Book
16

PUBLIC HEALTH RESOURCE NETWORK

PHRN

ISSUES IN URBAN HEALTH

NATIONAL RURAL HEALTH MISSION
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Book 16

Public Health Resource Network

ISSUES IN URBAN HEALTH

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Preface

Public Health Resource Network

Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantees of increased employment or career options. It is meant to support individuals and organizations both within and outside the health department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out with information, tools and a diversity of programme options and perspectives.

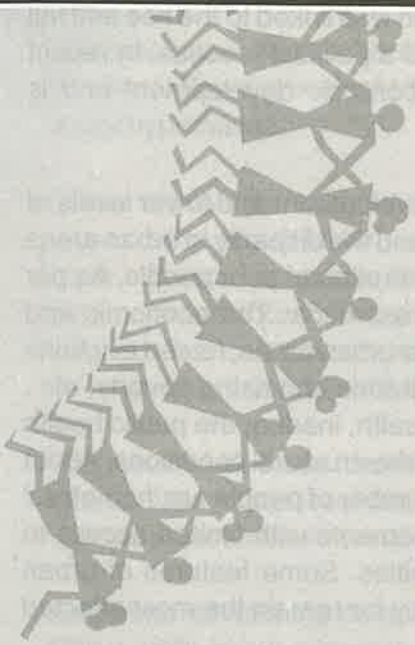
The Health Mission needs a combination of dedication and professionalism, where being a professional is not one more form of privilege- but a competence that anyone willing to put in the time and effort - and a little expense- can acquire!! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change. The immediate context is the National Rural Health Mission. But hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralized planning and decentralized governance and to all societal efforts towards an equitable and just society.

In the current context, urban health is still suffering from the lack of a policy and programme equivalent to the NRHM though a National Urban Health Mission has been in the offing for a few years. Despite this, planners at state and district level have begun to recognize the critical need for health interventions for the urban poor and have attempted to take some steps within their powers and constraints.

This book, the sixteenth book in the PHRN series, attempts to help health planners, managers and civil society groups to recognize and understand the various issues related to urban health so that they may continue to take action for urban health as well as be able to inform the upcoming policies and programmes through their own efforts.

Lesson ONE

Introduction to Urban Health



In this lesson we shall discuss:

- The definition of an urban area
- The process of urbanization in developing countries and in India
- How cities are classified and what mega cities are
- The urban poor, urban poverty and slums in an urban setting
- The determinants of health in an urban setting

INTRODUCTION

In the prehistoric period, urbanization was synonymous with the origin and rise of civilization itself and was thus essentially a cultural process. In the historical period, urbanization was linked to the rise and fall of kingdoms, dynasties and empires. Urbanization during this period was a political process. In recent times urbanization is associated primarily with industrialization and economic development and is therefore essentially an economic process.[1]

Urbanization is mistakenly considered to be associated with economic development and lower levels of poverty. This has to a large extent resulted in the existing ground realities and the disparity in urban areas remaining hidden and unaddressed. Large cities in fact have huge concentration of poor people. As per Census 2001, approximately 286 million people live in urban areas across India. The economic and political paradigm has over the past years intensified migration from rural to urban areas, forced evictions within towns and cities, loss of livelihoods, increasing informal sector activities and rising poverty, etc., with serious health implications. Lack of government priorities in urban health, inadequate public health infrastructure have resulted in varying socio-economic environment and infrastructural conditions. About 21 per cent of people live in slums or squatter settlements; a substantial number of people are 'homeless' and live under bridges, flyovers and pavements, or in overcrowded tenements with limited access to water, food, sanitation, health services and safe employment opportunities. Some features of urban areas affect rich and poor alike like environmental pollution but the poor by far remain the most affected and vulnerable due to inequitable distribution of basic services.

Health Care System in India has mostly focused on increasing coverage in the rural areas. There has been little or no development of organized health care services for the vast urban areas. The 3,600 odd cities and towns of India with some 40 million people living in slums have to depend largely on private practitioners (mostly unqualified medical practitioners) for their health care needs. Out of the 3,000 plus urban local bodies in India only about 100 have been some semblance to a health care service while the rest have only a sanitary inspector or even a lower functionary to look after the health care system.

What is an urban area?

In India, an urban area is defined as a human settlement with a minimum population of 5000 persons, with 75 per cent of the male working population engaged in non-agricultural activities and a population density of at least 400 persons per sq km. Further, all statutory towns having a Municipal Corporation, Municipal Council or Nagar Panchayat as well as a Cantonment Board are classified as 'urban'. India's urban population in 2001 was 286.1 million, which was 27.8% of the total population. Over the previous five decades, annual rates of growth of urban population ranged between 2.7 to 3.8%. During the last decade of 1991-2001, urban population of India increased at an annual growth rate of 2.7%, which was 0.4% lower than that registered during the preceding decade.

[1] Ramachandran, 1989

URBANIZATION IN INDIA: SCALE OF THE PROBLEM

Is the process of urbanization different in developing countries?

Historical process of urbanization in developing countries is different from that in advanced industrial societies. Rapid growth of cities and urbanization in the developing countries has been explained by two major hypotheses:

- Unusually rapid rates of population growth *vis a vis* limited land area, forcing landless labour into cities ('push factor'), and,
- Diverse economic forces attracting migrants ('pull factor') into the cities. Forces exerting the 'pull factor' include domestic terms of trade squeezing agriculture, diffusion of technology from advanced economies favouring setting up of large scale urban industries, foreign capital inflow into urban infrastructure, housing, power, transportation and large scale manufacturing.

The result of all these forces has been a process of rapid industrialization and concomitant demand for labour. New urban economics, therefore, explains the existence, size and structures of urban areas viewing cities as market responses to opportunities for production and incomes.

Like other developing countries, India has undergone rapid urbanization over the past 50 years. After China, India has the largest urban population in the world. In the post-independence period, the growth rate of the urban population in India has always remained higher than the growth rate of the rural population. Many Indian cities have reached a very large population size. The growth rates of most of these big cities have remained higher than the average growth rates of the urban population as a whole. Slums remain the fastest growing segment of the urban population, with almost double the overall growth of the urban population. The population share of the small towns was less than a tenth of the total urban population. In short, about half of India's population is projected to be urban by 2041.

Given below are some facts and figures:

- From 1951 to 2001, India's urban population grew almost fivefold, from around 62 million in 1951 to around 286 million in 2001.[2]
- Number of urban settlements increased from 2,843 in 1951 to approximately 5,100 in 2001.
- Between 1981 and 2001, the number of cities with over one million population nearly tripled, from 12 to 35. Four of these cities (Mumbai, Kolkata, Delhi, and Chennai) feature among the 20 largest cities in the world.
- Between 1991 to 2001, the population of India grew at an average rate of 2 percent per annum, the urban population grew at 3 percent, mega cities grew at 4 percent, and slum populations increased by 5 percent.

[2] Census (2001)

- As per the 2001 Census, 286 million people lived in urban areas. It is projected to increase to 357 million in 2011 and to 432 million in 2021.
- According to the medium range projections of the United Nations, 41 percent of India's population will live in urban areas by 2030.
- The 2001 Census put the proportion of urban population living in Class I cities (population of over 100,000) at 68.7%; the concentration of urban population in the larger cities has been a unique feature of urbanization in India with 35 million-plus cities.
- Among the largest Indian cities, the population of Delhi grew the fastest during 1961-81 and Calcutta, the largest of the four metros grew the slowest. Some studies have divided India into five regions - North, East, South, West and Central, dominated by Delhi, Kolkata, Chennai, Mumbai and Kanpur respectively.[3]
- From 1931-61, the eastern region was the most primate of the five regions dominated by Kolkata till 1971. The western region has remained the second most primate region. Delhi's domination of the northern region has increased over the decades.

What is a Primate City?

A **primate city** is the leading city in its country or region, disproportionately larger than any others in the urban hierarchy. A 'primate city distribution' has one very large city with many much smaller cities and towns. The 'law of the primate city' was first proposed by the geographer Mark Jefferson in 1939. He defines a primate city as being 'at least twice as large as the next largest city and more than twice as significant'. A primate city is number one in its country in most aspects, like politics, economy, media, culture and universities. Jefferson developed the law of the primate city to explain the phenomenon of huge cities that capture such a large proportion of a country's population as well as its economic activity. These primate cities are often, but not always, the capital cities of a country. They dominate the country in influence and are the national focal-point. Their sheer size and activity becomes a strong pull factor, bringing additional residents to the city and causing the primate city to become even larger and more disproportional to smaller cities in the country.

MIGRATION

The urbanization and migration trends in India - manifested in the construction boom of today - are in keeping with the predicted global trends. According to the India Census 2001, over 98 million people migrated within the country in the 90s - the highest for any decade since independence - an increase of 22% over the previous decade. This is very conservative, given that it only reflects long term movement of an individual from the place of birth/origin or normal residence to a new place of residence.

[3] Mills and Becker, 1986

In post independence India, rural-to-rural and rural-to-urban employment seeking migrations have been the predominant pattern. In the rural to urban movement there are several factors underlying migration - the working and living conditions of migrant families, the health status of children as an indicator of the lack of access to services at source/destination, interventions on the ground in the social sector, implications for law, policy and programmes.

Some major changes in the post-independence period in India:

- Influx of refugees and their settlement primarily in urban areas in northern India
- Construction of new industrial cities and industrial townships near existing cities
- Stagnation, and in some cases, decline of small towns
- Massive increase in squatters and proliferation of slums in major cities
- Emergence of rural-urban fringe
- Introduction of city planning and general improvement in city amenities

Growth of population in large cities is made up of two components - an intrinsic component of the large base population, and a relatively smaller extrinsic component which is net migration (out-migration minus in-migration). Typically, net migration gets emphasized in absolute numbers and represents an alarmist view - creating a chasm between the 'legitimate/legal' citizens (naturalized over time, if not indigenous) and 'unwelcome/illegal' migrants. These perceptions strongly influence the ideological orientation of population, health policies as well as legal and regulatory frameworks of the city and lead to stigmatization of immigration and migrants.

While migration, an integral part of industrialization and urbanization, holds the high promise of challenging traditional hierarchies and gender roles and promoting social mobility, in reality, it is driven by distress rather than opportunity. It is mostly about survival, hardship and exploitation. For women, it means further marginalization and the burden of poverty and for their children, a childhood lost.

The crisis in agriculture emerged as the main push-factor driving migration - increasing landlessness, lack of non-farm employment in the rural sector, declining investment in agriculture, displacement from village common lands and the growth of large scale, mechanized agriculture, and so on. Distress related and survival migration - of the short term, seasonal, cyclical, rural to rural and rural to urban variety - was growing. Research shows that seasonal, employment seeking out-migration from rural areas is a livelihood strategy of the rural poor.

Trends in the 90s based on macro/micro studies suggest:

- Rural out-migration definitely increased in the western and eastern parts and probably for India as a whole, especially over the drought years of 1998-2001

- An expanding informal sector absorbed the migrants (irregular, temporary contracts, outsourcing) reflected in an increase in the share of casual workers
- Most female migration is with families though single female migration increased in the 90s (sex trade, maid industry)

Most migrant workers are absorbed as the lowest paid unskilled workers in the building Industry (construction, quarrying, earthwork, etc.), transport and manufacturing (head-loaders of produce, loaders of truck, floating pool in ancillary occupations), domestic work and self-employment (rickshaw-pullers, hawkers) in the urban areas.

Study on construction workers

A quick survey of 12 construction sites in 1998 with Mobile Crèches (MC) and findings from a 2006 SEWA Bharat (SB) Study of 200 construction workers from Anand Vihar and Raghubir Nagar in Delhi reveal the following. It should be noted, that Mobile Crèches works on large sites and therefore with bigger contractors. SEWA Bharat, on the other hand, gathered its sample from the "nakas" and hence the likelihood that their contractors worked for smaller employers.

- 77% workers were unskilled; among unskilled 65% were women. Among the skilled there were no women - SB; 85% of women workers are "coolies" - unskilled workers who load/unload/carry - MC
- Only 2% get work all through the year; Most work 6-8 months, 15-20 days a month - SB
- No Maternity Leave/Benefits to women workers (MC & SB) and no childcare or crèches at work sites - SB
- All sites had a First Aid Box - MC; 97% of the workers had no insurance - SB
- 31% workers reported having an accident (SB) but none got compensation; no clear data and a lot variation on MC sites but 25% contractors were reported to give leave compensation or paid leave
- No minimum wage - Wide variation in wages to skilled/unskilled, full/part time, etc. Women always get less than men (on an average, Rs.85/day to men and Rs.70/day to women, MC, SB)
- Provident Fund (PF) given on just a few sites only to the skilled/ 'permanent' workers - MC
- Both parents work at the sites (except wives of foreman/supervisors) - MC
- 66% workers had their parents in construction and the rest in agriculture (possibly old and new migrants)
- None had heard of the Labour Welfare Board, registered with them or received any benefits from any schemes - SB

Anjali Alexander (2007), Migrants in the City: Work Wages, Living Conditions and Access to Services, Mobile Crèches, Delhi.

Apart from the forces of rural-urban migration and natural growth of population, the relocation of areas as urban between two points of time is a significant factor in the increase of urban population. The rural areas adjacent to cities or towns are reclassified as 'urban' than the relatively remote rural areas that are also growing rapidly. Economic activities get concentrated in a limited number of cities to maximize the advantages of interdependence of industries in terms of input-output linkages, availability of infrastructure and marketing. Therefore, groups of industries cluster around a core of industries and growth impulses are transmitted through both forward and backward linkages. As income levels of these areas are high, they create higher demands for other products and services leading to further overall growth of these centres. The adjoining semi-urban and/or rural areas also get involved in this process, giving rise to further urban agglomerations.

In the backdrop of increasing rural-to-urban migration, the supply of labour in the urban segment grows further. With employment opportunities in the high productivity sector being limited, the migrant groups generally get residually absorbed into low productivity activities. Two key factors that play a role in this is the poor asset base and the lack of specific skills of these population groups in search of employment. As a result, a large proportion of these activities are in the tertiary sector; rural-to-urban migrated labour raises the share of service (tertiary) sector in the total workforce.

CLASSIFICATION OF CITIES

According to 2001 Census there are 423 towns and cities having a population of more than 100,000. These cities have been broadly classified into 4 main categories:

- Mega cities with a population of more than 10 million
- Million plus cities
- Large cities with a population of 100 thousand - 1 million
- Towns with a population less than 100 thousand

The tiers and classification of cities differs from sector to sector. There is one classification of Indian cities into A (this includes A1, A2 and so on), B, C, and D based on house rent allowance and city compensatory allowance, which essentially classifies these cities based on cost of living. Based on the 2001 census there was reclassification of cities relating to grant of Compensatory City Allowance (CCA) and House Rent Allowance (HRA) to Central Government Employees. A list of cities/towns have been classified as A-1, A, B-1 and B-2 for the purpose of CCA and another list was classified as A-1, A, B-1, B-2 and C for the purpose of HRA.

What are mega-cities?

The United Nations coined the term mega cities in the 1970s for all urban agglomerations with a population of 8 million or more. In the 1990s, the United Nations raised the population threshold to 10

million, following the practice of institutions such as the Asian Development Bank. From this definition, the United Nations estimated that there were 19 mega cities in the beginning of the 21st century. In 1940, London and New York were the only two cities with more than 5 million inhabitants. By 1950, there were 83 million-plus cities around the world, 34 in developing countries[4]. Currently, there are 433 such cities, with over 280 of them in developing countries[5].

The UN listed 22 mega cities of the developing world in 2000 with a population of 8 million inhabitants or more.

Mexico City	Lima
Buenos Aires	Rio de Janeiro
Sao Paulo	Lagos
Cairo	Istanbul
Tehran	Karachi
Mumbai	Bangalore
Delhi	Calcutta
Bangkok	Dhaka
Shanghai	Tianjin
Beijing	Seoul
Metro Manila	Jakarta

WHAT IS URBAN POVERTY AND WHO ARE THE URBAN POOR?

As discussed in the introduction to the lesson, the urban poor constitute a large proportion of an urban city. During the 1980s and 1990s poverty has become increasingly concentrated in urban settlements for economic and demographic reasons. Structural adjustment policies introduced in the Third World have further accentuated this problem owing to rising food prices, declining real wages, and redundancy in the formal labour market and reduced public expenditure on basic services and infrastructure.

In absolute terms, the 61st Round of the National sample Survey (NSS) recorded an addition of 4.4 million urban poor persons between 1993-94 and 2004-05. This is explained, in part, by the fact that 79 % of the new jobs (increasingly informalized) totaling 19.3 million, between 1991 and 2001, were generated in urban areas. During this decade of casualization and feminization of workforce, the increase in 'marginal workers' was to the extent of about 360 % compared to an increase of only 23 % of main workers; simultaneously the proportion of female workers increased from 14.3 % to 16 %.

[4] UNFPA, 1996
[5] AD 2000 Global Monitor 1991
[6] Moser et al, 1993 and World Bank, 1991
[7] National Sample Survey, 61st Round

The number and proportion of urban poor in India and some major states are as follows:

Table: Number of Urban Poor

Number of Poor Persons (in million)	% BPL
80.8 Urban	25.7
220.9 Rural	28.3
301.7 Total	27.5
State	Number of Urban Poor Population (in million)
Maharashtra	14.6
Uttar Pradesh	11.7
Madhya Pradesh	7.4
Tamil Nadu	6.9
Karnatka	6.4
Andhra Pradesh	6.1
INDIA	80.8

Source: India Urban Poverty Report, 2009

Urbanization of Poverty

The ratio of urban poverty in some of the larger states is higher than that of rural poverty leading to the phenomenon of 'Urbanization of Poverty'. Urban poverty poses the problems of housing and shelter, water, sanitation, health, education, social security and livelihoods along with special needs of vulnerable groups like women, children and aged people. Poor people live in slums which are overcrowded, often polluted and lack basic civic amenities like clean drinking water, sanitation and health facilities. Most of them are engaged in the informal sector with threats of eviction, removal, confiscation of goods and almost non-existent social security cover. With growing poverty and slums, Indian cities have been grappling with the challenges of making the cities sustainable i.e. inclusive, productive, efficient and manageable.

Urban poor include day labourers, domestic helpers, small service providers, drivers, rickshaw pullers, hairdressers, vendors, beggars, street children etc. Some, however, work in factories or even as government employees at lower levels with wages that barely meet their needs. Most of them have migrated from villages in search of employment opportunities. The estimates of urban poor do not reflect

the true magnitude, as significant proportion of urban poor is "unaccounted" for as they stay unrecognized squatter-settlements, pavements, constructions sites, urban fringes, etc. Many of them lack basic documents of citizen identity including voters' lists and ration cards. Their births and deaths are often not registered. National data sets, the Census and the National Sample Survey, are inadequate in assessing the problem and therefore in developing plans and executing strategies to deal with it. Their inability to vote makes them unattractive to politicians and finds little favour from governments. Bureaucracy often sites the lack of identity as a reason to deny them basic services.

The challenge of the migrants' access to urban public services must be viewed in the context of the existing state of physical infrastructure and governance, vested builder interests and middle class hostility. In a country where labour laws are openly flouted, maternity entitlements are least understood, schools do not teach, and ICDS and Health Services do not guarantee basic health, even to the settled populations, ensuring that the migrant families get their due, as citizens of India, is a huge challenge.

The state responds to addressing these challenges through a series of policies, programmes and institutions. In Delhi these include:

- Policy for Senior Citizens
- Jan Shree Beema Yojana (life insurance protection to persons below/marginally above poverty line)
- Juvenile Homes
- Beggar Homes for the destitute
- After Care Homes, Widow Homes and Short Stay Homes for shelter, assistance, training, education, medical care and counselling to women in distress
- Night shelter for the homeless
- Financial assistance scheme to widows for self-employment.
- Self Help Groups, Mahila Panchayats, and Family Counselling Units called 'Sahyogani' formed by Delhi Commission for Women (DCW).
- Helplines to help women in distress
- Gender Resource Centres (GRCs).
- Girl Child Protection Schemes such as 'Ladli'
- Public Distribution System (PDS)
- Integrated Child Development Services Scheme (ICDS)

What are slums?

Settlements and infrastructure and services that go with it are always key issues that have to be considered while discussing the living conditions of migrants, most of them poor. The rapid growth of

urban poor in cities is almost synonymous with the growth of slums. The definition of 'slum' varies widely. Ordinarily a slum refers to mud-structures, over-crowded or dilapidated dwelling units. According to the Census 2001, 61.82 million persons or 23.1% of the urban population resides in slums.

The 'Slum Areas (Improvement and Clearance) Act' was enacted in Delhi in 1956 and was later extended to eleven other states. Under this act the slum was defined as areas where buildings that

- are in any respect unfit for human habitation
- are by reason of dilapidation, overcrowding, faulty arrangements and design of such buildings, narrowness or faulty arrangement of streets, lack of ventilation, light or sanitation facilities, or,
- any combination of these factors are detrimental to safety, health or morale

The Bharat Sevak Samaj (1958) used the following definition of slum in Delhi - "the term 'slum' should be applied to those parts of the city which may (on the face of it) be considered unfit for human habitation either because the structures therein are old, dilapidated, grossly congested and out of repairs, or because it is impossible to preserve sanitation for want of sanitary facilities including ventilation, drainage, water supply etc., or because the sites themselves are unhealthy." *'Katras'* or slum tenements referred to a group of single room tenements that were constructed generally in rows within a compound or enclosure having a single common entrance. 'Bastis' on the other hand were described as a "thick cluster of small kutcha houses or huts built on open land, often in an unauthorized manner".

The 1961 Census also adopted a similar definition to "include such dwellings which on account of such over-crowding, dilapidation and lack of ventilation are detrimental to safety, health and social morale." The Madras Corporation used this definition as well.

The Bombay Municipal Corporation uses a three-tier definition of slums:

- *Chawls:* areas with permanent multi-storeyed buildings built long ago according to the then prevailing standards but currently in a deteriorated condition.
- *Patrachawls:* areas with semi-permanent structures - both authorized and unauthorized, often built of tin *(patra)* sheets.
- *Jhopadpattis:* squatter settlements, shanty towns or hutment colonies

The Calcutta Corporation registered those slums whose "total area must not be less than 1/6th hectare, and the structures must be kutcha, that is, they should have a roof built without cement, with not more than 18 inches of the wall of pucca construction"[8]. Taxes are collected from these registered slums.

Most of these definitions are often not adequately for application and leave a lot of room for variation. Further, none of these definitions seek to define the basic minimum criteria for the dwelling units of the poor in an urban setting. The loose nature of the definitions are also impediments for estimation of slum populations and therefore of subsequent plans for their improvement.

