of hour is for ‘out of box’ thinking. If we have to address the health of the urban poor of the country, we cannot sit on the sidelines and wait for the appropriate time. Their health needs are now and they want a redressal now.

The campaign of the World Health Organization’s (WHO) World Health Day 1000 cities - 1000 lives needs to be accelerated; ‘1000 cities -1000 mobile health vans and 50 million beneficiaries’. Each mobile health van, from the All India Institute of Medical Sciences (AIIMS) experience, can cater to 50,000 of the urban population. Hence with 1000 vans, we can cater to 50 million beneficiaries. However, this may seem to be a small step, considering that the needs of 300 million are to be covered. To start with, 300 medical colleges can

be entrusted with running these mobile health vans, with Departments of Community Medicine as the focal points. Such a step will benefit both stakeholders. The urban slum population will benefit by getting access to quality health care facilities at their door step, and the medical colleges will get an excellent avenue to train medical students and nursing students in the unique setting of urban slums.

A healthy city provides access to health services for everyone; this is a challenge with the swelling urban populations that include migrants, casual laborers', and millions who live in encampments and unofficial dwellings. Decentralization of powers under the Twelfth Schedule of the Seventy-fourth Amendment of the Constitution of India is a clear opportunity for improving health service access in urban areas.⁽¹⁵⁾ Under this amendment, health services and slum improvement programs are mandated as functions of the Urban Local Bodies (ULBs) and appropriate financial powers have been sanctioned to ULBs to carry to these responsibilities. The participatory approach of involving the slum community and making use of the local knowledge is the only way out for the upgradation of slums and improving access to health care for the urban poor. USHA, with the help of NGOs and ULBs, can be trained to identify the nearest primary health care facility and refer the appropriate cases to these centers first, to decrease the work load on the secondary and tertiary health care facilities. The MAS can utilize a part of the fund granted to them for arranging transport facilities during emergencies thus improving access to health facilities. The huge amount of funds currently lying unutilized under the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) can be diverted to fund this initiative till a more permanent source of funding is identified and put in place. As per a recent review most of the Rs 66,000 crores fund allocated to JNNURM is lying unspent with many states just claiming a part of the money sanctioned to them.⁽¹⁶⁾ Although Goa has not claimed a penny, Delhi has taken only six percent of its share, Chandigarh 17 percent, Mizoram 10 percent, Sikkim 20 percent, and Manipur 30 percent. Goa has utilized < 10 percent of the allocation while Chandigarh, Jharkand, West Bengal, Nagaland, and Punjab have utilized only 50 - 60 percent of the allocation during January - March 2010.⁽¹⁷⁾ There is a significant overlap in the coverage of cities and services that JNNURM targets and those that were planned to be taken up under NUHM. Thus funds from the former can be easily utilized for later, at least in the common target cities.

Although working with the organized private sector may be easier (at least on paper), working with the unorganized informal private healthcare sector, which the urban poor frequent, would no doubt be difficult.

The main challenge, therefore, is to bring the informal service providers into the overall public policy net. A system could be devised whereby a special cadre of practitioners could be trained to deliver a select range of services. Monitoring and evaluation (M and E), with regular supervision, should be an integral part of this effort, to ensure good quality services. To ensure sustained performance, the State must evolve a policy to monitor / modify provider behavior. Involving NGOs and all providers in the field will make sure that the work is not carried out in silos.

Some of the problems of rapid, unplanned urbanization can be avoided by a health-conscious urban design – building in green 'spaces' and recreation areas that foster healthy lifestyles, from exercise to stress management. The urban environment overlays the natural environment, raising issues of sustainable use and protection of land, water, air, and soil. The management of this human-natural interface has a significant effect on the health of urban dwellers. There is a need to develop and enforce guidelines for building 'safe cities' with special focus on the health impact assessment of future planned cities. The city planners should not only provide for adequate health care facilities, but also provide a good environment (water, sanitation, nutrition, safe transport, etc.), to ensure healthy living by the new inhabitants.

While practicing public health, one does at times come to tears. It is then that the leaders of the City of Joy inspire us. To quote Mother Teresa, "We ourselves feel that what we are doing is just a drop in the ocean. But the ocean would be less because of that missing drop".

We all have to ask ourselves some hard questions. If not here, where? If not now, when? If not us, who? Addressing the health needs of the urban poor requires greater resource allocation, establishing coordination between a wide array of stakeholders, and commitment by the policy makers. More importantly we need a champion for the cause of the urban poor, who is capable of galvanizing the political system.

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- 62. Cash incentives for institutional delivery: linking with antenatal and post natal care may ensure continuum of care in India.** Lahariya C. Department of Community Medicine, G.R. Medical College, Gwalior, Madhya Pradesh, India. PMID: 19876449 [PubMed - in process] PMCID: PMC2763661

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