[8] Singh and D'souza, 1980

Heterogeneity among slum dwellers due to in-migration from different areas, instability of slums, varied castes and cultures, fewer extended family connections, and more women engaged in work, has lead to lesser willingness and fewer occasions to build urban slum community as a strong collective unit, which is seen a as one of the major public health challenge in improving the access. Even the migratory nature of the population poses a problem in delivery of services and makes planning and implementation of social mobilization activities challenging.

Displacement of Urban poor

The UN Commission on Human Rights in its Resolution on Forced Evictions emphasized that, "the practice of forced eviction constitutes a gross violation of human rights, in particular, the right to housing." The Commission recognized that, "instances of forced evictions occur in the name of development (and) city beautification programmes" and cautioned "state parties shall ensure, prior to carrying out any eviction, that all feasible alternatives are explored, avoiding or at least minimizing the need to use force and see to it that all the individuals concerned have a right to compensation."[9]

The Asian Human Rights Commission (AHRC) received information about case of forced eviction from West Bengal, India. In 2003, the Kolkata Municipal Corporation carried out a forced eviction along the canal side settlements at the Bagbazar and Cossipore area. About 1,500 families were forcefully evicted without any rehabilitation plan and it is estimated that almost 75,000 people became homeless due to this eviction.

In Mumbai 80,000 homes were demolished between December 2004 and January 2005, rendering 300,000 people homeless. For majority of those evicted there was no advance notice, the evictions were violently carried out and their belongings damaged. Those evicted were not even offered alternative accommodation. This resulted in severe criticism from various quarters, the chief minister justified the brutal demolitions as the only way to convert Mumbai into a world-class city.

In the past decade an estimated two million slum-dwellers have been evicted from city areas in just Delhi and Mumbai. Other cities are also not far behind in this regard. In fact the demolition of slums has become such a routine exercise that it hardly finds mention in the mainstream media any more.

WHAT ARE THE DETERMINANTS OF URBAN HEALTH?

Area effects and urban health outcomes

Area socio-economic characteristics have been associated by several scholars to different health outcomes in a wide range of contexts. Historically, social gradient of diseases by location were linked to

[9] Editorial (2004)

diseases. In such analyses, the combined (as opposed to the 'independent') effects of social class and area deprivation need to be captured.

"The assumption is that the people living in the least deprived areas are a good proxy for what the people living in the most deprived areas would be like if they did not live in the most deprived areas. Usually in epidemiological jargon, this implies no residual confounding by measured variables and no unmeasured confounders".[10]

Analysis of spatial distribution of cholera cases (by residential addresses of notified cases, 1994-2000) indicated that there were several areas from where cases are consistently reported. Incidence across municipal zones varied from 1.91 per 100,000 to 33.39 per 100,000. While cholera was sporadic in the zone with the lowest incidence, vulnerable hotspots accounted for 87% of cases.[11]

Malnutrition in Urban Areas

In most States, under-nutrition among urban poor children is worse than in rural areas. The prevalence of malnutrition is highest among urban poor children. Nearly half of them (47 %) are underweight for age compared with 26.2 % among the rest of the urban population and 45.6 % in rural areas. The overcrowding and poor environmental conditions in slums result in high prevalence of infectious diseases. The prevalence of tuberculosis among the urban poor is 461 per 100,000 population compared with 258 in the rest of the urban population.[12]

Nutritional Status of Urban poor children, NFHS 3

	Urban Poor	Urban non-poor	Overall urban	Overall rural	All India	Urban poor NFHS 2 (1998-99)
Children under 3 years who are stunted (%)	25.2	33.2	39.6	50.7	48.0	52.5
Children under 3 years who are underweight (%)	49.8	26.2	32.7	45.6	42.5	48.0
Anaemia among children						
Children under 3 years with anaemia (%)	79.8	59.0	63.0	71.5	69.5	79.0

Source: www.uhrc.in

[10] Diez Roux, 2005
[11] Dasgupta, 2003
[12] NUHM draft

Inadequate Infrastructure for the Urban Poor

The term "fourth world" has been used to describe a sub-proletariat with inadequate housing, sanitation, clothing and food; lack of support from politicians and unions; limited information, education and voice; and, are systematically prevented from exercising their rights that other people take for granted.[13] The poorer areas of cities lack safe drinking water and safe disposal of solid and liquid wastes, with its consequent impacts on human health. The sewage system in cities serves richer residential, government and commercial areas. Untreated human excrement and household wastewater end up in rivers, streams, canals and ditches. Diarrhoeal diseases, typhoid, intestinal parasites and food poisoning thus tend to be endemic problems.

"Health risks inside the home" i.e. behavioural factors and practices are often highlighted as key factors for determinants of diarrhoeal diseases. The dangers in the neighbourhood in which poorer households are located are no less critical.[14] The deficiencies impact on each other. The most critical neighbourhood factors are:

- Dangerous sites - large clusters of illegal housing are often located on steep hillsides, floodplains or desert land. They may also be located on unhealthy and polluted land sites; around solid-waste dumps, beside open drains and sewers or around industrial areas. Such sites are often the only locations where the poor can build or rent accommodation. Industrial areas provide employment. They are thus rational choices for reasons of survival.
- No collection of household garbage - about 30% to 50% of solid waste generated in these urban areas remain uncollected and accumulate in the neighbourhood. This results in proliferation of disease vectors and also constitute fire risk.
- Inadequate site infrastructure - particularly lack of transport and health services

The urban poor, therefore, face the problem of overcrowding in settlements. Many of which are unfit for human habitation. Clogged drains, presence of rodents, lack of facilities for garbage disposal, stagnant water are common seen around the residential areas of the urban poor. Under these conditions the urban poor fall prey to many illnesses such as diarrhoea, dengue, malaria, dysentery, cholera, jaundice and typhoid, which are closely related to poor environmental conditions.

Water and Sanitation

Water supply and sanitation is the major concern particularly for the poor.

Many of the health problems of the urban poor in the Third World cities are related to water. The main constraints related to access of adequate quantity of safe water include -

[13] Tabibzadeh et al, 1989
[14] Hardoy and Satterthwaite 1989

- Quality - either frankly contaminated or of unreliable quality
- Available quantity
- Cost of accessing water including time and travel costs
- The number of households served per public stand post (public hydrant)
- Improper disposal facilities for wastewater

A study conducted by the Jansahyog, an urban resource centre in Bangalore, revealed that 10 out of the 14 samples collected form water source for the urban poor were unfit for consumption. The urban poor also suffer from inadequate or lack of toilet facilities. In many places more people have to share a single common public toilet, which is poorly maintained. About one third of the population has no access to a lavatory, while another third share a latrine.

A study by the Central Pollution Control Board in 1989 on the status of wastewater collection and treatment in 212 Class I, and 241 Class II cities revealed that the total volume of water supply to and wastewater from Class II towns was about 10% of Class I cities. 45 class I cities generated more than 50 Million litres per day of wastewater, as 'major domestic pollution'. More than 70% of wastewater generated from Class I & II towns taken together, is accounted for by these 45 Class I cities. Mumbai and Delhi individually generated more wastewater then the 241 Class II towns taken together. Gandhi Nagar (Gujarat) was the only town having 100% wastewater collection and treatment facilities

The responsibility of providing services such as safe water, sewerage, sanitation and solid waste disposal rests primarily with state governments and is implemented through various agencies. In quite a few instances, water supply and sewerage boards have been set up to deal with these services. In some cities, specific projects are taken up to deal with slum colonies, such as those of the slum wing of the Delhi Development Authority/Municipal Corporation of Delhi. The urban poor draw water from public stand posts wherever such facilities exist. In other cases, tubewells and handpumps are installed by the municipal authorities for the slum and pavement dwellers (e.g. Kolkata Municipal Corporation, the Municipal Corporation of Delhi). However, there still remains a large chunk of the poor, who have to depend on tankers in cities like Delhi and Madras.

30 litres for some, 1,600 for others: Inequities in Delhi's water supply

An average room in a five-star hotel in Delhi consumes 1,600 litres of water every day. VIP residences consume over 30,000 litres per day. But 78% of Delhi's citizens, who live in sub-standard settlements, struggle to collect or buy 30-90 litres per capita per day.

According to the Bureau of Indian Standards (BIS), the average water requirement of a Delhi citizen is 160 litres per capita daily (lpcd). The Planning Commission has estimated the average requirement for different income groups -- 130 lpcd for lower-income groups, 150 lpcd for middle-income groups,

and 200 lpcd for higher-income groups. The average comes to 160 lpcd. Let us now look at the water availability in Delhi.

Delhi, as a city, ranks highest in per capita availability of water -- about 280-300 lpcd. But the distribution of this water is extremely inequitable. According to officials, different quantities of water are provided to different settlements since their standard uses differ, and certain standards have been established in this regard. The standard for planned colonies is 225 lpcd, for resettlement colonies and urban villages it is 155 lpcd and for jhuggi-jhopdi (JJ) clusters it is only 50 lpcd.

According to a recent report, the average water consumption in a five-star hotel room is above 1,000 litres. For instance, the average consumption of water in a Hotel Taj Man Singh room is 2,000 litres a day, while at the Oberoi it is 1,120 litres per day per room. The average consumption at the Taj Hotel is 1,400 litres per room, while Janpath Hotel, including its banquet halls and restaurants, consumes around 67,000 litres per day. On an average, each room in a five-star hotel consumes 1,600 litres of water every day.

VIP residences do not lag far behind in guzzling water. For instance, the prime minister's house at 1 Race Course Road accounts for around 73,300 litres of water per day, and the presidential residence, Rashtrapati Bhavan, consumes about 67,000 litres per day. Similarly, ministers' residences consume 30,000-45,000 litres per day.

The hutment clusters of southwest Delhi, on the other hand, are in a state of perpetual water crisis. In 1999, Delhi had 1,100 slum clusters with an estimated population of 3.2 million. In addition, there were 1,500 unauthorised colonies with an estimated population of 3.5 million, 52 resettlement colonies with a population of 2 million and 216 urban villages with an estimated population of 0.6 million. Thus, in 1999, more than 10.3 million people -- 78% of the city's population -- were living in sub-standard settlements. In 2001, this dropped marginally to 76%. It is this population that is worst hit as far as water supply is concerned. East Delhi district is home to one-third of the city's population. This district has the highest concentration of multi-storeyed housing complexes in Delhi. Consequently, those who can afford it have installed high-powered booster pumps directly on the main transportation water lines, for personal use. The government has done virtually nothing to rectify this uneven distribution or check malpractice.

The problem in Delhi is not related to inequitable distribution alone: according to official sources, about 40% of the total water supplied in Delhi is put to wasteful use. Most important among these is water usage in industrial units: there are hardly any existing or operational mechanisms for the recovery of secondary and tertiary water, so, once water becomes industrial waste it is put out of use permanently. There are a number of wasteful household activities too, such as washing cars, bathing dogs, etc. The upkeep and maintenance of civic water taps is pathetic practically throughout the city, resulting in substantial water loss. The solution is not to augment water, as is being advocated by

politicians, but to manage and conserve it better by increasing awareness and involving society in public-private partnerships. For example, although the per capita availability of water in the city of Copenhagen (Denmark) is 200 lpcd, the city council has fixed a target of reducing it to 110 lpcd through better management of water utilization.

By Arun Kumar Singh available at: http://infochangeindia.org/200510155601/Agenda/The-Politics-Of-Water/30-litres-for-some-1600-for-others-Inequities-in-Delhi-s-water-supply.html

As far as sanitation facilities are concerned, most of the poor are dependent on free community latrines and lack of adequate number of public toilets also leads to defecation in open spaces. Improper disposal of human excreta leads to major public health problems such as groundwater contamination. Keeping all these factors in mind, a number of urban development programmes were designed in the 1980's which emphasized the provision of water supply and sanitation services. These included Basic Services Programmes (e.g. Environmental Improvement of Urban Slums, Urban Community Development Programme, etc.); Integrated Development of small and medium towns for slum improvement and low cost sanitation; Low Cost Sanitation Programme, etc. However, Kundu (1993)[15] in an analysis of these schemes observed that the success achieved in terms of the target has been extremely limited. As a result the scenario at the end of the International Water Supply and Sanitation Decade, remained virtually unchanged, especially in terms of access of the poor to such facilities. Kundu's study also revealed that there is a positive relation between the accessibility to a toilet facility and per capita monthly expenditure. He found that a heavily subsidized system of toilet and sanitation facilities is available to relatively well off sections of the population. To illustrate, higher consumption groups who have flush latrines connected to the sewerage system, for which only a nominal user charge is levied by the authorities. On the other hand, even after availing of subsidies from local authorities, the poor often find it too expensive to incur the capital expenditure involved in constructing such flush latrines.

Housing

About 45 % of the people living in the slums of India live in single room tenements. About 50 per cent of houses are made of cement and concrete, while 17 per cent are made of mud and thatch. Most urban poor live on places that are overcrowding with poor sanitary conditions, not meant for human habitation lacking facilities such as water supply, toilet facilities, and place for waste disposal. Some of these places are permanent and others are temporary[16].

The spotlight is focused on the mismatch between demand and supply of housing units. 99% of the housing shortage of 24.7 million at the end of the 10th Plan pertains to the Economically Weaker Sections (EWS) and Low Income Groups (LIG) sectors. Given the fact that 26.7% of the total poor in the country live in urban areas, the issue of affordability assumes critical significance. In terms of numbers, 26.7% of the total poor implies 80.7 million persons or about one-forth of the country's total

[15] Kundu, A.1993
[16] UN Habitat, 2003

urban population. 1.5 Further, the National Sample Survey Organisation (NSSO) 61st Round reports that the number of urban poor has risen by 4.4 million persons, between 1993-94 and 2004-05. It is, therefore, of vital importance that a new National Urban Housing and Habitat Policy carefully analyses ways and means of providing the 'Affordable Housing to All' with special emphasis on the EWS and LIG sectors.

Source: National Urban Housing and Habitat Policy 2007

Unique problems of Urban Poor

One of the major problems linked to the urban poor is the issue of their identity. This leads to issues of access to basic services and also voting rights. They lack residential proof and even if they fall below poverty line they do not have access to ration cards. The processes of illegalization and criminalization work together. Imprisonment is one of the common tools. Another is de facto denial of citizenship. In an age of targeting as opposed to universal access, the fate of the poor increasingly hinges on possession of 'legal' documents. These have become indispensable not only for protecting citizenship and assets but also as instruments for the needy to rightfully avail of the services of a welfare society as enshrined in the constitution of the land.

In the case of homeless people and migrants living in slums, the very concept of citizenship is denied by the State itself in India. Two basic documents that are widely perceived as de facto proof of citizenship - ration card and voter's card - are not available to the overwhelming majority. The reason often cited by the authorities is their unavailability of a permanent address. But in many instances it is seen that the voter's card is made available to the urban poor to garner votes during elections while there is absence of ration cards which is more important to address basic subsistence needs. Often the urban poor, residing in slums, are worse off than their rural counterparts. They face issues of legitimacy, insecure tenure rights, are cut off from their community and are thrown into anonymity and formality of urban life. They have to pay for every civic amenity like, toilets and water.

The government in a recent move plans to issue biometric identity card and provide to all its citizens a 'unique identification number' as an attempt to improve the delivery of inefficient public services. The fallout of this as voiced by human rights activists is that it is an act of surveillance and raises concerns over various migrant populations who may not be given the rights of citizenship.

People's tribunals in Mumbai and Delhi found that unlike rural areas, there are no systematic BPL surveys. People apply for BPL ration cards, and food department officials estimate people's income that is arbitrary. Almost every state has faltered on conducting regular urban BPL surveys, while it has been done regularly for rural areas. Regular surveys are necessary to eliminate the bogus cards, renewal of old cards and sanction of new cards to overcome exclusion errors and also ensure that the food grains meant for the poor actually reach them.[17]

[17] Eight Report of the Supreme Court Commissioner's Office

A Jan Sunwai held in Delhi in May 2010 identified the following problems faced by the urban poor:

- The government's failure to recognize, identify and entitle the urban poor, whether in slums or resettlement colonies
- A gross denial of rights to basic services such as electricity and water in permanent settlements that have provided habitation for decades and decades
- Complete apathy on the part of the local Municipality Board and the failure of the government to be able to influence them for basic services
- A gross denial of the right to legally defined wages
- A gross denial of children's rights to survival, protection and development
- A general lack of health and ECCD (Early Childhood Care and Delivery) services as per prescribed norms
- Apathy and obstructiveness on the part of service providers to enable poor people access to their entitlements
- No difference between the overall situation of services between unauthorized slums and resettlement colonies

More specifically, the issues that emerged were detailed as follows:

1. Water: severe difficulties and daily struggle in access to safe water that was simply not adequate.
    - No regular systems
    - Very poor quality, mixed with drainage, etc
    - Children involved in fetching water, sometimes at the cost of schooling
    - Frequent diarrhoea episodes leading to severe malnutrition and deaths
2. Electricity: no formal arrangements for metered electricity in the slums causing accidents, ill health and impediments to education. Parents stay up nights to fan their children while they sleep. A child was kidnapped while sleeping outside the home with parents to remain cool and killed.
3. Proof of Residence: Inability to access proof or residence resulting in inability to get birth registration, ration cards and access schemes such as Ladli and Janani Suraksha Yojna.
4. Anganwadis: Infringement of Supreme Court Orders to provide Anganwadis to slums on priority as well as to provide anganwadi on demand within 3 months of demand.
5. Crèches: Infringement of Construction Workers Act, 1996, to provide crèches on worksites.
6. Maternity Entitlements: no maternity entitlements for poor women working in informal sector who are having to return to work as early as 19 days after delivery and are not able to exclusively breast feed.
7. Wages: Infringement of Minimum Wages Act with unskilled workers getting Rs. 80 - 100 instead of 203 rupees.

8. Health Care: Severe difficulties with access, quality and costs leading to ill health and deaths: due to distance; lack of a local health centre; lack of referral transport; due to attendant costs of transport as well as management; due to lack of residential proof; due to two child norms being placed on services such as registration of pregnant women for antenatal care; prohibitive costs for common illnesses such as diarrhoea (Rs 9500 in a case of a child suffering from diarrhoea); prohibitive costs for special cases such as tendon release operation of child with cerebral palsy (10,000), congenital polycystic disease (10 lakhs in once case); flimsy excuses for not making immunisation card, for not informing about JSY or giving JSY.
9. Children with Disability: being denied admissions to school and lack of supportive services for the rights of disabled children
10. Children with severe acute malnutrition have not been admitted by the govt. facility and managed according to the protocols to be followed (9 mo old child of Savita, Kirby Place, weight 3.5 Kgs, MUAC 110 cms).

Report prepared by Delhi-FORCES, June 2010.

Unique problems of Urban Health Services

There is no single structure of health services in urban areas. There are multiple state actors/agencies at all levels who provide health services which results in overlapping of services, lack of coordination and concentration of services in some areas. Urban areas have high concentration of public and private health services. Public services are relatively low at the primary level, especially in the matter of community outreach at the urban fringes. Secondary and tertiary services are more highly developed; all secondary and tertiary institutions are situated in urban areas. Availability of private providers is high at all three levels. The secondary and tertiary hospitals serve both the urban and the rural people; up to a third of tertiary hospital attendance in metropolitan cities are from adjacent states. The lack of focus on the planned development of a 'comprehensive health service system' in urban areas has been officially recognized at least since the 1980s, with the Krishnan Committee report of the central government. The lack of peripheral services, multiple authorities providing services and overlapping responsibility of the institutions and agencies leads to overcrowded hospital OPDs and wards.

The private sector issues largely pertain to services in urban areas where they too tend to concentrate. Issue of free land to private corporates without their fulfilling the obligations in the contract are issues of urban governance. Increasingly, public funds are providing support to the private sector through the social insurance (CGHS, ESI, etc.). The private services also engage in greater practice of over-medication and set up models of prescribing of unnecessary medical interventions which, besides adding

to costs also bring in iatrogenic conditions, which adds to the burden on the public health services. The regulatory framework of private providers remains extremely weak.

Roles of state government and local bodies as health service providers are often not clearly defined. Local bodies are largely resource constrained and therefore the 'burden' of secondary and tertiary health care institutions is 'borne' by the state governments. Secondary and tertiary care institutions are/will almost as a rule is located in urban centres and also act as referral units for the general/district health services. That argument will de facto imply that urban local bodies confine themselves to the primary level only. Though the Bombay Municipal Corporation operates services at all levels including medical education, it is an exception than a rule. Recommendations of Committees appointed so far - Krishnan Committee, Pattanayak Committee - to rationalize and integrate existing public health agencies need to be properly implemented.

Public health programmes operate vertically in most urban areas. Though Ward Health Units exist in some cities/towns, rarely do they deliver integrated comprehensive services. Urban local bodies, and their personnel, are oriented largely towards slum populations. The relatively better off urban sections access private medical care through out of pocket expenditure and to a limited extent through medical insurance. The delivery structure of urban health services will be discussed in detail in Lesson 3.

Dimensions in which urban environments differ from rural

1. Greater inherent risks of communicable diseases using STIs
2. Possibly lower unit costs for provision of safe water
3. Different range of occupational health and safety risks
4. Greater numbers of urban poor at risk from some natural disasters because of population concentration
5. Possible economies of proximity in health media campaigns and informational spillovers from the educated to the less-educated and through social networks
6. Greater access to health services through private markets and mixed public-private provision
7. Quicker access to emergency services, of great importance to maternal mortality
8. Composition of disease within the population altered by higher incomes and better public provision of services

Montgomery et al, 2003

Review Questions:

1. What is migration? How is it linked to urbanization?
2. How are urban and rural areas different when talking of determinants of health?
3. What are the unique problems faced by the urban poor as compared to their rural counterparts?

Application Questions:

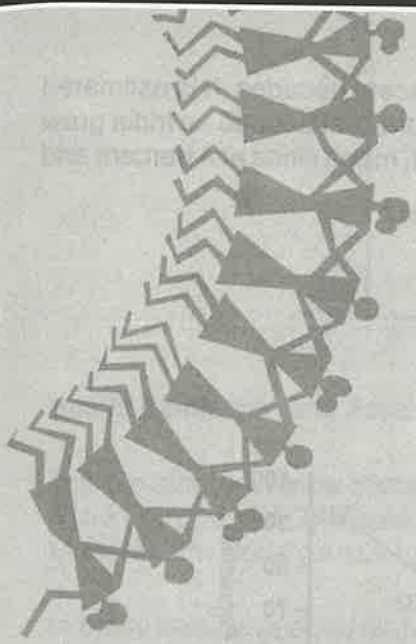
1. A slum is being demolished and people are being evacuated to another place. What are the rehabilitation measures that are essential to take care of the immediate needs of the people? As a public health person how would you coordinate the whole process of evacuation with other sectors?

Project Assignment:

1. Visit a slum in your area. Do a brief write up on the availability of basic services in the area - water, sanitation, type of housing, PDS, and health services.
2. Map the various actors in the same area who are providing urban health services at all levels.

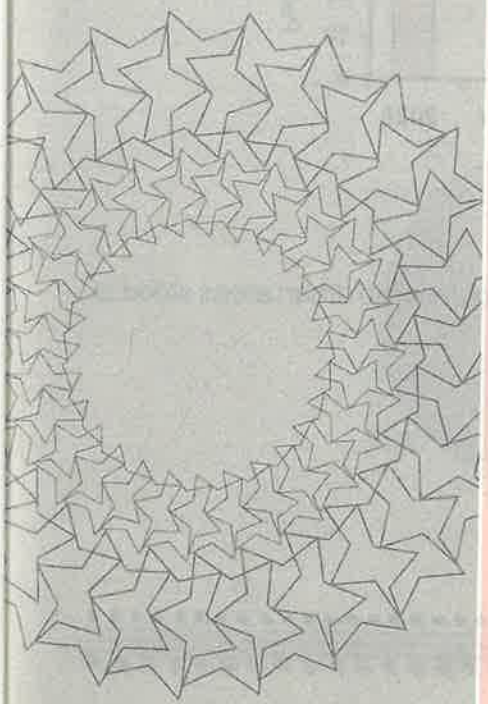
Lesson TWO

Health Indicators in Urban India



In this lesson we shall discuss:

- The growth of urbanization and urban poor in India
- Health status of the urban poor in India - some health indicators
- Morbidity and mortality profile of the urban population - The Epidemiological transition

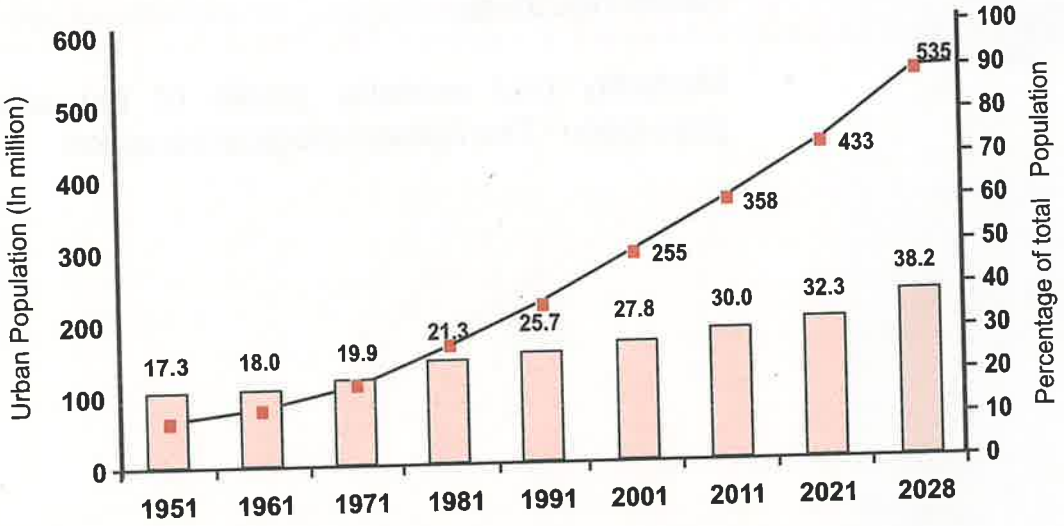


INTRODUCTION

This chapter gives some facts and figures on the urban situation in India and discusses some health indicators.

As discussed in the previous lesson, India has been urbanizing rapidly in recent decades. It is estimated that the urban population will nearly double to reach 534 million by 2026. In the last decade as India grew at an average annual growth rate of 2 percent, urban India grew at 3 percent, mega cities at 4 percent and slum populations rose by 5-6 percent.[18]

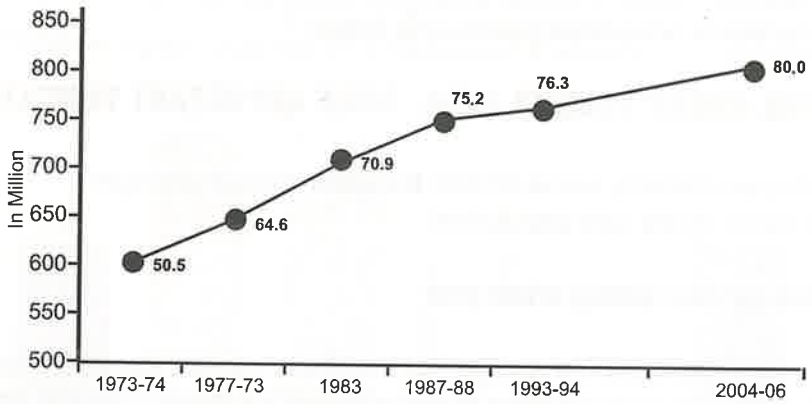
Urbanization in India 1951 - 2026



The number of urban poor population in India has also grown. The BPL population in urban areas stood at 25.7 percent compared to 28.3 percent in rural areas, as per NFHS-3 data.

[18] NUHM (draft), 2009; www.uhrc.in

Number of Urban Poor Population in India 1973-74 to 2004-05

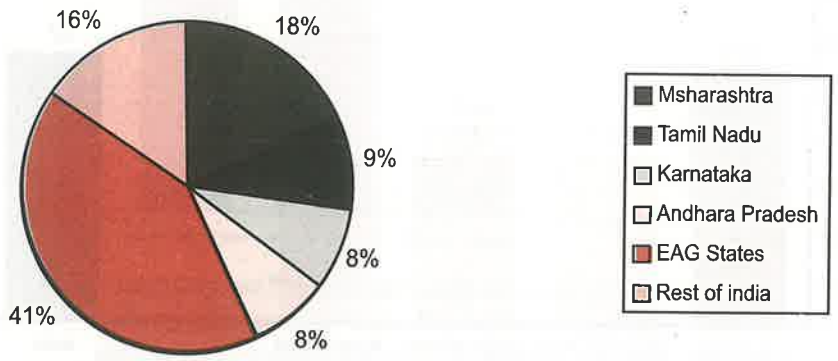


Health Conditions and Access to Services in EAG States

The pie diagram below shows the share of urban poor in some of the developed states and Empowered Action Group (EAG) states of India. EAG states comprise of 41 percent of urban poor population. Maharashtra alone constitutes about 18 percent urban poor.

In these less developed states under-5 mortality and Infant mortality among the urban poor is about 1.3 times and 1.6 times higher than their respective national figures. Access to RCH services amongst urban poor is also worse than other states of the country. Institutional deliveries, among urban poor in UP are 6.5 times lesser (13.1%) than in Tamil Nadu (85.6%). Similarly, complete immunization coverage among urban poor in UP is 29.7 percent compared to 74.4 percent in Tamil Nadu. Poorer access to services has contributed largely to deprived health conditions of urban poor in these states.

Share of Urban Poor



Significant proportion of the urban poor are Scheduled Castes and from Other Backward Castes and few from the category of Scheduled Tribes. They constitute almost 80 percent of the urban poor. Nearly one-third of slum population consist of Scheduled Castes and Tribes.[19]

HEALTH STATUS OF THE URBAN POOR IN INDIA: SOME IMPORTANT INDICATORS

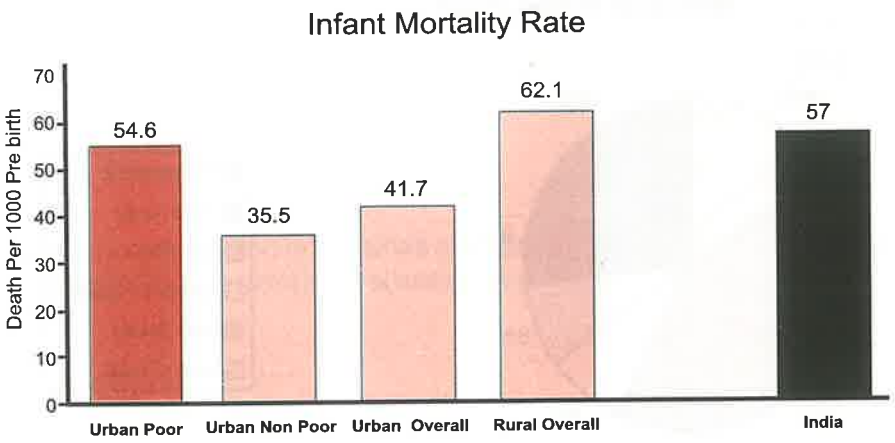
Health of the urban poor is considerably worse off than the urban middle and high income groups and is as worse as the rural population.

Child,infant and neonatal survival among urban poor

There are thousands of easily preventable maternal, child and adult deaths each year and millions of days of productivity lost each year. One in ten children in slums do not live to see their fifth birthday. As per the analysis of the NFHS-III, under-5 mortality rate among the urban poor is at 72.7 as compared to the urban average of 51.9. Malnutrition among urban poor children is worse off than in rural areas. About 47.1 percent of urban poor children under three years are underweight as compared to urban average of 32.8 percent and 45 percent among rural population. 71.4 percent of urban poor children are anaemic as against 63 percent urban average.

Only 42 percent of slum children receive all the recommended vaccinations. Over half (56 percent) of child births take place at home in slums putting the life of both the mother and new born to serious risk. Poor sanitation conditions in slums contribute to the high burden of disease in slums. Two-thirds of urban poor households do not have access to toilets and nearly 40 % do not have piped water supply at home.

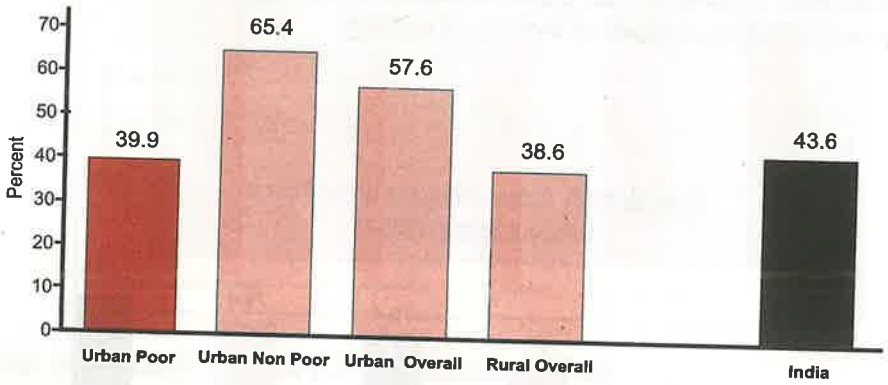
Lack of access to health care, nutrition and poor environmental conditions all contribute to high infant and child mortality in the slums. Nearly one lakh babies die before reaching their fifth birthday.[20]



[19] ibid
[20] ibid

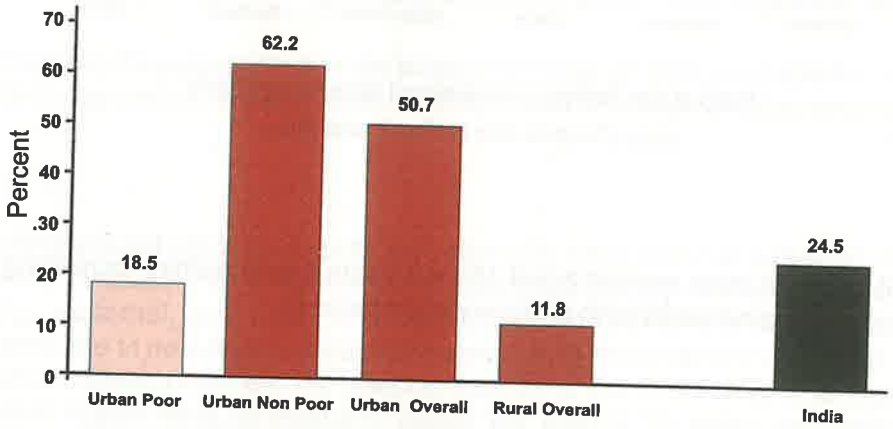
Only 40 percent of children from urban poor households receive all the recommended vaccinations.

Children Aged 12-23 Months Receiving Complete Vaccination



Unlike rural areas which have a dedicated government health care structure, urban areas do not have such a structure. The rapid growth of urban population in recent decades has rendered the already inadequate primary health care facilities further deficient. Cost, timings, distance and other factors put the secondary care and private sector facilities out of reach of most urban poor residents. Other factors like slums inhabiting land belonging to other agencies and therefore illegal and vulnerable to eviction, rapid migration and mobility among slum population also affect health delivery in urban poor communities.

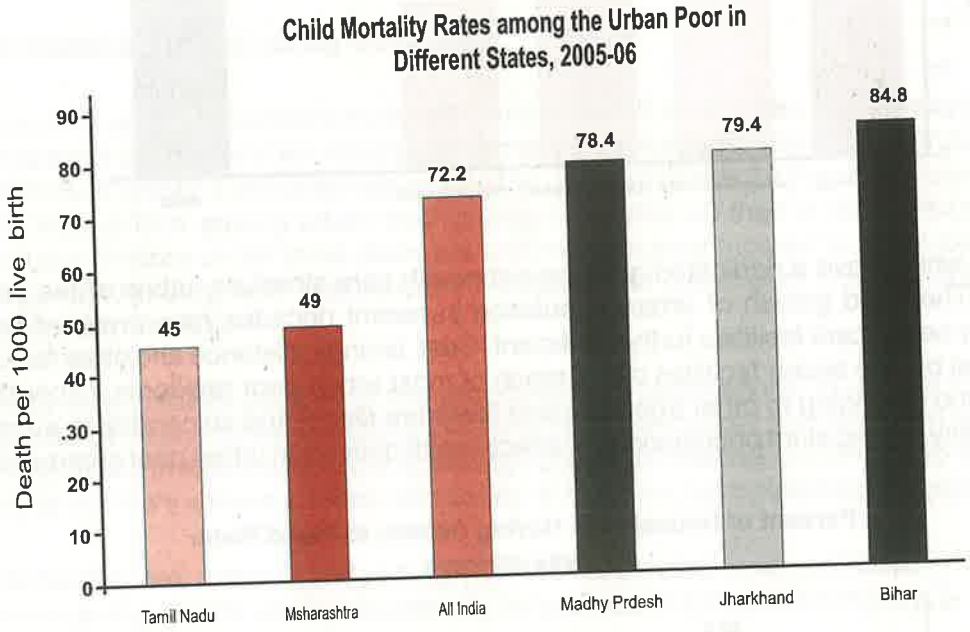
Percent of Households Having Access to Piped Water Supply at Home



Less then one fifth of slum households have access to piped water supply at home. Poor water and sanitation contributes to a higher prevalence of morbidity in slums.

High Incidence of under-nutrition among urban poor children

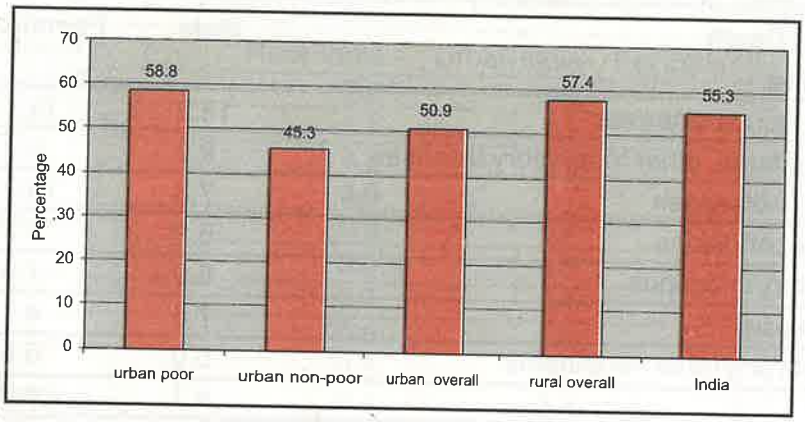
More than half of India's urban poor children are underweight. In most States, undernutrition among urban poor children is worse than in rural areas. Survival patterns among the urban poor, clearly point at the need for extra focus on this large segment of India's population.



Health of slum dwellers in less developed states are significantly worse off than the slum dwellers in other states.

Nearly 60 percent of urban poor women aged 15 - 49 years are anaemic, increasing the likelihood of maternal and infant death, premature birth and low weight babies.

Prevalence of Anaemia among women



MORTALITY AND MORBIDITY PROFILE IN URBAN AREAS

An examination of the causes of morbidity and mortality in India since Independence shows that while communicable diseases constitute the largest percentage, the non- communicable diseases have been gradually increasing over the last few decades. As a result the gap in the proportion of communicable and non-communicable diseases has narrowed over this period. This is largely due to increase in life expectancy and decrease in death rates across all age groups.[21] With increase in life expectancy there is a shift from communicable to non-communicable diseases as a major cause of morbidity and mortality. Hence, India faces a dual burden of communicable diseases and non-communicable diseases in the future. Given the stratified nature of Indian society the rise of non communicable diseases are largely a problem for the middle and upper middle classes but not merely restricted to them. Studies have shown that even those who belong to the working class and the poor are afflicted by chronic diseases.

We look at the changing disease pattern in the population through data available for causes of death and burden of disease in population, and hospitalisation by cause of ailment in urban and rural areas.

Mortality

India is experiencing a rapid epidemiological transition with large and rising burden of chronic diseases, which are estimated to account for 53 percent of all deaths. Although rural areas report more deaths due to communicable, maternal, peri-natal and nutritional conditions, the urban areas have a higher proportion of deaths due to non-communicable diseases. Injuries constitute about the same proportion in both rural and urban areas, however, the specific causes of the injury vary. It is important to note that urban areas report higher rates of mortality above the age of 25 years as compared to their rural counterparts. The top ten causes of deaths in rural and the urban areas are common except for deaths due to peri-natal conditions and digestive diseases though their relative order varies.

[21] GOI, 2005

Top 10 causes of death, India: Rural and Urban (SSD, 2001-03)

Rank	Cause of Death	Male	Female	Person
	Rural Area			
1	Cardiovascular diseases	18.2	15.1	16.8
2	COPD, asthma, other respiratory diseases	9.5	8.3	9.0
3	Diarrhoeal diseases	7.3	10.7	8.8
4	Perinatal conditions	6.9	6.7	6.8
5	Respiratory infections	6.0	7.6	6.7
6	Tuberculosis	7.3	4.7	6.1
7	Malignant and other neoplasms	5.0	5.6	5.2
8	Senility	4.1	6.3	5.1
9	Unintentional injuries: Other	5.4	4.5	5.0
10	Symptoms signs and ill-defined conditions	4.7	5.1	4.9
	Urban Area			
1	Cardiovascular diseases	30.3	26.3	28.6
2	Malignant and other neoplasms	7.5	8.5	7.9
3	COPD, asthma, other respiratory diseases	8.1	6.7	7.5
4	Tuberculosis	5.9	4.5	5.3
5	Senility	3.4	7.4	5.1
6	Diarrhoeal diseases	3.9	6.1	4.8
7	Unintentional injuries: Other	4.1	4.7	4.4
8	Symptoms signs and ill-defined conditions	4.0	4.6	4.3
9	Digestive diseases	5.0	2.5	3.9
10	Respiratory infections	3.0	4.5	3.7

According to the Medical Certification of Causes of Death (MCCD), 25.1 percent of total deaths in urban areas are attributable to diseases of the circulatory system. The estimated prevalence of coronary heart disease is around 3-4 percent in rural areas and 8-10 percent in urban areas among adults older than 20 years, representing a twofold rise in rural areas and a six-fold rise in urban areas over the past four decades.

Morbidity

The NSSO data on Morbidity gives the household data on the number of people hospitalised by type of disease or ailment. This clearly shows that many cases of hospitalisation are sought for non-communicable diseases especially heart disease, hypertension, and kidney related and in communicable diseases, diarrhoea is the most common cause for hospitalisation even in urban India.[22]

[22] Nundy, M. (2010)

Cases of hospitalisation by type of ailment in India and Delhi (in percentage), 2006

S. No.	Nature of Ailment	Rural India	Urban India	For India (%)	For Delhi (%)
1	Diarrhoea/dysentery	**7.6**	**6.2**	**7.2**	**8.3**
2	Hepatitis/Jaundice	1.5	2.2	1.7	2.9
3	Gastritis	**4.8**	**3.9**	**4.5**	**3.5**
4	Tuberculosis	**3.0**	**1.7**	**2.6**	**1.1**
5	Amoebiosis	0.3	0.4	0.3	0.1
6	Malaria	**3.2**	**3.6**	**3.3**	**0.9**
7	Diptheria	0.1	0.4	0.2	0.6
8	Whooping	0.6	0.6	0.6	0.2
9	Tetanus	0.3	0.2	0.3	0.3
10	Worm Infestation	0.4	0.4	0.4	0.8
11	Conjunctivitis	0.2	0.2	0.2	0.2
12	Heart Disease	**4.3**	**8.0**	**5.4**	**12.4**
13	Hypertension	**1.8**	**3.2**	**2.3**	**3.9**
14	Respiratory	**3.5**	**3.0**	**3.3**	**2.4**
15	Bronchial Asthma	**3.4**	**3.0**	**3.3**	**2.1**
16	Disorder of Joints	**2.5**	**2.6**	**2.5**	**1.7**
17	Kidney	**3.7**	**4.9**	**4.1**	**6.1**
18	Prostatic Disorder	0.4	0.4	0.4	0.5
19	Gynaecological	**5.2**	**5.0**	**5.1**	**1.7**
20	Neurological	**3.2**	**3.2**	**3.2**	**2.4**
21	Psychiatric	1.0	0.6	0.9	0.2
22	Cataract	**2.9**	**2.4**	**2.7**	**2**
23	Skin	0.6	0.6	0.6	0.6
24	Goitre	0.1	0.1	0.1	0.2
25	Diabetes	1.8	2.4	2.0	1.6
26	Under nutrition	0.1	2.4	0.1	0.3
27	Anaemia	0.9	1.1	0.9	1.2
28	Locomotor	1.3	0.9	1.2	0.1
29	Visual	0.4	0.3	0.4	0.5
30	Hearing	0.2	0.1	0.1	1
31	Mouth	0.2	0.2	0.2	0.4
32	Accident	**10.1**	**8.8**	**9.7**	**9.7**
33	Cancer	**2.8**	**3.2**	**2.9**	**4.6**
	Others				
34	Fever of unknown	**7.9**	**6.7**	**7.5**	**9.5**
35	Other Diagnosed	**16.4**	**16.6**	**16.5**	**15.5**
36	Undiagnosed	1.9	1.5	1.8	0.8
	Total	100	100	100	100

Source: NSSO, 60th Round, 2006 (Total of all diseases here will not amount to 100 as not all categories of diseases have been listed here) cited from Nundy, M. (2010)

The table below shows the estimated cases of Coronary Heart Disease in India in 2000 and 2005. The urban cases were about 46 percent of the total CHD cases of the country, whereas the percentage increased to about 50 percent by 2005.

Number of estimated cases of Coronary Heart Disease in India, 2000 and 2005

S. No.	Age in years	2000			2005		
		Rural	Urban	Total	Rural	Urban	Total
1	20-29	1799691	2711501	4511192	2012363	4138045	6150408
2	30-39	2854247	2635019	5489266	3383816	3869904	7253720
3	40-49	3342472	2776974	6119446	4217201	4116830	8334032
4	50-59	3590885	2288412	5879296	4544974	3171320	7716294
5	60-69	3153512	1888199	5041711	3849544	2582790	6432334
	Total	14740808	12300104	27040912	18007899	17878889	35886789

Source: National Commission on Macroeconomics and Health (2005)

Cancer

Data on cancer mortality is available from six centres across the country, which is part of the National Cancer Registry Programme of the Indian Council of Medical Research (ICMR). The age-adjusted incidence rates in men vary from 44 per 100,000 in rural Maharashtra to 121 per 100,000 in Delhi. The major cancers in men are mostly tobacco-related (lung, oral cavity, larynx, oesophagus and pharynx). In women, the leading cancer sites include those related to tobacco (oral cavity, oesophagus and lung) and cervix, breast and ovary cancer.

Diabetes

India also has the largest number of people with diabetes in the world, with an estimated 19.3 million in 1995 and projected 57.2 million in 2025. The prevalence of Type 2 diabetes in urban Indian adults has been reported to have increased from less than 3 percent in 1970 to about 12 percent in 2000. On the basis of recent surveys, the ICMR estimates the prevalence of diabetes in adults to be 3.8 percent in rural areas and 11.8 percent in urban areas.

Tuberculosis/Malaria and Asthma

Annual rate of tuberculosis infection (ARTI) studies, conducted in 2000-03, showed an ARTI of 1.5 percent at the national level. There are striking rural-urban differences in ARTI - 2.1 percent in urban areas and 1.2 percent in rural areas. The risk of urban malaria has been constantly increasing due to

urbanization and industrialization leading to mass migration of people and increase in vector breeding on account of stagnant water. Migration of labourers coming from areas with drug-resistant malaria in to such areas further worsens the situation. A prevalence of 5.7 percent among the rural and 16.64 percent among the urban groups shows that the prevalence of asthma is 2.9 percent times higher in urban children.

Accidents and injury

Although the injury mortality rates were 5/1000 with rates in urban, slum and rural areas being 4, 5.1 and 7.4/1000 respectively, the 23 metropolitan cities have a Road Traffic Injury mortality rate of 1200 per 100,000 which is higher than the national average of 800 per 100,000.

Mortality and Morbidity related to Violence

The rate of violence related deaths and injuries in urban India, especially in cities, was 19 per 100,000 which is much higher than the national figures. The highest number of deaths (82 percent) occurred in the age group of 15-44 years, with a male to female ratio of 4:1. In a recent examination of domestic violence in the cities of Thane, Bangalore and Mumbai, it was observed that women subjected to violence approached official agencies only as a last resort. As per a pioneering study undertaken in seven Indian cities during 1997-99, domestic violence is common in urban India. Overall 45 percent of women reported experiencing at least one physical or psychological violent act in their lifetime.

Disability

The disability rate in India was 1.9 percent of its population in 1991; it increased to 2.1 percent in 2001. Injuries of various types are directly responsible for one-third of all disabilities. Based on this estimate, 70 lakh people are disabled due to injuries. As per the 47th round of National Sample Survey, the prevalence of injury related visual disability was 32/1000 in urban areas. Burns caused locomotor disability in 211/1000 population in urban areas.

Mental Health

Mental health has been a much neglected field until recently. There is, however, increasing realization that conditions such as schizophrenia, mood disorders and mental retardation can impose a marked disease burden in India. Two studies have attempted to generate all-India prevalence rates of mental health disorders. Reddy and Chandrashekhar (1998) in a meta-analysis reported the total prevalence to be 58/1000 with 49 per 1000 for the rural population and 80.6 per1000 for the urban population.

Substance Abuse

Regarding substance abuse, the head of the household study by Mohan et al (1992) in Delhi is more robust when compared with other epidemiological studies. The study reported that 26 percent of

residents in urban slums were substance abusers, the majority involving alcohol. In another survey of 32,400 people in and around Bangalore, 1.2 percent of men were found to suffer from alcohol dependence syndrome. In regards to child and adolescent mental health problems, the urban and rural rates were found to be 8.9 and 6.4 per 1000 respectively.[23]

Review Questions

1. How is the health status of the urban poor different from its other urban counterparts?
2. What are the trends in morbidity patterns in urban India as compared to rural?

Application Questions

1. Look at data sets of health indicators over a period of time and discuss how India has gone through an epidemiological and demographic transition.

2. Take any city (could be from any country of your choice). Study the trends in mortality and its causes. Hypothesize how this could impact the urban poor.

3. Discuss trends in health indicators of any city of your choice in India and give possible reasons for these trends.

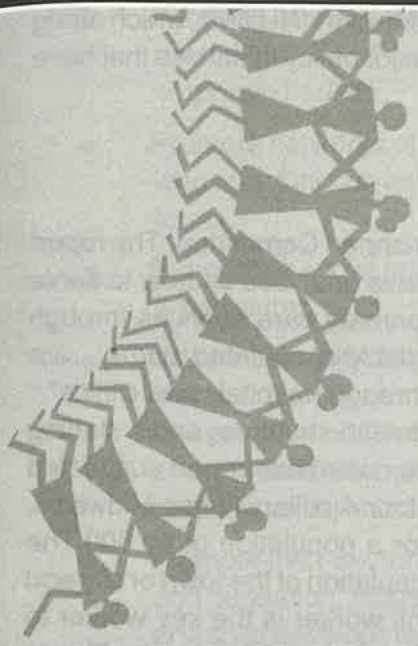
Project Assignment

1. Visit a tertiary care private and a tertiary care public hospital in the nearest city. Compare the services offered by both institutions. If possible gather data for past one month on the type of ailments for which hospitalisation is sought for by patients. Make 5 recommendations to improve services of tertiary public care

[23] NUHM(Draft), 2008

Lesson THREE

Urban Health: Policies, Programmes and Delivery Structures



In this lesson we shall discuss:

- Policy initiatives till date on urban health
- Disease Control Programmes in urban areas
- RCH strategies in urban areas
- Delivery structures of health services in urban areas - the extant, recommendations from NUHM and how it could be structured

POLICY INITIATIVES

Few policies in the past have given some space to address urban health issues. The Eleventh Five Year Plan aimed for inclusive growth by introducing the National Urban Health Mission (NUHM), which along with NRHM, was said would form *Sarva Swasthya Abhiyan*. Some of the major policy initiatives that have focused on urban health issues are listed below.

Krishnan Committee Report on Urban Primary Health Care,1983

One of the first committee set up to address urban health issues was the Krishnan Committee. The report prepared by this Committee in 1983 remains one of the most comprehensive analyses on how to serve the health needs of the urban poor. This scheme proposed to provide primary care services through 'health posts'. "Primary health care facilities in urban areas, especially in thickly populated slums....are almost absent and health services in the city to be largely cure oriented through hospitals and clinics".[24] The Krishnan Committee proposed an organized and integrated primary health structure, and a staffing pattern for health posts according to the size of the town's population. The committee report suggested the establishment of a health post run by a doctor, a Public Health Nurse, four Auxiliary Nurse Midwives, four multipurpose workers and twenty five Community Health workers for a population of 50,000.The Krishnan committee recommended four types of health posts as per the population of the town or city and established norms for staffing the health posts. The voluntary woman link worker is the key worker to provide community-based services. One such worker is recommended for every 2,000 people. This is followed by a second tier consisting of nurse mid-wives and male multipurpose workers. The report recommended that the health post staff should reach out to the community and involve the community in the implementation of the primary health care programme.

Urban Revamping Scheme,1983-84

This scheme was introduced following the recommendation of the Krishnan Committee in 1983. The main focus was to provide services through setting up of Health Posts mainly in slum areas. The services provided are mainly outreach of RCH services, preventive services, first-aid and referral services including distribution of contraceptives. Four types of health posts were set up depending on the allotted population in the catchment's area of the Centre covered. For Type A, the criterion is less than 5000 population. For Type B it varies between 5-10 thousands whereas for Type C it is 10-20 thousands. For Type D the limit is 25-50 thousands population. Only Type D Health Posts have a post of Medical officer.

Urban Health in National Population Policy, 2000

In order to assess population issues for urban populations, the National Population Policy 2000 proposed

[24] Cited in Duggal, 2009.

the following for urban slums:

- Finalize a comprehensive urban health care strategy.
- Facilitate service delivery centres in urban slums to provide comprehensive basic health, reproductive and child health services by NGOs and private sector organizations, including corporate houses.
- Promote networks of retired government doctors and para-medical and non-medical personnel who may function as health care providers for clinical and non-clinical services on remunerative terms.
- Strengthen social marketing programs for non-clinical family planning products and services in urban slums.
- Initiate specially targeted information, education and communication campaigns for urban slums on family planning, immunization, ante-natal, natal and post-natal check-ups and other reproductive health care services. Integrate aggressive health education programs with health and medical care programs, with emphasis on environmental health, personal hygiene and healthy habits, nutrition education and population education.
- Promote inter-sectoral coordination between departments/municipal bodies dealing with water and sanitation, industry and pollution, housing, transport, education and nutrition, and women and child development, to deal with unplanned and uncoordinated settlements.
- Streamline the referral systems and linkages between the primary, secondary and tertiary levels of health care in the urban areas.
- Link the provision of continued facilities to urban slum dwellers with their observance of the small family norm

Urban Health in National Health Policy (NHP), 2002

The NHP-2002 envisaged setting up of an organized urban primary health care structure. Since the physical features of urban settings are different from those in rural areas, the adoption of appropriate population norms for the urban public health infrastructure was proposed. The structure conceived under NHP-2002 is a two-tiered one: the primary centre is seen as the first-tier, covering a population of one lakh, with a dispensary providing outpatient facility and essential drugs; this would also enable access to all the national health programs. A second-tier of the urban health organization would be the Government general hospital that would form the referral system. The Policy envisages for the urban primary health system will be jointly borne by the local self-government institutions and State and Central Governments. The establishment of fully-equipped trauma care networks in large urban agglomerations to reduce accident mortality was proposed as a new initiative.

National Urban Housing & Habitat Policy,2007

The salient features of the National Urban Housing & Habitat Policy, 2007 are:

- Focus on affordable urban housing with special emphasis on the urban poor
- Role of housing and provision of basic services to the urban poor integrated into the objectives of the Jawaharlal Nehru Urban Renewal Mission (JNURM)
- Special emphasis on Scheduled Castes / Tribes / Backward Classes / Minorities, empowerment of Women within the ambit of the urban poor
- Focuses on symbiotic development of rural and urban areas in line with the objectives of the 74th Constitution Amendment Act
- Emphasis on urban planning, increased supply of land, use of spatial incentives (like additional Floor Area Ratio), Transferable Development Rights, increased flow of funds, healthy environment, effective solid waste management and use of renewal sources of energy.
- Encouraging integrated townships and Special Economic Zones.
- 10-15% of land in every new public/private housing projects or 20-25% Floor Area Ratio (FAR) whichever is greater to be reserved for Economically Weaker Section (EWS) / Lower Income Group (LIG) housing through appropriate spatial incentives.
- Private Sector to be permitted land assembly within the purview of Master Plans.
- Action Plans to be prepared for urban slum dwellers and special package for cooperative housing, labour housing and employees housing
- States to be advised to develop 10 years perspective plan for housing of EWS/LIG.
- Primacy to provision of shelter to urban poor at their present location or near their work place
- In-situ slum rehabilitation; relocation only in specific cases
- Micro-finance institutions to be promoted at state level to expedite flow of finances to urban poor
- Model municipal laws to be prepared by the Central Government
- Detailed city maps to be prepared based on GIS, aerial survey and ground verification
- Development of mass rapid transit system at sub-regional level
- Green cover for cities to be encouraged

Jawaharlal Nehru National Urban Renewal Mission (JNNURM)

The Jawaharlal Nehru National Urban Renewal Mission (JNNURM) is a project of the central government. Through this project, the central government will fund cities for developing urban infrastructure and services. The cities will have to carry out mandated reforms in return. The mission will last for a period of seven years starting December 2005. The JNNURM's focus is on urban renewal and

the aim is to encourage reforms and fast track planned development of identified cities. Focus is on efficiency in urban infrastructure and service delivery mechanisms, community participation, and accountability of ULBs/ Parastatal agencies towards citizens. The objectives of the JNNURM are to ensure that the following are achieved in the urban sector;

- Focused attention to integrated development of infrastructure services in cities covered under the Mission;
- Establishment of linkages between asset-creation and asset-management through a slew of reforms for long-term project sustainability;
- Ensuring adequate funds to meet the deficiencies in urban infrastructural services;
- Planned development of identified cities including peri-urban areas, outgrowths and urban corridors leading to dispersed urbanization;
- Scale-up delivery of civic amenities and provision of utilities with emphasis on universal access to the urban poor;
- Special focus on urban renewal programme for the old city areas to reduce congestion;
- Provision of basic services to the urban poor including security of tenure at affordable prices, improved housing, water supply and sanitation, and ensuring delivery of other existing universal services of the government for education, health and social security;

63 cities across the country have been short listed to carry out the projects under the mission for seven years starting from 2005-06.

Some of the major criticisms that the JNNURM faces is:
Only one out of the seven objective mentions about services for the poor. It is evident that the Sum Mission on basic service to urban does not intend to offer free service to the urban poor instead prescribes user fee as mandatory for services. As the mission fails to identify who the urban poor are and the magnitude of urban poverty it talks about user fee and affordable cost. The mission statement talks abut private sector participation in development, management and financing of urban infrastructure but it does not give reasons why private sector participation is needed and no guide line on who from the private sector would participate. Mandatory reforms such as repeal of urban land ceiling Act, rent control reforms and stamp duty rationalization, and easy conversion of agricultural land will enable the land mafia and real estate agencies to procure more and more land. The mission talks about security of tenure to slum-dwellers at an affordable cost. This is a very complicated issue, as slums are located in land belonging to many private owners and government. There is no mention on how these issues will be addressed. In many places slums have been in existence for years without recognition and deprivation of basic needs. The goals of MDGs are being achieved without giving basic services to the poor.[25]

[25] Chandra, J.S.

National Urban Health Mission (NUHM draft,2008)

NUHM has not been formally launched but the draft was made available to the public for a period of time. It was then decided that it would be launched formally with the Twelfth Plan. The draft NUHM recognized both growth of urban areas and the growth of urban poor, especially those living in the slums. It recognizes the inaccessibility of the health care facilities in the urban areas due to the following reasons; overcrowding of patients, ineffective in outreach and referral system and lack of standard and norms for urban health care delivery system, social exclusion, lack of information and assistance to access the modern health care facilities and lack of economic resources. Acknowledging the diversity of the available facilities in the cities, NUHM recommends flexible city specific models led by the urban local bodies. The NUHM will leverage the institutional structures of NRHM for administration and operationalization of the Mission. It will also establish synergies with programmes with similar objectives like JNNURM, Swarna Jayanti Shahari Rojgar Yojana (SJSRY), ICDS to optimize the outcomes.

DISEASE CONTROL PROGRAMMES IN URBAN AREAS

Urban Malaria Scheme

The proposal of the Urban Malaria Scheme (UMS) was sanctioned in 1971 when it was realised that urban malaria was a significant problem and if effective anti-larval measures were not undertaken in urban areas, the proliferation of malaria cases from urban to rural might occur in a bigger way. About 10 percent of the total cases of malaria are reported from the urban areas. At present 131 towns and cities in 19 States and Union Territories are under the UMS.

The vector of malaria in the urban areas breeds largely in man-made containers including over head and underground storage tanks, water coolers, flower vases, ornamental ponds etc. large construction activities also provide suitable breeding sites for the mosquitoes; the number increase manifold after rains. The objective is to control malaria by reducing the vector population in urban areas through recurrent anti-larval measures.

- Criteria for selection of areas for action: population more than 50,000; Slide Positivity Rate (SPR) more than 5, or, case population of fever cases more than 30 percent.

- Control strategies include:
  - o early diagnosis and treatment through malaria clinics, hospitals and dispensaries;
  - o bio-environmental management by filling ditches, pits, low lying areas, streamlining channelling, de-silting, de-weeding, trimming of drains, water disposal and sanitation;
  - o emptying water containers once in a week and observing weekly dry day;

- o anti-larval methods by weekly application of Mosquitoes Larvicidal Oil (MLO), temephos and fenthion;
- o use of carnivorous fish in clean water bodies;
- o formulation and implementation of urban bye-laws, for example in Delhi, Mumbai and Goa to control breeding places.

Revised National Tuberculosis Control Programme (RNTCP) in Urban Areas

Other than DOTS centres in urban areas, as an initial step in the country-wide scale up of Public-Private Management (PPM), the RNTCP in 2003 launched an 'intensified PPM DOTS' initiative in 14 major urban districts of the country. RNTCP-WHO (PPM) medical consultants were posted in these districts to provide technical assistance to the respective state and district TB officers. These sites implemented PPM in a very systematic manner, and a modified surveillance system to the routine RNTCP one was implemented in these districts. To provide disaggregated data, health care providers were broadly classified into six categories viz. state health department facilities, government facilities outside state health department, medical colleges, corporate sector, private hospitals and practitioners, and the non-governmental organisations.

The intensified PPM sites showed a steady and gradual increase in case detection. Analysis of quarterly data from the intensified PPM districts revealed the enormity and diversity of the health care provider categories. It also provided valuable information on the role and contribution of the various health care provider categories in the management of TB cases. A higher proportion of cases were detected by the medical colleges and larger hospitals. In all sites, the State government health sector was the largest contributor to case detection. Medical Colleges, though fewer in number, contributed to about 15-20 percent of the detected cases. The NGO sector is also an important source for care in TB. By January 2006, intensified PPM was expanded to a total of 70 districts.

The RNTCP has recognized the Indian Medical Association (IMA) as a major partner in expanding PPM-DOTS services in the country. The IMA has nominated national and state level coordinators for RNTCP. The IMA in Kerala, with support from WHO, organized training on RNTCP for more than 1000 private medical practitioners. A senior member of the IMA was nominated by the RNTCP to be the representative of a professional association from India on the global steering committee, which supervised the development of the International Standards for TB care (ISTC) document. With the assistance of IMA and WHO technical support, a coalition of professional medical associations has been established to assist RNTCP in TB control activities in the country. In 2007, the IMA in collaboration with RNTCP launched a Global Fund to Fight AIDS/TB and Malaria (GFATM) assisted project in six states to systematically enlist, sensitize, train and involve private practitioners in the programme.

Bigger NGOs like World Vision, mission hospital associations like Christian Medical Association of India (CMAI), Christian Health Association of India (CHAI), and R.K. Mission etc. are collaborating with RNTCP at national and state levels. RNTCP has developed and disseminated an advocacy kit containing special material and documents for sensitizing private medical practitioners on RNTCP. A concise training module for medical practitioners has also been developed by RNTCP. This module has a shortened duration of training of 6 hours. The RNTCP encourages operational research on PPM DOTS. Priority topics identified for research are available on the RNTCP website.

Dengue Fever (DF) and Dengue Hemorrhagic Fever (DHF)

Dengue outbreaks have been reported from urban areas from all states in India. All the four serotypes of dengue virus exist in the country. Several reasons are responsible for its resurgence:

- unplanned and uncontrolled urbanization
- inadequate waste management and water supply
- increased distribution and densities of vector mosquitoes
- lack of effective mosquito control
- increased spread of dengue viruses
- deterioration of public health infrastructure and surveillance system.

From mid-august to end November in 1996 an epidemic of Dengue Hemorrhagic Fever (DHF) and Dengue Shock Syndrome (DSS) occurred due to Type II dengue virus that caused 10,000 cases and 400 deaths during that period in Delhi. Similar outbreaks were reported from Rajasthan, Tamil Nadu, Karnataka, Kerala, Maharashtra, Uttar Pradesh and Gujarat. The cause of the epidemics were attributed to breeding conditions in these areas that are a constant threat - desert coolers, water storage tanks and utensils, leaking water supplies, wells and fountains, rain water collection and water bodies, tyre dumps, junk cans, rain soaked and un-cleared garbage provide substrate for Aedes breeding. Following the 1996 epidemic, the then National Anti- Malaria Program was reorganised and named as National Vector Borne Disease Control Program (NVBDCP).

REPRODUCTIVE AND CHILD HEALTH (RCH) STRATEGIES IN URBAN AREAS

India Population Project

Due to rapid growth of urban population, efforts were made in the cities of Chennai, Bengaluru, Kolkata, Hyderabad, Delhi and Mumbai for improving the health care delivery in the urban areas through World Bank supported India Population Projects (IPP). 479 Urban Health Posts, 85 Maternity Homes and 244 Sub-centres were created in Mumbai & Chennai (IPP V) and in Delhi, Bengaluru, Hyderabad and Kolkata

(IPP VIII). The goal of IPP VIII was to achieve 'Health for All' by 2000 AD and to achieve NRR of 1 by 2000 AD. The strategy was to increase MCH services and to improve the quality of MCH services through training of health staff, mothers and other women groups; improve utilisation of services by generating community participation and improve socio-economic status of women. The Health Post was created as the primary unit of service delivery for every 10,000 population with the help of 1 ANM, 5 Basti Sevikas and 5 trained Dais selected from the community. All family welfare services were provided through these posts. One *Health Centre* for every 50,000 population provided curative and family welfare services. Two medical officers along with one public health nurse and two ANMs were posted on this centre. To cater to a population of 12.5 lakh there were 6 maternity centres that provided services of laboratories and specialists to conduct normal and high risk pregnancies. MTP and terminal methods of family planning were also carried out in maternity homes. Under this project there was a scope of research and development in the area of improvement of women skills, education, awareness on environmental sanitation, nutrition, detection of breast and cervical cancers. These objectives were achieved through training, IEC activities, and MIS.

Building Public Sector- NGO Partnerships for Urban RCH Services

The scheme on Urban Family Welfare Centres (UFWCs) is functioning since 1950 to provide Family Welfare Services in the urban areas through existing health institutions and newly established clinics. Also, through the Urban Revamping Scheme (1983), Health Posts (HPs) have been established to provide outreach services, primary health care, family welfare and MCH services in urban areas, particularly slums. Currently there are 1,083 UFWCs and 871 Health Posts, many running from hospitals, not proximal to slums. With the total urban population of 290 million, (with 1954 UFWC's & HP's), this works out to one UFWC/HP per 148,413 Urban population. There are 1,562 Postpartum Centres (PP Centres, 1966) many closing down owing to discontinuation of central funding. Through IPP VIII (1993 to 2003) which covered 7 million slum population in 4 mega cities and 94 smaller towns in 4 states new health centres were established. For example, in Bangalore city 55 health centres were established in the project adding to the existing 37. Nevertheless problems of delivering health services and improving reach continue as described in various scenarios below.

Siddharth Aggarwal

RCH-II Guidelines for Urban Health Projects

Strategies

i. Improving access to Family Welfare (FW) and Maternal and Child Health (MCH) services through renovation/up-gradation and re-organization of existing facilities, redeployment of available staff

from State Government's Health Department and ongoing programs and schemes and establishing new facilities wherever required with provision of furniture, equipment and need-based mobility support on hiring basis and utilizing trained female volunteers at the Community level.

ii. Strengthening of existing urban health infrastructure at first tier and second tier to cover all slum areas.

iii. Improving the quality of Family Welfare Services through supervisory, managerial, technical and interpersonal skill to all levels of Health Functionaries including training of female volunteers to help outreach service delivery through pre-service, in-service and on-the-job training.

iv. Involving of NGOs and the Private sector in various aspects of urban primary health care delivery.

v. Increasing the demand for Family Welfare services comprising modern contraceptive usage, adoption of terminal methods, delivery care and child health services such as immunization and new born care. This would be done through IEC activities and enhancing the participation of communities and municipal leaders in the design, implementation and supervision of the services.

vi. Promoting convergence of efforts among multiple stakeholders, including the private sector to improve the health of the urban poor.

vii. Developing effective linkages between the communities and 1st Tier service delivery point and between the 1st Tier facility and referral units at 2nd Tier.

viii. Strengthening Monitoring and Evaluation mechanisms

Service Delivery Model

Under the ongoing program of the Ministry of Health & Family Welfare, different types of Urban Family Welfare Centers (UFWCs) and urban health posts (UHPs) are already functioning in different States/UTs. The Government of India is supporting 1083 UFWCs, 871 UHPs, 3239 beds under sterilization beds scheme. The Post-Partum centres (550 at district level and 1012 at sub-district level) supported till 2002 by GOI are now being funded by the State Governments with additional support from Planning Commission. In addition, the other programs run by State Governments/Municipalities/NGOs/Private Sector are also available to provide Primary Health Care Services in urban areas. In view of the different nomenclatures and types of facilities, the program envisages implementation of a uniform service delivery model by a) integration of the facilities run by State Governments / Municipalities and other private agencies, b) upgrading / strengthening of the existing infrastructure, and c) establishing new facilities in rented building. Though the programme envisages flexibilities in implementation of different service delivery models suiting to local situations, a suggestive model is described as under:

- The first tier (i.e. Urban Health Centre) will be set up, one for approximately 50,000 populations (the norm may be suitably modified by the State / City UH Task Force to ensure coverage and access by the most vulnerable populations) and second tier will be the referral hospital (city / district hospital / maternity home / private and NGO Nursing Homes). The number of second-tier

facilities would depend on the population needs, existing facilities and the geographic spread of the existing cities.

- Existing service delivery system should be reorganized and restructured to serve a defined geographical area for a defined population. Renovation / up-gradation of existing Government facilities should be proposed, rather than new constructions
- The location of the UHCs, and area coverage under each should be indicated on the map.
- Potential private partners for either tier should be identified to improve the quality and standard of health among the urban poor, to capitalize on the skills of potential partners, encourage pooling of resources, and to reduce the investment burden on the government.
- Timings of UHC should be such that services can be made available to the target population at a time convenient to them. It is recommended that UHCs operate for 8 hours. Each UHC may modify its timings after assessing the needs of the slums it is catering to. Outreach activities should be planned at least once a week.

Package of Services

A minimum package of services should be provided in either tier. Improving quality of Family Welfare services entails focus on serving the mother as complete human individual and family as a social unit. The first tier Urban Health Centre will provide only OPD services. The UHC will provide a comprehensive package of Family Welfare services (Family planning, child health services, including immunization, treatment of minor ailments, basic lab facilities, counselling and referral to 2nd Tier) in order to encourage slum dwellers to utilize the 1st Tier facility. The complicated referral cases and indoor services will be available only at the First Referral institutions.

THE EXTANT URBAN HEALTH STRUCTURES

Despite the recent emphasis on 'infrastructure', primary health care in urban areas is largely neglected. Urban local bodies have also reoriented themselves to a slew of reforms initiatives where the urban poor do not feature in any major way and healthcare less so. Reviews on Urban Revamping Schemes have pointed out the gaps in reaching health care services to the needy in urban slums. The gaps are mainly in terms of location of Health Posts as they are outside slum areas or not situated within a distance of 2-3 kms of the residence of the poor. This reduces accessibility. Unlike the rural health services, there have not been any well-planned and organized efforts to provide primary, secondary and tertiary care services in geographically delineated areas in urban health care. As a result, there is either non-availability or substantial under utilization of available primary care facilities along with an over-crowding at secondary and tertiary care centres.

The urban areas are characterized by presence of large number of for-profit/not-for-profit private providers. These providers are frequently visited by the urban poor for meeting their health needs. The

first interface for out-patient services for the urban poor in many cities is the private sector, chiefly due to inadequacy of infrastructure of the public system and non responsive working hours of the facilities. In some cases, partnership with private/charitable/NGOs have been introduced in order to expand services as is evident in Agra and Bengaluru. In several IPP-VIII cities services have been expanded by partnerships with profit/not-for-profit providers. Kolkata has the distinction of implementing the programme through establishment of an effective partnership with private medical officer and specialists on a part time basis, fees sharing basis in different health facilities resulting in ensuring community participation and enhancing the scope of fund generation. Andhra Pradesh has completely outsourced service delivery in the newly created 191 Urban Health Posts in 73 towns to NGOs. The experimentation it appears has been quite satisfactory with reduced cost. But these experiments have been scattered and specific to contexts and one has to be careful when replicating these models.

Utilization patterns of health services in urban India

Utilization of health services in Urban India is clearly skewed towards the private sector. The private sector consists largely of sole practitioners or small nursing homes having 1-20 beds, serving an urban and semi-urban population focused on curative care.

The macro data sets reveal an increase in the utilization levels in the private sector for outpatient and in patient services over the last two decades. While for outpatient services the private sector has been the dominant provider, for in-patient services the utilization has gradually increased in the private sector and this increase is more dramatic in urban areas.[26] This does not imply that the private sector is providing quality services and that people are willing to pay but the public sector is loaded with cases and people resort to going to a private provider because choices are limited.

Utilization of public and private facilities for the three rounds of NSSO

	All India					
	42nd (1986-87)		52nd (1995-96)		60th (2004)	
	R	U	R	U	R	U
Outpatient						
Public	25.6	27.2	20	19	22.3	19.2
Private	74.5	72.9	80	81	77.7	80.8
Inpatient						
Public	59.7	60.3	45.2	43.1	41.7	38.2
Private	40.3	39.7	54.7	56.9	58.3	61.8

Source: NSSO, 42nd, 52nd and 60th Round; R: Rural; U: Urban

[26] Nundy, 2010

There is variation across socio-economic groups with respect to utilization of services with the upper and middle classes depending much more on private services. The upper class at times utilizes government hospitals to get expensive diagnostic tests done. They approach government doctors in private practice and therefore can hope for receiving preferential treatment in the public hospital. Macro data for urban India shows that utilization of public hospital by the upper income quartile for hospitalisation increases when duration of stay increases.

Percentage distribution of preferred source for inpatient care treatment by Monthly per Capita Expenditure (MPCE) quartile group and duration of hospitalisation, Urban India 1995-96

MPCE quartile group	Duration of hospitalization							
	1-4 days		5-9 days		10 + days		Total	
	Public	Private	Public	Private	Public	Private	Public	Private
0-25	57.5	42.5	57.5	42.5	70	30	60.8	39.2
25-50	42	58	43.2	56.8	63	37	48.3	51.7
50-75	34.7	65.3	38.6	61.4	49.8	50.2	40.3	59.7
75-100	24.2	75.8	25.5	74.5	34.2	65.8	28.3	71.7
Total	38.9	61.1	40.5	59.5	50.9	49.1	43.1	56.9

Source: T. Dilip and R. Duggal (2002), Incidence of non-fatal health outcomes and debt in Urban India, Paper prepared for Urban Research Symposium, 9-11 December 2002, at The World Bank, Washington DC

A survey of all health facilities in eight districts across eight states done for the National Commission on Macroeconomics and Health (2005) in Khammam (Andhra Pradesh), Nadia (West Bengal), Jalna (Maharashtra), Kozhikode (Kerala), Ujjain (Madhya Pradesh), Udaipur (Rajasthan), Vaishali (Bihar) and Varanasi (Uttar Pradesh) showed:

- A highly skewed distribution of resources- 88 percent of towns have a facility compared to 24 percent in rural areas, with 90 percent manned by sole practitioners
- The private sector has 75 percent of specialists and 85 percent of technology in their facilities
- The private sector account for 49 beds and an occupancy ratio of 44 percent whereas the occupancy rate in the public sector is 62 percent
- 75 percent of service delivery for dental health, mental health, orthopaedics, vascular and cancer diseases and only 40 percent of communicable diseases and deliveries are provided by the private sector.

Cost of services

The following table from NSSO 60th round (2004) for Urban India shows that there is negligible free care in the private sector and a large proportion of the lowest four class groups still resort to public sector for free services. The middle class avails free public services and access 'paying general' category of private hospitals. The upper class utilizes the 'paying general' and 'special' wards of private hospitals.

Hospitalisation by type of ward in public and private hospitals and by MPCE for Urban India, 2004

	Public facility			Private hospital		
Urban MPCE	Free	Paying general	Paying special ward	Free	Paying general	Paying special ward
0-300	48.3	7.0	2.6	2.2	33.2	6.7
300-350	56.5	3.2	0	1.2	37.2	2.0
350-425	48.7	6.8	0.9	2.6	35.9	4.9
425-500	45.6	8.7	0.1	1.4	39.5	4.5
500-575	44.0	6.7	1.9	2.1	34.7	10.6
575-665	31.7	5.9	1.0	1.5	51.0	8.9
665-775	34.2	7.5	0.5	1.8	46.1	9.8
775-915	30.1	7.9	1.1	0.9	44.8	15.1
915-1120	28.8	5.9	1.4	2.0	49.2	12.7
1120-1500	20.3	6.6	1.2	1.4	44.7	25.7
1500-1925	13.3	5.5	1.5	1.2	41.3	37.1
1925+	10.0	5.0	2.0	1.4	36.6	45.0

Source: NSSO, 60th Round, 2004

Costs of care have clearly gone up over the last two decades and there is increase in out-of-pocket expenditures. Data also shows that between the 42nd (1986) and 52nd (1996) rounds of the NSSO there was a decrease in access to free care from 19% to 10% and an increase in the number of persons not seeking care due to financial incapacity.[27] The table below shows that costs have clearly risen between 1995 and 2004. The household expenditure for outpatient care in urban areas increased from Rs.7251.45 crores in 1995-96 to Rs.22415.01 crores in 2003-04, thereby exhibiting a growth rate of 15.15 percent; the same for in-patient care in urban areas increased from Rs 2092.9 crores in 1995-96 to Rs. 6954.1 crores in 2003-04, thereby exhibiting a growth rate of 16.19 percent.

[27] GOI, 2005

Average medical expenditure per hospitalisation for India and Delhi (in Rs)

	All India				Delhi
	Rural		Urban		Combined
Type of facility	1995-96	2004	1995-96	2004	2004
Public	2080	3238	2195	3877	8161
Private	4300	7408	5344	11553	33799

Source : NSSO, 52nd and 60th Round, 1995-96; 2004.

Utilization of medical technology

Mahal (2005) looks specifically at imports of MRIs and CT Scans and observes that there has been a sharp increase in their imports since 1990s. The demand side picture shows that households had started spending much more on diagnostics between the 42nd round of the NSSO (1986-87), the 52nd round in 1995-96 and 60th round in 2004.[28]

Patients getting an X-ray, ECG (electrocardiogram) and ESG (electrosonogram) by payment mechanism for India

	1986-87			1995-96			2004		
Out patient	Free	Part free	Payment	Free	Part free	payment	Free	Part free	Payment
R	21.58	5.28	73.14	9.14	0.35	90.51	11.8	2.0	86.3
U	29.16	5.49	65.35	11.16	1.09	87.75	12.5	3.1	84.4
Total	24.63	5.37	70.01	9.69	0.55	89.76	12.1	2.5	85.3
In-patient									
R	39.69	3.12	57.19	35.75	10.57	53.68	11.3	6.4	82.2
U	46.22	3.70	50.08	41.94	13.69	44.37	15.3	6.5	78.1
Total	41.91	3.32	54.78	38.01	11.71	50.28	12.7	6.5	80.8

Source: Mahal et al (2005) and NSSO, 60th round, (2006)

[28] Mahal, 2005; Nundy, 2010

The private sector undoubtedly plays a dominant role in health provisioning in the urban areas but there are serious supply issues and inequities in distribution of services. Costs in this sector are not regulated and there is a lot of irrational use of drugs and technology.

The major urban health components are given below:

Urban Health: Components

Primary	Secondary/ Tertiary	Programmes	Others	Regulatory / Legal
Dispensary (allopathic, ISM)	Hospitals	TB / DOTS	Outbreak investigation and management	Health trade licensing
Mobile Dispensary	Medical colleges diseases	Water borne grounds	Cremation Inoculation	International
Maternity & Child Health	Blood Bank	Vector Borne Diseases	Burial grounds	Bio-medical waste
Ambulance		School Health	Hearse Vans	Private nursing homes and hospitals
		Rabies	Slaughter house	
		STI / HIV / VCTC	IEC	
			Training	

We now look at the existing health delivery structures in some selected cities.

Health Services Delivery Structures in Selected Cities

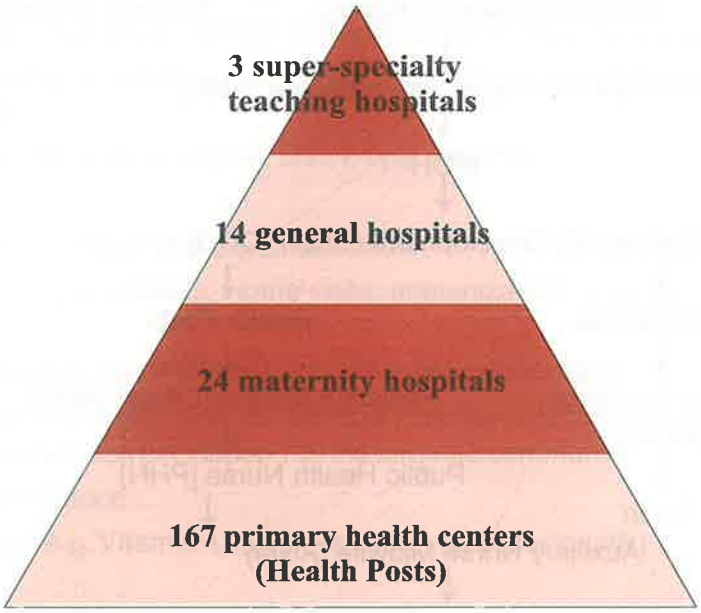
1. Public Health Services Structure in Mumbai

Mumbai is one of the most populous cities in India, which has more than 50 percent of its population living in slums. The city has vast supply of public and private care services. The public health system consists of

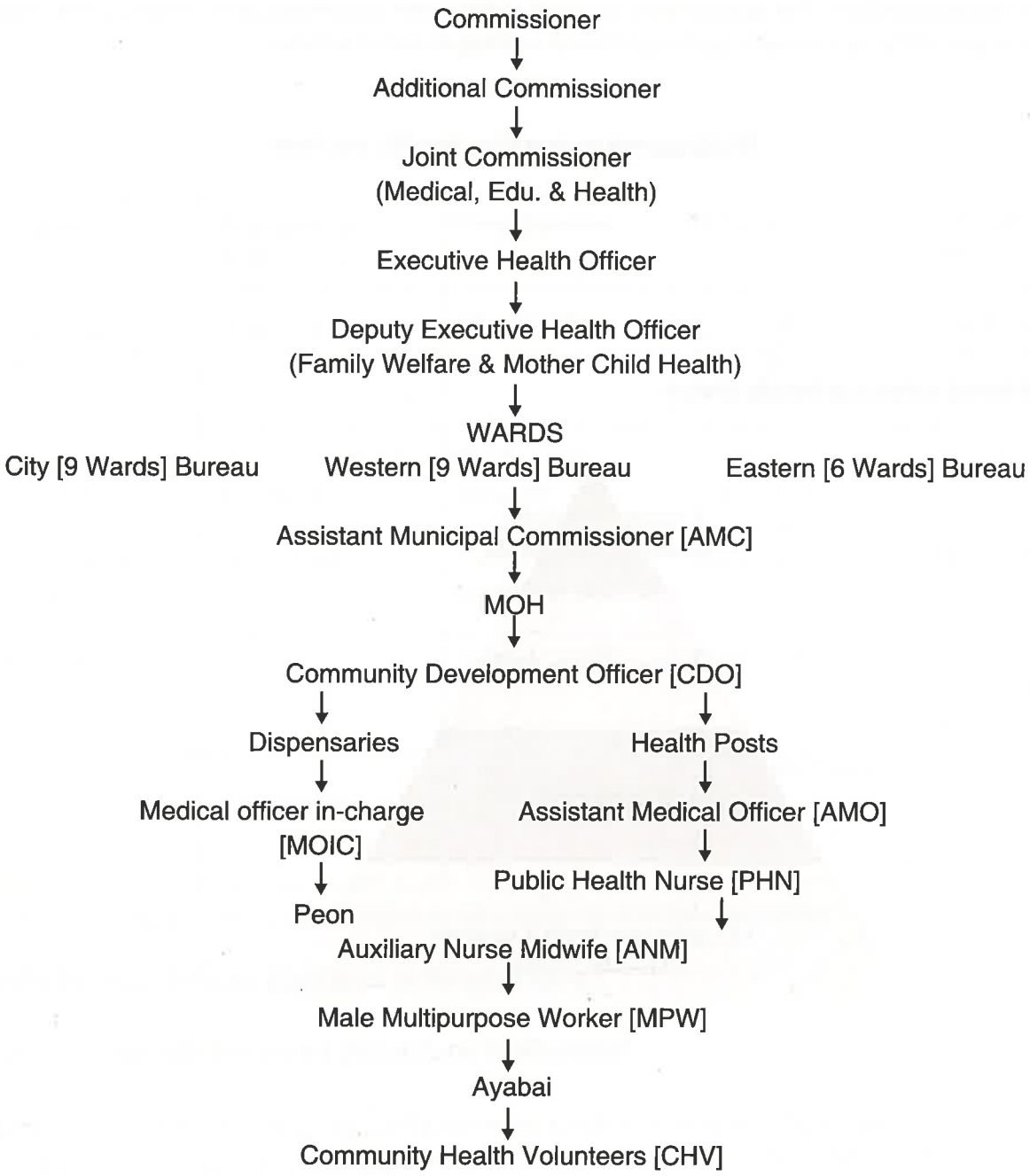
three levels of care primary, secondary and tertiary care. The public health department is headed by the Executive Health Officer who is responsible for the primary healthcare system including health posts and maternity homes. The secondary level which includes the peripheral hospital is overseen by the Chief Medical Superintendent. The tertiary level consists of the three super-speciality hospitals are headed by the deans and all this is overseen by the additional municipal commissioner.

Multi-tiered extensive health system

Multi-tiered extensive health system



Administrative Structure of the Public Health Department of Municipal Corporation of Greater Mumbai



Health Posts

There are 167 health posts spread across the 24 wards in the city. These health posts were established under India Population Project V in early 1988. Meant for controlling growth rate and reducing maternal and infant mortality, these are usually headed by public health nurse who implements and supervises the team at the health posts. Under the IPP-V, basic ante-natal care (ANC) interventions were built into primary level care through an integrated approach in which community health volunteers (CHVs) identify and monitor married couples to identify pregnant women, ensure they access antenatal care, support institutional births, and follow up infants after birth to ensure immunization and encourage family planning.

Unfortunately, this mother and child focus has been displaced as other community health programs - TB DOTS, Pulse Polio, immunization, and treating periodic outbreaks like dengue - take priority at the health posts. This has been compounded by rapid population growth; each health post is supposed to cover a population of 60,000, but actual coverage is closer to 1 lakh . Each CHV is expected to reach 4000-6000 population in her area. This population is unrealistic for the role envisioned for the CHVs. The Dharavi baseline data shows that 87 percent of pregnant women did not receive a visit from a community health worker. The services at the Health Posts include:

- Immunization of children at the clinic and the community
- Immunization of pregnant women at the clinic, giving iron and folic acid
- Family planning: increasing awareness, motivation, Copper-T insertion, distribution of condoms and Mala-D
- DOTS clinic: home visits, regular check-ups, providing medicines, follow up
- Leprosy
- Information, Education and Communication
- Polio: recruiting volunteers, Home visits, immunization, area camps, awareness building, follow ups
- Dengue / Malaria: Identifying cases and referring to hospitals
- Coordination with PMPs (Private Medical Practitioners) when doctor is not available at the HP to provide immunization or Copper-T to the targeted community
- Disease surveillance
- Other surveys e.g. Vitamin A, livestock counting(occasionally)

Maternity Homes

There are 24 maternity homes run by the municipal corporation. These maternity homes are meant for conducting normal deliveries. They were also meant to be a referral point from the primary health care systems either health post or dispensary. A medical officer either MBBS, Diploma in Gynaecology Obstetric or MD in gynaecology heads this facility. The staff includes fully trained nurses, ANMs, cleaning

and support staff. The total staff strength varies from 25 to 40. The bed strengthen varies between (obstetrics 10+10 neonatal) and 80+20 weekly ANC, Paediatric and Gynaecology OPDs are conduced at these facilities. A nominal charge of Rs. 10 is taken as case paper fees. As the anaesthetic services are available only on call no emergency services are provided at these facilities. The high risk and complicated cases are transferred to the secondary level or peripheral hospital. The inpatient services are free of cost except for the first two deliveries; subsequent deliveries are charged Rs. 500 per delivery.

Peripheral Hospitals

There are 14 peripheral hospitals in Mumbai. They serve as general hospitals for all cases of health and first referral units for maternal health. They are equipped to handle emergencies.

Tertiary Hospitals

There are three tertiary hospitals which are super-specialty facilities and teaching hospitals. They handle the majority of case load and are accessed directly by patients. Complications are handled at this level as are routine out-patient cases

2. Kolkata Urban Health System

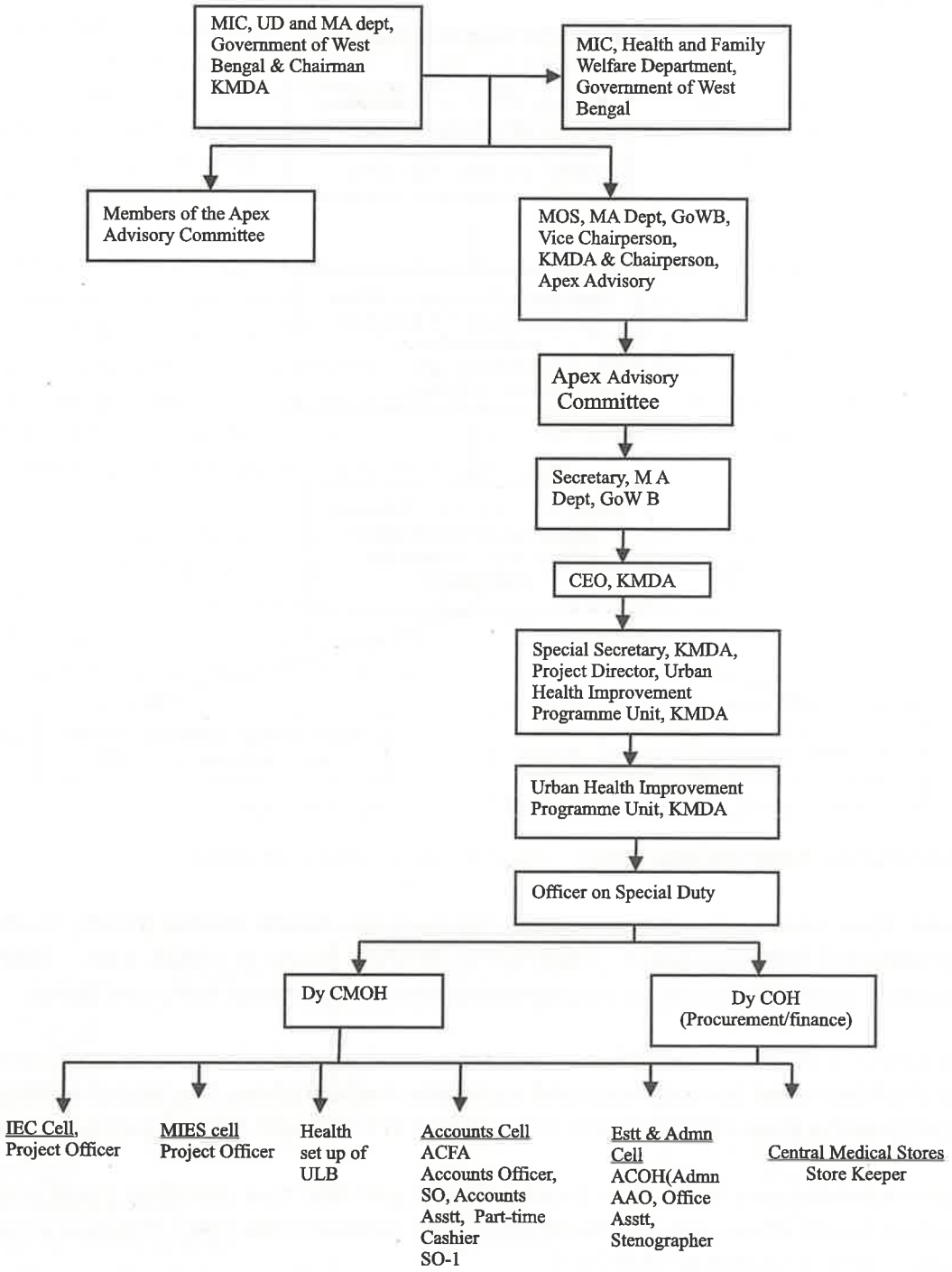
The Urban Health System under the Kolkata Metropolitan Development Area (KMDA) consists of KMDA provided services, the private sector and the State Health Department provided services. Kolkata Urban Services for the Poor (KUSP) is being implemented across 40 municipalities of the administrative unit of KMA, besides the existing health systems and infrastructures under the KMDA. By including pro-poor planning devices, KUSP endeavours to provide: - "A comprehensive community-based preventive and promotive health delivery system by involving the community and entrusting the relevant responsibilities to Urban Local Bodies (ULB) through a decentralised approach."[29]

The area it covers is 1785.04 sq. kms serves a population of 14.68 million (2001 Census), a population density of 8223/sq km. The slum population is 33 percent of the total population. It consists of 41 ULBs.

The following diagram describes the KMDA health structure:

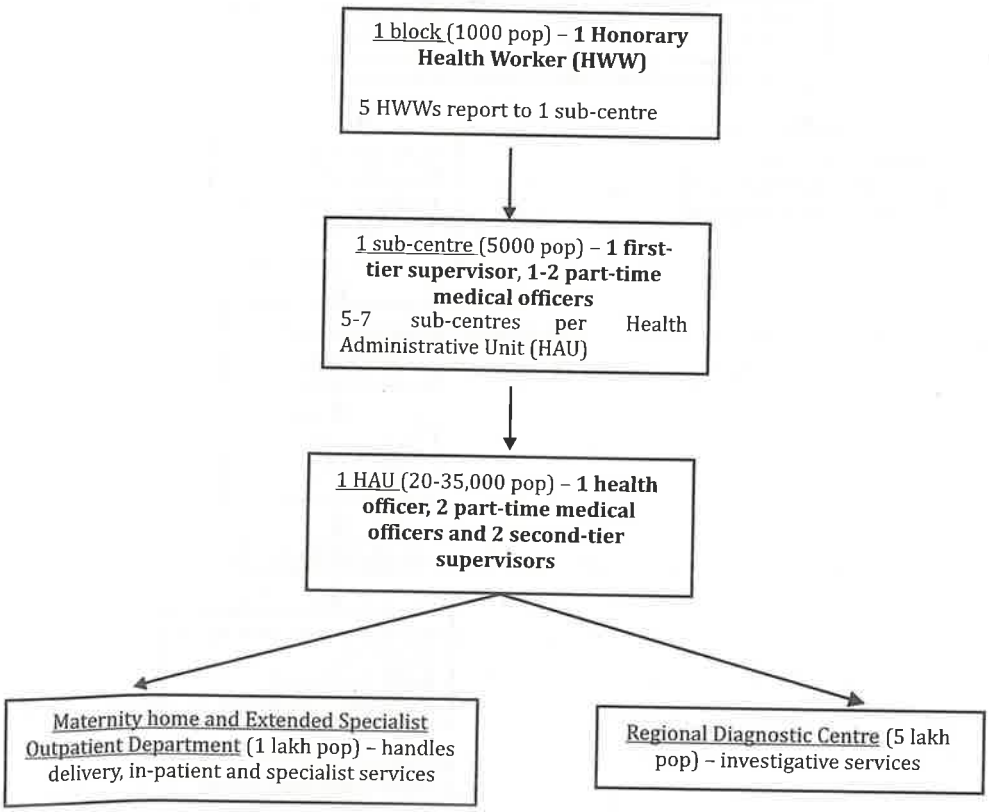
[29] Price-Waterhouse Coopers and Action Aid India, (2004)

KMDA Health Structure: Administration and Governance



The following diagram gives details of the Honorary Health Worker (HHW) programme in urban slums of KMA municipalities:

The KMDA health structure



Details of each Facility/Level of Care:

A. Blocks: Each block is an area serviced by the Honorary Health Worker (HHW). Each block has approximately 1000 population. There are in all 5585 blocks in KMDA area. Note this 1000 population is selected to include the poorest but also to be geographically contiguous.

B. Sub-centre: A cluster of 5 HHWs are linked to a sub-center which caters to a population of 5000 and which has a first-tier supervisor and a part-time medical officer. The total of 1097 Sub-centers spread over the 40 muncipalities are, in turn, linked to 174 Health Administrative Units (HAUs).

C. Health Administrative Unit: One Second Tier Supervisor, one part-time medical officer, one assistant health officer and one health officer are located in the HAU. It serves a population of 35,000. There are currently 174 HAUs.

Infrastructure available under the HHW programme:

A. The Maternity Hospitals: There are 25 Maternity Homes created under the three programmes to promote institutional delivery and provide for safe abortion services and emergency obstetric care. These act as referral centres to the HHW programme. Each maternity home is manned by three specialist doctors, two medical officers, three nurses, four ayahs and one laboratory technician cum storekeeper. There are considerable variations from this norm -based on local needs and decisions. They are operational in 23 ULBs.

B. The ESOPDs (Extended Specialised Out-Patient Departments): 35 of these have been created for referral for complicated cases from the HHW system. Each ESOPD has 8 specialist doctors, 2 part time medical officers, one nurse, one laboratory assistant, one pharmacist cum storekeeper, 2 attendants and 2 sweepers. This is often in the same premise as the maternity home but such is not necessary and there are separately placed clinics also. In patients are referred to the state health system hospitals or sometimes- more as an informal arrangement, admitted in the maternity homes. These are operational in 35 ULBs

C. Regional Diagnostic Centres: These are operational in 8 ULBs- usually but not necessarily located as adjuncts to the ESOPDs. They offer a set of pathological, radiological ,bio-chemical and micro-biological services. Each RDC is manned by one administrative management professional, one radiologist, one pathologist, one sonologist, 3 technicians cum radiographers, one cashier cum clerk and 2 sweepers.

Strengths of the programme

The main achievements are the remarkable improvements shown since the base line figures of 1992.

Health Indicators in Kolkata - 1992 versus 2002

Indicator	Baseline (1992)	Last Evaluation (2002)
Crude birth rate	19.6	14.8
Crude death rate	5.91	4.0
IMR	55.6	23
Immunisation coverage (measles)	54	90.0
Institutional deliveries	53.9	95.6
Antenatal care	NA	96.0
Couple Protection Rate	NA	71.6
Beneficiaries aimed to cover	3.8 million	3.72(98% achievement)

This remarkable achievement seems to have been achieved largely by the HHWs having been able to catalyze a major change in health seeking behaviour. In the community, there is not only an acceptance but a demand for services such as institutional delivery, contraceptive services, emergency care, maternal and child care - and this demand has been almost universally established, even in the poorly - serviced areas and in most marginalized sections. Prompt referrals are the most important component of this success - with anyone requiring these services being urged to seek appropriate care in the state government hospital, in the ULB-run secondary services or in the private sector - in that order of frequency.

Immunization and contraceptive services have also reached a near universal outreach. A noteworthy outcome of this programme is the establishment of a chain of rate- fixed, high quality secondary referral centres run by the Urban Local Bodies supplementing resources from its own funds and with minimal dependence on external funding. Very few ULBs anywhere in the country have been able to emulate this level of hospital care. The high degree of decentralization associated with this programme has led to the character of governance being characterized by a significant level of ownership, accountability and political willingness. The Health and Family Welfare Committee of the municipality is the decision-making authority, responsible for monitoring and implementation of the programme. Within this body, there is considerable decentralization in administration and financial matters. ULBs make the recruitments, select the beneficiaries, procure the drugs and supplies and are potentially free to form their own plans of action.

Challenges within the programme

In the process of the evolution of the programme over the decades, certain challenges have arisen. Many of these current limitations flow from the very selective nature of "target beneficiary identification" - thus, the poorest fall through the gaps due to exclusion from services. In addition, the goal of comprehensive health care has become substituted with only RCH services, and within this, only a limited sub-set of RCH services. Moreover, the manner in which these limited RCH needs are satisfied often mean there is considerable out-of-pocket expenditures and consequent exacerbation of poverty levels. Additionally, quality of care and community participation remains particularly weak areas.

3. Health Services in Delhi

The Public Sector

Delhi government implements its health activities through the Department of Health and Family Welfare. This department has three directorates under it: Directorate of Health Services, Directorate of Family Welfare and the Directorate of Indian System of Medicines. The Department of Health & Family Welfare of Government of NCT of Delhi is headed by the Principal Secretary. S/he coordinates on behalf of the

Government of NCT of Delhi with the Ministry of Health & Family Welfare, Government of India at the Centre. S/he is the controlling authority for all agencies providing health services.

There are multiple state agencies providing health services in Delhi at the primary level of care and also at secondary and tertiary levels. The agencies include: Directorate of Health Services, Directorate of Family Welfare; all large Hospitals under Government of NCT of Delhi; autonomous Bodies under Government of NCT of Delhi providing medical care, Delhi AIDS Society, Centralised Accident and Trauma Services (CATS); Directorate of Food Adulteration; Drug Controller and other National Health Programmes. The Health & Family Welfare department has to liaison with all other local bodies - MCD, NDMC, Cantonment Board and other Government and Non Government health care facilities functioning in the State of Delhi.

This however has also resulted in overlapping of services and since these agencies are controlling authority for the dispensaries and hospitals under them there is vertical and horizontal segregation and lack of coordination with other agencies. The various state agencies with health facilities in the NCT of Delhi are: The Directorate of Health Services and Family Welfare, Directorate General of Health Services (DGHS), Municipal Corporation of Delhi (MCD), New Delhi Municipal Council, Central Government Health Scheme (CGHS), Employees State Insurance Corporation (ESIC for factor employees), Autonomous Bodies (6 autonomous public hospitals) have health facilities. The Directorate of Health Services is supposed to coordinate the work of all state agencies that provide health services. Other government agencies like the *Delhi Cantonment Board* has three hospitals and one Polyclinic for the defense personnel, *Northern Railways; Delhi Jal Board; Delhi Transport Corporation; the Reserve Bank of India; the State Bank of India and the Social Welfare Board* also have few hospitals and dispensaries under their jurisdiction.

Compared to other states, Delhi as a whole has a well developed health infrastructure. Delhi Government and the Municipal Corporation of Delhi (MCD) form the backbone of the public health service delivery system in the city providing most of the health services in the public sector. Private health providers too are key players in the overall provisioning of the care services. At the primary health care level, Delhi has a wide network of 987 clinics and dispensaries providing primary health care through Delhi Government, three local bodies (MCD, the New Delhi Municipal Committee and the Delhi Cantonment Board) and central agencies (including CGHS, ESIC and Railways).

The IPP-VIII was implemented in Delhi from August, 1994. Under this project the MCD has opened several Maternity Homes, Health Centres and Health Posts to improve maternal and child health care, as well as family planning services. The funding for this project from the World Bank has ceased and the facilities created under the programme are now being managed by the MCD.

At the secondary and tertiary health care levels, there are 706 hospitals including 550 registered nursing homes with 33,711 beds. There are 118 hospitals in the Govt. sector in Delhi. 31 hospitals are being run

by the Govt. of NCT of Delhi, 53 by the MCD, 4 by the NDMC. There are also 24 Central Government Hospitals including ESIC, Railway Hospitals etc. Delhi's bed-population ratio is 2.07 beds per 1000 population which is better as compared to the national average of one per 1000. The Delhi State Health Mission would function under the chairmanship of the Chief Minister. In May 2007, the Cabinet of the Delhi Government approved the deployment of 5,450 ASHAs to cover 109 lakh residents of slums, JJ cluster, resettlement colonies, unauthorized colonies and rural villages.

Agency-wise distribution of beds

	Agencies	No. of units	Beds
1	Delhi Government	19	5475
2	Directorate of Health Services	14	900
4	MCD (Maternal and Child Welfare)	23	301
5	MCD (Health)	30	3673
	MCD (IPP-VIII Maternity Homes)	6	90
6	NDMC (Health)	4	220
7	CGHS	5	126
8	DGHS	6	3727
	AYUSH Department	2	100
9	ESIC	4	1220
10	Autonomous/Statutory Body	6	2496
11	Northern Railway	2	466
12	Delhi Cantonment Board	3	1855
	Total public	**124**	**20649**
13	**Private (Profit/Non-profit)**	**562**	**12381**
	Total public and private	**686**	**32760**
	% beds in public sector		63.03
	% beds in private sector		37.79

Source: Directory of Health Services, 2006

At the tertiary level of care a new scheme called the Arogyanidhi was launched recently to cater the BPL population for catastrophic illness.

Delhi Arogyanidhi

Arogyanidhi is a State Illness Assistance Fund, which provides financial assistance to the poor patients who are suffering with life threatening disorders for their treatment in the Government Hospitals. The fund is managed by the Society known as Delhi Arogya Nidhi (DAN). The Society is registered under the Society Registration Act, 1860.

The eligibility criteria for this are that the patient should have a domicile proof of residing in Delhi since January 2007; should be below poverty line; treatment should be from government hospital; and that the patient should be suffering from a life threatening disease. The application is to be submitted to the office of Chief Medical Officer (Delhi Arogya Nidhi) with proof of continuous residence in Delhi since 2007 to date with either Ration Card or Electoral Voter's Photo Identity Card (in case the patient is a minor Birth Certificate). The photocopies of these documents to be attached and original to be brought at the time of submission of application form for verification. Estimate Certificate about the expenditure to be incurred on the treatment at a Govt. hospital duly signed by Consultant/ Medical Superintendent/ Chief Medical Officer of the Hospital has to be submitted in original. A copy of BPL Ration Card has to be submitted and in case BPL Ration Card is not available an Income Certificate issued by area SDM has to be submitted in original certifying that the family's income is up to Rs. 24200/- per annum.

After this all the applications received are periodically examined in the Governing body meetings and decision is taken on them. Cheques are issued directly to the hospital for those patients whose cases are approved.

There have been several new programmes that have been started. There has been a move to converge activities of various departments and the focus is on urban poor.

Mission Convergence

The Government of NCT of Delhi (GNCTD) in a new development is committed to improving the quality of life of its citizens especially the most vulnerable and disadvantaged sections of society. To this end the State Government has decided to undertake a Mission Mode project to develop a convergence model for the State. To achieve this vision, the Government of Delhi has created Samajik Suvidha Sangam, registered as a Society for effective implementation of the objectives of the Mission convergence.

The initiation of the Mission aims at convergence of various departmental efforts for bringing about positive change in the lives of the urban poor communities. It is the intention of Government of National Capital Territory of Delhi to spend all available resources for the betterment of the urban poor.

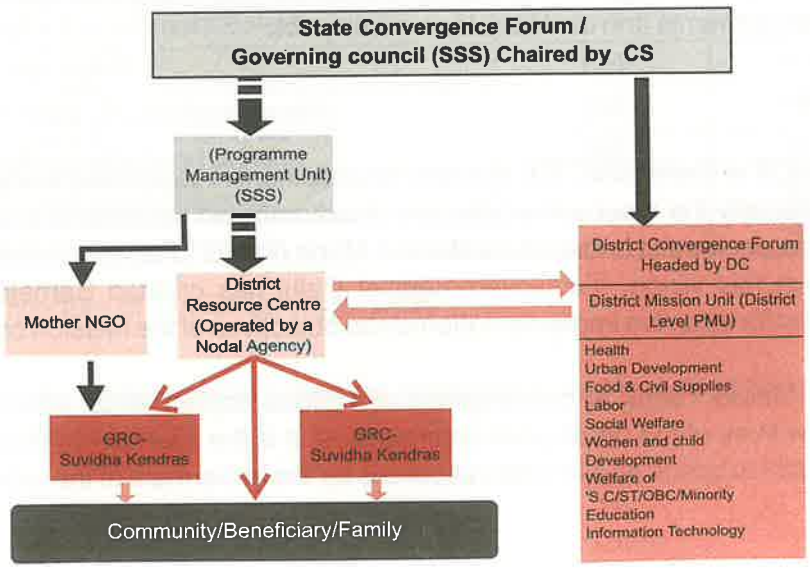
To operationalize the convergence mission the specific objectives are to:

- Enhance the visibility of social sector/welfare entitlement schemes to all targeted communities.
- Enhance the control/influence of the community/service recipient over these schemes.
- Strengthening the computerized uniform database thus created will generate an unique ID for each individual covered under the survey with respect to their families. Hence, this unique ID will be the new identity of the individuals to access their entitlement benefits from the government schemes. The database so generated also helps the Government to plan for its social policies with realistic estimates of numbers, needs and geographic spread. The Organizations / Structures (DRC/GRC-SK/Government Line Dept) and its processes related to prompt service delivery.
- Incentivize and reinforce appropriate mechanisms for receiving/providing services.
- Development of robust IT enabled MIS system for real time monitoring and tracking.

The mission will be achieving its goals by improving the key indicators as mentioned in the Delhi Development Goals:

Goal 1: Eradicate extreme poverty and hunger
Goal 2: Achieve universal elementary education
Goal 3: Promote gender equality and empower women
Goal 4: Reduce child mortality
Goal 5: Improve maternal health
Goal 6: Combat HIV/AIDS, malaria and other diseases
Goal 7: Ensure environmental sustainability
Goal 8: Strengthen Bhagidari

Institutional Structure



Features of Mission Convergence

Institutional Innovations:

Strengthening the community node at the base, the Gender Resource Centres (GRCs), already involved in livelihood and women empowerment activities, have become augmented community nodes with an increase both in their numbers (from 44 to 70), as also the quality of support they render to the Mission. Their role includes a transition to becoming a Samajik Suvidha Kendras (SSK) reaching out to the vulnerable, and facilitating the process of easy delivery of social services forunit of 20000 households. The Samajik Suvidha Sangam are registered autonomous societies and main facilitating agency for the Mission Convergence for the different departments who currently operate various entitlement schemes and a interface between departments, DCs office and Nodal Agencies and Field NGOs. With the integration of SSS the scope of work, as well as the responsibilities of the GRCs, have increased. The GRC-Suvidha Kendra have to look after the needs of the whole family, children, adolescents, youth, senior citizens, differently abled, etc., besides women who are already covered under GRCs. There has to be special emphasis on the most vulnerable people like the homeless, women and children headed families, families involved in certain trades like rag pickers, sex workers etc. NGOs role will include direct intervention through the existing GRC components like Health, Nutrition, Non-Formal Education training, Formation of Self Help Groups, Nutritional awareness etc and facilitator role like creating awareness about government entitlements and empowering them to come to SSKs to avail the benefits. The GRC-Suvidha Kendra is true convergence and facilitation center at single window and becomes the first interface for the people of the community.

These platforms are being provided with adequate community outreach support by giving a structure of one area. Area Volunteers for Tertiary Accessibility of Resource (AVTAR) for a unit of one thousand households. This structure would enable regular update of the database and improve the access of the vulnerable population to the different schemes of the govt. and other development initiatives.

Strengthening the Districts the District machinery has been strengthened for implementing developmental programmes by bringing administrative convergence at the Deputy Commissioner's level. A District Convergence Forum has been constituted as an apex empowered committee for bringing effective convergence and monitoring of the delivery of social sector schemes in the areas of Health, Education, Social Security and Livelihood.

The nodal officers from respective line departments will be functionally reporting to DCs, thus ensuring accountability to the District Convergence Forum headed by the DC. In order to help the DCs

in carrying out the functions, District Mission Units have been set up comprising of a combination of the contractual employees attached to the DC and a District Nodal Agency. District Resource Centre's (DRC) have been setup which will be operated by these nodal NGOs/agencies. The DRC will work with GRCs - Suvidha Kendras and the relevant departments at the district level for enabling the citizens to avail their entitlements.

E-Governance initiatives:

To address issues of lack of transparency, lack of information, duplication of efforts etc., mechanisms of service delivery is being strengthened through 3 channels:

- A computerized uniform data bank that involves digitization of manually recorded data of various departments; and digitizing survey data to identify additional potential beneficiaries based on the new criteria. The computerized uniform database will not only helps the Government to plan for its social policies with realistic estimates of numbers, needs and geographic spread but will generate an unique ID for each individual covered under the survey with respect to their families and a new identity to access their entitlement benefits from the govt. schemes.
- A computer system at each delivery point connected to one server: Each of the GRC's and DRC's are e-enabled and connected to one server, so as to facilitate and expedite delivery of scheme related service.
- A unique biometric e-benefit smart card for all potential beneficiaries to make identification easier and instant access leaving less room for error

Entitlements involving direct cash transfers like old age pension, widow pensions and student scholarships will be directly transferred to the individual's bank account. Besides ensuring transparency, this will be new attempt for financial inclusion of poor. The use of Information and Communication technology at all possible levels and processes is envisaged to create an e-governance model that can bring in transparency, efficiency and quality standards in service.

Monitoring and evaluation:

Mission Convergence will have an effective system on concurrent monitoring and evaluation system in place for regular reviews and impact assessments. This would help in midterm corrections and take quick remedial actions. Apart from regular M&E system there would also be a Third Party Independent Monitoring and Evaluation of the program implementation. Two Mother NGOs, namely Modicare & SOSVA (N) have been engaged for an ongoing monitoring and regular review over the activities of GRC-Suvidha Kendras. At district node the District Nodal NGO/DRC has been set up for handling grievances and for random checking of identifications/verification done by the GRC-Suvidha Kendra.

The Private Sector in Delhi

The Directorate of Health Services registers allopathic private bedded facilities (nursing homes and hospitals) under the Delhi Nursing Home Registration Act, 1953. The number of private nursing homes also shows a drastic increase. In 1993 there were only 130 registered nursing homes compared to the 1070 unregistered ones.[30] The directorate has registered 562 nursing homes/hospitals in the year 2005 and they claim that around 1,560 are not registered. In terms of numbers another 1000 nursing homes/hospitals (registered and unregistered) have established themselves in the last decade which has been the direct result of the subsidies given by the government as part of the reform process and the increased commercialisation of the health services sector. The public sector has always provided more number of beds as the larger institutions is public and there are many small private institutions. The total bed capacity of the 1560 unregistered private facilities is 5000, thus on an average the institutions have 3-4 beds. The table below gives the distribution of health facilities by bed and shows that there is a larger concentration of small-bedded facilities in the private sector. The government partners with the private hospitals at the tertiary levels by giving subsidies to them in land and equipments. The condition attached to these subsidies is that the hospitals would provide a certain percentage of services (out-patient and in-patient) for free to the poor but this is seldom complied.

Distribution of health facilities by number of beds

	1-4	5-10	11-20	21-35	36-50	51-100	101-250	>250	Total
Public		15	31	13	6	16	6	20	107
Private	66	265	122	56	21	14	12	8	564

Source: compiled from Directory of Health Services, 2006; DHS

A high level commission (Qureshi Committee) set up by the Government of NCT of Delhi in 2000 to study private hospitals in Delhi gives insights into the working of some eighteen private hospitals (for-profit and non-profit). Many of these institutions were given land at concessional rates by the government. The enquiry was commissioned to cover all aspects of functioning of these hospitals that included management and administration, costs of care, whether conditionalities are being fulfilled and percentage of poor patients are getting treated free of cost and conditions of workers in these hospitals. The study showed that several hospitals in Delhi had been given land almost free. It revealed that the existing free treatment facilities extended by charitable and other hospitals, who had been allotted land on concessional terms is extremely low. Number of hospitals said that they could not comply with the conditions of providing free treatment as it affected the financial viability of the hospitals. They argued that the cost of medicines and medical consumables were very high and it

[30] Nanda and Baru, 1993

was not possible to provide totally free services to even 10-15 percent of in-patients. DDA felt that there was a need for transferring those registered as 'trust' or under 'companies act' to 'society' to claim land from DDA. There have been certain contradictions and aberrations in this regard by some hospitals as claimed by DDA. Four detailed case studies were carried out with four hospitals that were allotted rates at concessional rates but had violated the original purpose. The study was difficult and majority of the hospitals did not comply to the questionnaire while the ones who did give information were not completely open thus proving that conditionalities were not being fulfilled.
Government of NCT of Delhi, 2002

We have looked at health services delivery structures in the three big cities of India. We can visualize the different approaches at work and the multiple agencies. If we desire some uniformity in the health services in urban areas what would it be like? We first look at what the NUHM draft proposes and then pose some ideas and recommendations as to what could be the possible structures in place.

WHAT DOES THE NATIONAL URBAN HEALTH MISSION (NUHM) PROPOSE?

The draft NUHM proposed to meet health needs of the urban poor, particularly the slum dwellers by making available to them essential primary health care services. This would be achieved by investing in high-calibre health professionals, appropriate technology through PPP, and health insurance for urban poor. Recognizing the seriousness of the problem, urban health was to be taken up as a thrust area for the Eleventh Five Year Plan. NUHM is now to be launched in the Twelfth Five Year Plan.

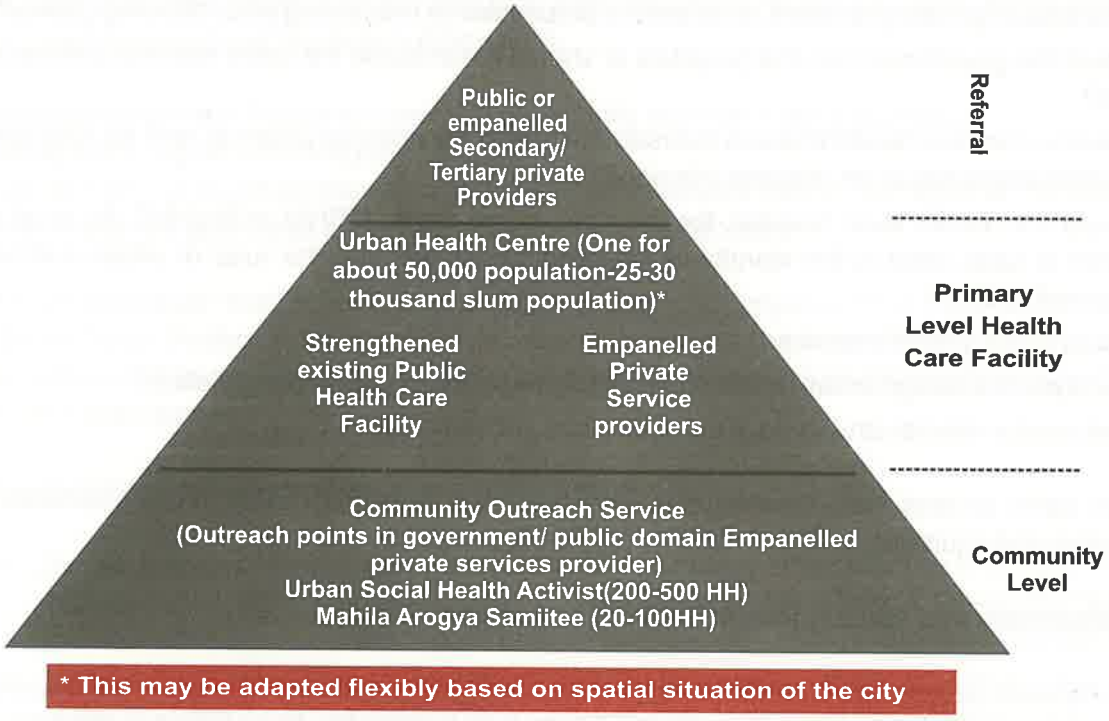
At the State level, besides the State Health Mission and State Health Society and Directorate, there would be a State Urban Health Programme Committee. At the district level, similarly there would be a District Urban Health Committee and at the city level, a Health and Sanitation Planning Committee. At the ward slum level, there will be a Slum Cluster Health and Water and Sanitation Committee. It will seek to build a bridge of NGO-GO partnership and develop community level monitoring of resources and their rightful use.

NUHM proposes to ensure the following:

- Resources for addressing the health problems in urban areas, especially among urban poor.
- Need based city specific urban health care system to meet the diverse health needs of the urban poor and other vulnerable sections.
- Partnership with community for a more proactive involvement in planning, implementation, and monitoring of health activities.
- Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.

- Framework for partnerships with NGOs, charitable hospitals, and other stakeholders.
- Two-tier system of risk pooling: (i) women's *Mahila Arogya Samiti* to fulfill urgent hard-cash needs for treatments; (ii) a Health Insurance Scheme for enabling urban poor to meet medical treatment needs.

The proposed National Urban Health service delivery model would make a concerted effort to rationalize and strengthen the existing public health care system in urban areas and promote effective engagement with the non governmental sector (for profit/not for profit) for better reach to urban poor, along with strengthening the participation of the community in planning and management of the health care service delivery. All the services delivered under the urban health delivery system will be based on identification of the target groups (slum dweller and other vulnerable groups); preferably through distribution of Family/ Individual Health Suraksha Cards.



NUHM would cover all cities with a population of more than 100,000. It would cover slum dwellers; other marginalized urban dwellers like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, and street children, construction site workers, who may be in slums or on sites. The existing Urban Health Posts and Urban Family Welfare Centers would continue under NUHM. They will

be marked on a map and classified as the Urban Health Centers on the basis of their current population coverage. All the existing human resources will then be suitably reorganized and rationalized. These centres will also be considered for upgradation. Intersectoral coordination mechanism and convergence will be planned between the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and the NUHM.

WHAT HEALTH SERVICES/DELIVERY STRUCTURES COULD BE IN PLACE? SOME RECOMMENDATIONS

The existing urban health scenario throws up several dilemmas with regard to health care provisioning. Due to multiple agencies operating in urban areas, there is fragmentation of service delivery and accountability and a problem of overall governance. Some critical questions are:

- Where does the planning for urban health happen? - In municipal bodies or state health departments
- In the case of private providers, what are the processes for monitoring and enforcing quality?
- Should the government run the hospitals or should it reimburse the costs spent on private health care?
- Should a common health mission oversee the health services for urban as well as rural areas or should there be separate, discrete missions?
- Should the district level hospital, for example, come under NRHM or NUHM? As most of the district is rural, what is the identity of the district hospital? Will the rural or urban authority be responsible for it?
- Should primary health services be completely with the municipality?
- How does one design urban health services for towns below one lakh population?
- What are the referral structures at the secondary and tertiary level?

There have been several recommendations and proposals to make urban health services more comprehensive and equitable.

Primary, Secondary and Tertiary Health Delivery Structures: The Options

The health services needed could be discussed as happening at four levels. One is the community level which includes outreach activities and preventive and promotive health. The second is the ambulatory (outpatient) level medical consultation. The third is the secondary level - the first referral level or most peripheral point of hospitalisation. When we say primary health care we usually mean all three levels taken together. Above this is the tertiary level care.

In the provision of *community level services* we need:

a. Health workers and nurses going to convenient outreach points where intervention is done, ante-natal care is provided. It is not essential to envisage an outreach service point where the primary health care facility is nearby. It is also not necessary to envisage a sub-centre building, though it is essential to put in place at least one nurse-midwife (ANM) for every 5000 population.

b. We also need health workers preferably nurses making home visits. To some sections this is essential because people cannot or will not access services during working hours. All sections need this for health consulting and health promotion. It is also needed for health surveillance. Home visits can be done by health workers who have a 1000 population under them like the ASHA.

c. We also need health workers who look after vector control programmes, investigate epidemics, and they can be at larger population units.

A municipality has two choices on how such community level services is provided:
a. it could hire a regular staff and pay them
b. it could hire a non-governmental organisation or a suitable health management agency to provide these services in a given area for an allotted number of households.

Both have been tried - the former Kolkata (KMDA) is a good example (refer to previous section on KMDA) and in the latter Andhra Pradesh and Assam are examples. It is worth noting that the KMDA model sustained over 30 years, whereas, the outsourced models are given to cyclical collapses and resurrection over 3 to 5 years period.

Ambulatory medical care could be provided in two ways:

a. By the outpatient clinics of a municipality run dispensary / hospital. The only condition for it to be effective is that it should also work in evening hours. A doctor visiting a sub-centre has little to offer over what the trained worker could provide in outreach services. But in the out-patient time of a hospital the entire range of diagnostics would be available. However, since it is primary health care, providing it out of a tertiary care centre is time consuming for the patient and it overcrowds the hospital. It has to be either a well organized secondary care centre or a PHC. Example: The National Health Service in UK has General Physicians who are the first point of contact for the patients and they have their out-patient clinics from where patients are referred if necessary.

b. The second way is that it could also be provided by attaching each patient to a local doctor doing

private practice. For each patient so attached, the doctor gets a flat fee, plus a payment for every patient seen. The patient gets a cashless service, though one could have a token consultation fee. The patient would have a limited choice of doctors to choose from. This has not been tried in India and it would be a challenge to administer but could be a formal form of PPP for outpatient care. Most insurance programmes as we know do not cover outpatient care at all.

There could be three options for providing hospitalisation services:

a. Government/municipality run hospitals at the secondary level and at the tertiary level the hospital is the one attached to the medical college. District medical colleges need to be set up to provide all possible services at the tertiary level.

b. Partnerships - there are several models of partnership now available at the secondary and tertiary level across states. Partnerships could be in provisioning and recruitments for clinical and non-clinical services

c. Insurance - there are several insurance models supported and initiated by the government to cover in-patient services. RSBY is the recent most initiative that attempts to cover BPL population. Can such a model be extended to the urban poor?

RSBY

A lot of health insurance schemes have been launched in the recent past, with Rashtriya Swasthya Bima Yojana (RSBY) being the most important one, announced in the Union Budget 2007-08. RSBY launched in October 1, 2007, provides coverage to workers in the unorganized sector who come in the category of Below Poverty Line (BPL) and their families are covered under the Scheme. The scheme also has a provision of smart card to be issued to the beneficiaries to enable cashless transaction for health care. Total sum insured is Rs. 30,000 per family (for 5 members) per annum with Government of India contributing 75% of the annual estimated premium amount of Rs. 750 subject to a maximum of Rs. 565 per family per annum while State Governments are expected to contribute the remaining 25% of the annual premium as well as any additional premium. The cost of smart card is borne by Central Government. RSBY scheme intends to cover an estimated 60 million BPL families (300 million persons) in 600 districts of the country are targeted for coverage by 2012-13.The beneficiary has to pay Rs.30 per annum as registration/renewal fee.

The benefit package of the scheme covers the unorganized sector worker and his family (unit of five) on a family floater basis. The scheme covers all preexisting diseases and cashless attendance is provided to all covered ailments using a unique smart card. The scheme also provides for provision

for pre and post-hospitalization expenses for one day prior and 5 days after hospitalization. Transportation costs are also reimbursed within an overall limit of Rs.1000.The benefits of the scheme can be availed from public as well as empanelled private hospitals.

RSBY scheme is implemented in selected districts by state governments through a concentrated effort of various departments comprising of labour, health and family welfare and rural development and many states have formed state nodal agencies for implementing this scheme. After the identification of the Districts to be taken up in a particular year, the State Governments are required to select one or more health insurance service providers on a periodic basis according to a tender process which would take account both the price of the insurance package and technical merit of the proposal. The tender is open to both public and private insurers who meet the standards fixed by Insurance Regulatory Development Authority (IRDA).The selected insurance company has to have back to back arrangement with (a) Health service providers (b) Smart card service providers (c) Third Party Administrator (TPA). Only such health service providers are empanelled by the insurance company who are able to meet the predefined selection criteria. The hospitals have also to agree to a predetermined package of medical and surgical procedures and the costs and no preauthorization is required in case of predetermined packages. Currently the scheme has covered over 17 million households comprising 80 million people across 22 states of India. Union budget for 2010-11 extended the RSBY scheme to NREGS workers, ASHA and many other categories of workers. One unique model of the RSBY scheme is being implemented in the State of Kerala and this is called the "Comprehensive Health Insurance Scheme". Under this scheme all the secondary and tertiary level hospitals in the public sector are listed as empanelled providers along with the private sector. The money flows back to the public sector and money received from the insurance companies are deposited in a separate bank account started by Rogi Kalyan Samitis for RSBY/CHIS. The payments are retained at the facility level and 75% of the insurance amount is earmarked as RKS share and the remaining 25% earmarked as the incentive share to all health functionaries at the hospital level. The RKS can use insurance funds along with the National Rural Health Mission funds for equipping the hospital to provide better quality health services.

Many state governments have also initiated various social protection schemes for the BPL population and unorganized workers and some of the notable schemes are - Arogyasri (Andhra Pradesh, for high-end medical and surgical procedures), Kalianger scheme for life-saving treatments (Tamil Nadu), Suvarna Arogya Surakhsa Scheme (Karnataka).

The extension of health insurance schemes as a part of social protection mechanisms for the poor and marginalized sections raises some concerns also. One major issue is regarding the benefit package and coverage of these schemes. Presently RSBY and other schemes like Arogyasri

provide cashless cover for predetermined procedures which are of secondary and tertiary nature. But the recent studies based on consumer survey conducted by NSSO reveals that out-patient care and expenditure on drugs forms the bulk of out-of pocket expenditure incurred by households and presently our schemes are not covering this expenditure. The studies also highlight the fact that non-hospitalization expenditure has greater impoverishing effect and 3.8 percent of households in urban areas fell below the poverty line due to out-patient care expenditure whereas the corresponding figure for in-patient care was 1.2 percent. Moreover the exclusion of OPD services by this scheme can lead to moral hazard which is typical of many pre-payment schemes as there is every incentive for the provider to convert these into inpatient services. In this context the "Mukhya Mantri Jeevan Raksha Kosh"-MMJRKS scheme in Rajasthan can be tried as a model in urban settings. Under this scheme government provides direct support to Rogi Kalyan Samitis for providing free IPD/OPD health care to all BPL families including the referral services. This scheme covers the expenditure of drugs and diagnostics related to both outpatient and inpatient care to BPL patients accessing any government facility from primary health care centers to tertiary hospitals.

Further the subsidized insurance schemes incur many governance issues due to the absence of adequate monitoring mechanisms. There is every chance of overbilling and unnecessary procedures being done due to the absence of regulatory mechanisms, treatment protocols and quality standards. There is no incentive for the provider or the intermediary to cut cost as most of these schemes, the premium is borne by the government on behalf of the beneficiary. Moreover, many poor households are not aware of the services which can be accessed through these schemes due to lack of awareness about the scheme. The impact and role of public sector is very crucial for any social protection scheme for urban poor as affordable primary care services can reduce the catastrophic expenditure to a great extent.

The RSBY limits coverage till Rs 30,000 but there are instances where poor are covered for catastrophic illness under another insurance scheme as mentioned above. This is seen in the case of *Arogyanidhi* in Delhi (mentioned in the previous section) and Arogyasri in Andhra Pradesh.

Preliminary findings on a recent study conducted by PHRN on RSBY in Chhattisgarh showed that awareness about the scheme was relatively high though information on empanelled institutions and the process was limited. There was lack of information on empanelled private hospitals. Out-of-pocket expenditure was higher in private hospitals and expenditure was incurred for drugs and diagnostics. The areas of concern raised in the study were: enrolment rate was less; utilization rate is low; claims ratio is adverse and lack of awareness on choices available; out-of pocket expenditure is still high and high percentage of false claims made by institutions. These are some critical issues that need to be addressed at the larger level.

Aarogyasri for catastrophic illness

The government of Andhra Pradesh in an effort to assist the Below Poverty Line families (BPL) has decided to introduce health insurance for treating life-threatening diseases. In order to facilitate the effective implementation of the scheme, the Government has set up Aarogyasri Health Care Trust. The trust in consultation with the specialists in the field of insurance and medical professionals has devised a tailor made insurance scheme - The Rajiv Aarogyasri Community Health Insurance Scheme and is being implemented since April 2007.

The scheme provides financial protection to families living below poverty line up to Rs. 2 lakhs in a year for the treatment of serious ailments requiring hospitalization and surgery. 330 procedures are covered under the scheme. The scheme is being implemented through Insurance Company, selected through a competitive bidding process. The objective of the scheme is to improve access of BPL families to quality medical care for treatment of identified diseases involving hospitalization, surgeries and therapies through an identified network of health care providers. The scheme provides coverage for the systems like Heart, Lung, Liver, Pancreas, Renal diseases, Neurosurgery, Paediatric Congenital Malformations, Burns, Post-Burn Contracture Surgeries for Functional Improvement, Prostheses (Artificial limbs), Cancer treatment (Surgery, Chemo Therapy, Radio Therapy), Polytrauma (including cases covered under MV Act) and Cochlear Implant Surgery with Auditory-Verbal Therapy for Children below 6 years (costs reimbursed by the Trust on case-to-case basis). All the pre existing cases of the above mentioned diseases are covered under the scheme. The beneficiaries of the scheme are the members of below poverty line (BPL) families as enumerated and photographed on the Rajiv Aarogyasri Health Card/ BPL Ration Card. The benefit on family is on floater basis i.e. the total reimbursement of Rs.1.50 lakhs can be availed of individually or collectively by members of the family. An additional sum of Rs 50,000 is provided as buffer to take care of expenses if it exceeds the original sum i.e. Rs 1.50 lakhs per Individual/Family. Cost for Cochlear Implant Surgery with Auditory-Verbal Therapy is reimbursed by the Trust up to a maximum of Rs.6.50 lakhs for each case. The transaction is cashless for covered procedures. BPL beneficiary can go to hospital and come out without making any payment to the hospital for the procedures covered under the scheme. The same is the case for diagnostics if eventually the patient does not end up in doing the surgery or therapy. Hospitals have to conduct at least one free medical camp in a month, there by taking advanced evaluation to the doorstep of patient. All the Primary Health Centers (PHCs) which are the first contact point, Area/District Hospitals and Network Hospitals, are provided with Help Desks manned by Aarogyamithras to facilitate the illiterate patients. The Aarogyamithras were selected by the Mandal Samakhyas under Indira Kranti Patham (Self Help Group Movement).

Rajiv Aarogyasri Community Health Insurance Scheme (Aarogyasri-II)

Since July 2008, the government of Andhra Pradesh has launched, the Aarogyasri-II scheme, to

include a large number of additional surgical and medical diseases to enable many more BPL people who are now suffering from acute ailments, to lead a healthy life.

Aarogyasri-II scheme is an extension of the ongoing Health Insurance Scheme. The front end of the ongoing scheme viz. network hospitals, Aarogyamithras, Health Cards etc., will remain the same. Only difference would be that the preauthorization and claim processing for the new diseases would be done by the Trust directly and funded from the Chief Minister relief fund (CMRF). 30 groups of eminent doctors from the Government and corporate hospital sectors have through a series of discussions and in consultation with the managements of corporate hospitals finalized a list of 389 surgical and 144 medical diseases and also evolved package rates for its cashless treatment.

With the launch of Aarogyasri-II, cashless treatment of BPL population for all major diseases will become possible in Government/Corporate hospitals. Diseases covered under ongoing Aarogyasri-I and those proposed to be covered under Aarogyasri-II are complimentary to the facilities available in Government hospitals and put together substantially meet the medical requirement of general population. To the extent the scope of Aarogyasri-I is enlarged by Aarogyasri-II, it would no longer be permissible for the BPL population to approach the Government for providing relief for medical purposes from the CMRF.

Source : www.aavogyasri.org

The delivery structure therefore could have various combinations to have a comprehensive structure. The options:

1. A Public delivery Structure

Community outreach + Out-patient = Government
Hospitalization at secondary and tertiary = Government

2. Public-Private Mix and Insurance

i. Community outreach + Out-patient = Government
Hospitalisation = Insurance/PPP

ii. Community outreach = Partnership with NGOs
Out-patient = Government
Hospitalization/in-patient = Insurance

Overall, it is clear that urban health care services should be structured in such a way that they are comprehensive and reach out to everyone especially the urban poor. The government has to actively plan and strategise the delivery structures so that they are made available with effective referrals. The delivery

models will vary catering to size of the town and the city. While partnerships may work in some contexts it may not in others. So the existing health services in a city needs to be taken in to account before planning a comprehensive delivery model.

We use the following recommendations that were submitted to the National Human Rights Commission (NHRC) by the Jan Swasthya Abhiyan (JSA) as a guide.

RECOMMENDATIONS TO NHRC ON URBAN HEALTH SERVICES

1. The respective roles of state government and local bodies as health service providers in urban areas need to be clearly defined. Should local bodies be confined to primary health care services only? The general trend is that local bodies are resource constrained and therefore the 'burden' of secondary and tertiary health care institutions are 'borne' by the state governments. Secondary and tertiary care institutions are/will almost as a rule be located in urban centres and also act as referral units for the general/district health services. That argument will *de facto* imply that urban local bodies confine themselves to the primary level only. Though the Bombay Municipal Corporation operates services at all level including medical colleges that is an exception than a rule and the financial health of the organisation supports such endeavours.

2. Recommendations of Committees appointed so far - Krishnan Committee, Pattanayak Committee - to rationalise and integrate existing public health agencies need to be adopted and implemented. Public health programmes operate vertically in most urban areas. Though Ward Health Units exist in some cities/towns, rarely do they deliver integrated comprehensive services. What is delivered is (as is common in the rural system also) selective primary health care or programmes in campaign /mission mode like Pulse Polio. There is a need to integrate and rationalise the manpower and services.

3. Urban local bodies, and their personnel, are oriented largely towards slum populations but to provide comprehensive and universal services they have to address the needs of all sections of the population.

4. Strengthening of Primary Level Institutions:
   - peripheral areas of towns and cities (generally populated by poorest segments) often lack institutional coverage; these areas require special attention and institutional coverage should be expanded
   - equipment and infrastructure backup should be available in dispensaries (and Primary Health Centres, wherever they exist within the municipal/corporation limits of urban areas) including provision of laboratory support and basic emergency services
   - vacant posts of personnel should be filled up, their allocation rationalized and regular attendance and performance monitored
   - the Maternal and Child Health Centres / Family Welfare Centres should provide full range of primary gynaecologic, obstetric and paediatric services; special emphasis needs to be given to institutional deliveries

- there is a need to train and integrate dais who operate in lower income groups of urban areas with the formal primary health care system
- the sub-centre network should be expanded in rural areas that should be linked to the respective PHCs, wherever PHCs exist
- public health programmes and personnel need to be reorganized/restructured and these institutions need to integrate with the local curative institutions.
- involvement of local communities (through Local Health Committees, for example) in local level planning and implementation of services; the departments of health, water, sanitation, education and social welfare should be involved and accountable to these local committees.

5. Secondary level institutions (60-100 bedded) need to be available and accessible to prevent overload of tertiary hospitals, that is almost a rule across urban centres of India. These institutions should be linked with the local primary level institutions with a proper referral mechanism. Secondary level speciality services and requisite equipment and supplies should be available. Rational prescribing practices should be implemented. Special emphasis needs to be given on environmental and occupational health problems.
6. Adequate supply of drugs and supplies, rational prescribing and clinical auditing will go a long way in making tertiary level services sensitive to the needs of the community.
7. Social security (contribution linked) services like Central Government Health Services (CGHS) and Employees' State Insurance Corporation (ESIC) should not refer patients to the corporate hospitals and instead should integrate and network with secondary and tertiary level public institutions.
8. The urban health system should be able to achieve complete notification of notifiable diseases including epidemic-prone diseases and all deaths should be medically certified. This should be achieved within a time-bound frame.
9. All level of institutions and support services like blood banks, ambulance services and hearse van services should be networked for efficient functioning and reduction of response time.
10. Birth and death registration should be integrated with these networks.
11. Licensing of health trades should be simplified and suitable computerisation models should be adopted for this purpose. There is also a need to bring licensing norms to the public domain both to reduce corruption and enable the community to have access to these information.
12. Cremation services using cheap and clean technologies like Compressed Natural Gas (CNG) furnaces should be adopted. Wherever traditional wood pyres are being used use should be made of modern designs wood-saving furnaces.
13. Grievance redressal mechanisms within each agency providing public health services.

Review Questions

1. What are the major policy decisions that have been ever taken by the government on urban health. What has been the major focus?
2. What have been the constraints in having a uniform model of health service delivery in urban areas?
3. How are the three models of public health delivery structures that have been discussed in the lesson different from one another?

Application Question

1. In your opinion why has poor priority been given to urban health policy and planning. Discuss with evidence.

Project Assignment

1. Briefly describe any urban health programme of your choice and its current implementation. Analyze its strengths and weaknesses and make recommendations for improvement.

CHALLENGES OF COMMUNITY MOBILIZATION IN URBAN AREAS

The notion of community participation was first formally introduced at the Alma Ata Conference in 1978 but still continues to capture the attention of health policy-makers around the world. 'Community participation' in health has been discussed in detail in PHRN Book number 4 and 7. The focus has been in the context of the National Rural Health Mission, as to why community participation is essential in improving health of the population and what strategies one needs to develop in order to ensure effective and sustainable community participation.

Mobilizing communities in urban areas poses some specific challenges due to the unique socio-economic conditions of urban poor as mentioned in Lesson 1. It is argued that since most of the poor in urban areas are first or second generation migrants, the social networks that exist in rural areas do not hold here. People living in the same area are many times from different regions, cultures and speaking different languages. This kind of social fragmentation makes it difficult to bring people together for any collective action.

Further, the daily struggle for access to basic services such as water and sanitation faced by the urban poor, leaves them with very little time and energy to participate in community mobilization efforts. Their questioned citizenship or legality makes them very vulnerable and reluctant to actively demand for their rights.

There is also a lot of heterogeneity among the urban poor. While many have been living in the same place for many years, in settlements organized on the basis of belonging to the same region or caste or religion etc. there are also many who are short-term migrants living close to their work places, on construction sites and on the streets. (A study by Mobile Crèches tracking children for a study on child care interventions found that 64 percent of the children migrated away from the area within six months of starting the study). Such high level of mobility among the community also makes it difficult to organize them.

Another challenge in ensuring community participation in urban areas is the absence of community spaces such as the *gram sabhas and gram panchayats*. Although under the 74th amendment, urban local bodies such as municipal councils and municipal corporations are supposed to set up ward committees this has not been done in practice in most places.

As discussed in the previous lesson there is a dense availability of numerous actors and overlap of services and there has been no comprehensive plan to put a community health worker in place by the government. Delhi has recently launched the ASHA programme with 2000 ASHAs now in communities. Most instances of community participation in urban areas are linked to work done by NGOs. There are

some examples of successful community participation in public programmes in urban areas - led by the government or NGOs - using mechanisms such as forming SHGs, ward/mohalla sabhas, local committees, appointing of ASHAs in urban areas, and decentralizing health services. Some such case studies are given in this chapter.

The role of SHGs in urban health

Almost two-thirds of India's population does not have access to formal financial services. The women's self help movement has emerged as an important strategy for achieving financial inclusion, contributing to inclusive growth, and generating social capital in order to address larger issues like poverty eradication and women empowerment. One of the main reasons for organizing women into Self Heath Groups (SHGs) was to provide them with a social institution and a pool of social capital from which they could draw the support and confidence to tackle such issues collectively, and to establish informal savings and credit schemes. The experiments started some thirty years ago with NGOs piloting SHG promotion, which has evolved into a national movement--with the proactive role of the state governments--gaining recognition from all the major stakeholders. Self-help groups are being used to improve the lives of poor, vulnerable women in rural areas. However, the focus of most of the NGOs is in rural areas. The data on SHGs provided by NABARD reveals that 80 percent of SHGs are in rural areas. Urban women were left out on account of three main reasons: (1) Urban poverty was not considered as acute as rural poor; (2) There was an apprehension that making the thrift and credit concept a success in urban slums which usually have a significant/migrant population, could cause further in-migration; and (3) thrift and credit activities were deemed difficult to organize in slums given that there are so many internal population movements. There are many instances where slum dwellers sell their dwelling huts for high price and rent a hunt in other places or move from one corner to corner. Multi-religious, multi-caste, multi-lingual, and multi-livelihood patterns of urban settlements limit the forming and sustaining of cohesive groups. The poorest women in such locations often have no assets and very little time. And, most feel trapped in a situation they feel it is impossible for them to change.

Karnataka Urban Infrastructure Development Programme (KUIDP) was the first project that facilitated the formation of the SHGs in urban slums of Karnataka. The evaluation report on the project found that for many of the NGO partners, this was a new experience, a first time of association with the urban poor. The study also revealed that contrary to popular belief, NGOs which worked with KUIDFC have subsequently found that it is easier to 'empower' urban women than rural women. Urban poor women may be more exposed to the happenings around them. The study added further that urban women are more open to participating in new programs, are more focused, and want social recognition and mainstreaming.

The study found that there has been an increased awareness among members of SHGs on health

related issues-personal hygiene, communicable diseases, effects of malnutrition and sanitation-as a result of training programs. The study also found that SHGs can also provide women with the support they need to cope with partners who damage the financial stability of the family by drinking and gambling - two common problems in urban areas.

by Shashikala Sitara (2007), Evaluation Working Paper, India: Promoting Urban Social Development Through Self-Help Groups in Karnataka - A Report to the Operations Evaluation Department for the Project Performance Evaluation Report of Karnataka Urban Infrastructure Development Project in India.

CASE STUDIES ON COMMUNITY HEALTH SERVICES IN URBAN AREAS

Community Health Worker in Urban Areas

The case study below demonstrates how in an urban context, the community health worker is envisaged to facilitate improved access to public and private health services at the community-level and in general, bring about a better health status in the local areas.

Case Study 1: "Sakhis" in Mumbai

SNEHA (Society for Nutrition, Education and Health Action) is a Mumbai-based organization that works towards innovative, sustainable and replicable interventions that tackle problems in nutrition, education and health in urban slums of Mumbai.

In 2004, SNEHA developed an initiative known as the City Initiative for Newborn Health (CINH). This was an action research study that aims to lower maternal and newborn morbidity and neonatal mortality among underprivileged slum communities in Mumbai through strengthening health systems as well as community-based strategies. The project was spread over 24 slum clusters across 6 wards of the city, with an active surveillance system covering a population of 400,000 approximately.

The community-based component was built upon mobilizing community groups to stimulate improved maternity care in the home and to encourage appropriate use of health care services.

Twenty-four locally recruited female facilitators (called *sakhis*-literally 'female friend') were assigned to randomly allocated intervention clusters. The name was chosen by the facilitators to identify themselves with the local population. Their role was to establish community groups and to facilitate experience-sharing discussions on pregnancy, childbirth, postpartum care and newborn health. In this context, they were conceived of as both brokers of information and agents of change.[31]

[31] Alcock et al (2009).

The conceptual basis of the intervention was an action research cycle that was dependent on women's groups who met every two to four weeks to discuss perinatal health issues (see Figure 1).

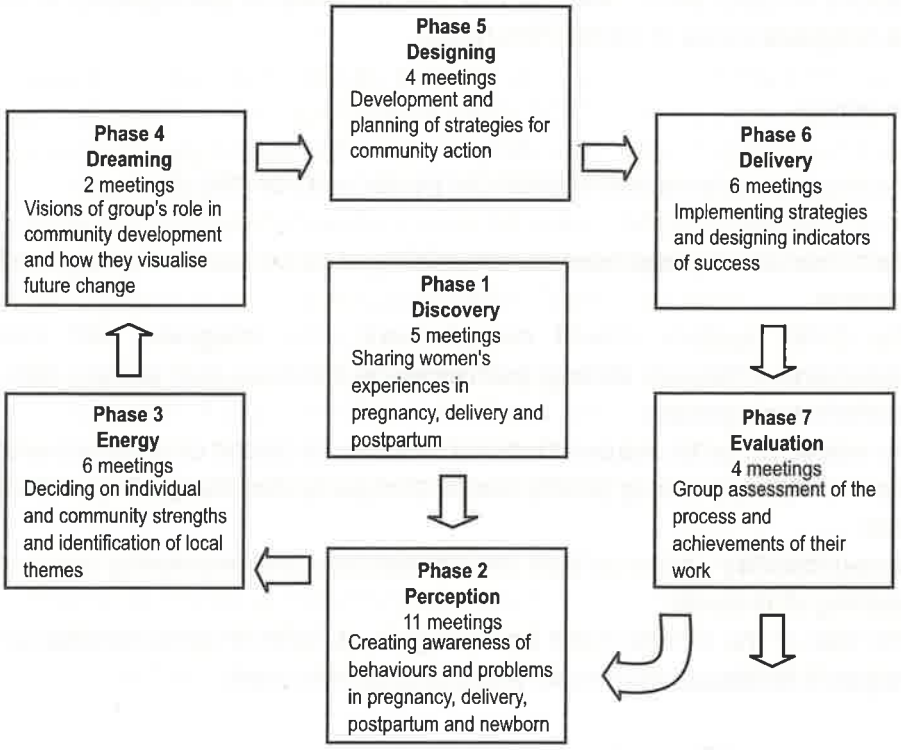
The cycle has four main aspects - identification and prioritisation of problems; planning strategies; implementing strategies and finally, evaluation

The cycle can be set out as below:

1. women share their experiences and draw up an analysis of health issues in area
3. further discussion and strategic involvement of 'experts' to augment understanding of health issues
4. prioritization of issues that need to be addressed
5. design of strategies to address problems at a local level
6. sharing of these potential strategies with other community members
7. rolling out of planned activities
8. evaluation of success

For further clarification, the figure below illustrates this cycle in a diagrammatic form.

Conceptual basis of intervention



Sakhis were employed on a full-time basis and received a small fixed monthly salary. Recruitment criteria prioritized experiential knowledge and personal qualities over specialized skills and qualifications. Although sakhis had to be literate-preferably with 10 years of schooling-a willingness to learn and build leadership skills was also considered important. Only women were selected, with a preference for those who were married with children. As local residents, sakhis were expected to be familiar with the slum context and have a good rapport with community women. The nature of their work required acceptance by family members and a degree of autonomy to allow them to travel outside their communities.

Impact

Since the introduction of sakhis, there have been significant improvements in the community. For instance, there has been an increased utilization of services at primary level - the numbers registering for early antenatal care has risen by 20% and among these women, 20% are, in fact, visiting the institutions two times or even more during this period.

Moreover, there have been advances made with regard to the facilities, partly due to an increase in awareness and health-seeking behaviour of the community. There has been better coordination and communication between the facilities with regional referrals rising from 0% and 3.1% in two regions to 24% and 13% respectively. There has been the institutionalization of new methods such as partography[32] to reduce risk factors in child birth - the median maintenance of partography in 20% of deliveries calculated in three hospitals is now in the 50-70% range.

Principles of intervention

Therefore, the following principles of intervention can be derived from this strategy:-

- The model should **empower communities,** build on local knowledge and strengthen local capacity
- The CHW system should **complement** and **integrate** with existing structures, implemented through **strong partnerships** between civil society and government e.g. local women's groups
- The system must be **responsive** and **flexible,** be based on a holistic understanding of the community, addressing priority needs and generating **tangible positive actions** at local level
- **Accountability** must be built into the system, and monitoring and evaluation linked to learning at all levels
- The role of the CHWs must be **recognised,** both in remunerative terms and through **frequent feedback** from supervisors and beneficiaries

[32] Partograph is a graphical method of recording the events in labour. This is displayed for easy and quick assessment of labour progress and timing of management decisions.

Basically, the general notion is that there is no 'urban community' as such. The urban context is extremely heterogenous, individuated and dispersed and lacks cohesion. Platforms such as the gram sabha and panchayats which for all their weaknesses do provide a space for coordinated action and decision making in rural areas are not available in the same way in urban areas - the differences between people residing in the same geography are sometimes too vast. This chapter should address these challenges of working with urban communities.

Community groups

Collective health action is essential to improve quality of services and thus the involvement of community groups is imperative. Community structures provide potentially vibrant spaces for the promotion and dissemination of vital health knowledge and action. Moreover, they can also function as platforms for the expression of demand and the assertion of accountability on the health providers operating in their communities. As the previous example from SNEHA shows, community structures can also provide valuable support to CHW programmes. Health strategies that activate such relational resources are therefore likely to be especially effective in negotiating change and bringing about an improvement in the health status of a community.

Case Study 2: National Slum Dwellers Federation and Mahila Milan - construction of community toilets, Pune[33]

The National Slum Dwellers Federation (NSDF) was founded in 1974, and has a membership of 750,000 poor households spread over 70 towns and cities in India. NSDF assists slum dwellers to obtain secure tenure, access adequate housing and develop basic infrastructure including water and sanitation.

Mahila Milan is a collective of women slum and pavement dwellers. Mahila Milan was formed in the 1980s, when NSDF agreed to help create a sister organisation complementary to its own, to encourage more women to enter leadership roles in slum development and poverty alleviation.

One particular example of a successful collaborative initiative is the design, building and management of toilet blocks in Pune. More than 400 community toilet blocks were built between 1999 and 2001, which have greatly improved sanitation for more than half a million people. They have also demonstrated the potential of municipal-community partnerships to improve conditions for low-income groups.

Pune has 2.8 million inhabitants, two-fifths of whom live in over 500 slums. Various local government bodies, such as slum boards, housing authorities, development authorities and municipal corporations, are meant to provide and maintain public toilets in these settlements. But provision is far below what is needed; indeed, for much of the 1990s, the city authorities failed to use much of the budget allocated for public toilets.[34]

[33] Burra, S, Patel, S. and T. Kerr. 2003.
[34] Ibid.

NSDF and Mahila Milan had formed an Alliance with an NGO named SPARC (Society for the Protection of Area Resource Centres). This Alliance had been working in Pune for the previous five years, supporting a vibrant savings and credit movement among women slum dwellers.

Based on their previous experiences, the Alliance conducted community-managed slum surveys to demonstrate the need and the inadequacy of public provision.

Community-managed surveys and maps: a tool to build community capacity

Community-managed household, settlement and city surveys are important in helping communities to look at themselves, to strengthen their organization and to create a capacity to articulate their knowledge of themselves to government agencies and others with whom they interact.

Surveys can be undertaken at various levels, including listing of all settlements, household enumeration and intra-household surveys. Communities also need to build skills in mapping services, settlements, resources, problems, etc., so that they get a visual representation of how their present physical situation relates to them. These maps are also particularly useful in developing plans for improvements with external agencies.

The information-gathering process often begins with a hut count when a community is visited for the first time - men and women from the Federation and Mahila Milan hold meetings with residents, explaining their work and the reason for their visit. Questionnaires and other survey methodologies are discussed with communities and modified as necessary, and all data is fed back to them to be checked and, where needed, modified. Detailed hut counts, with each hut given a number and marked on detailed maps, have proven particularly important in managing resettlement. The repeated interaction with a community through hut counts, household surveys and settlement profiles also establishes a rapport with them and creates a knowledge base that the community owns and controls.
Burra et al, 2003

Consequently, the Alliance designed and costed the project, the city provided the capital costs, and the communities developed the capacity for management and maintenance.

All aspects of costing and financing were publicly available. Burra et al (2003) state that access by community organizers to senior officials kept in check the petty corruption that characterizes so many communities' relationships with local government agencies.

One factor that constrained community participation was the municipal commissioner's desire to complete the programme while he was still in office. In addition, some NGOs with contracts to construct

toilets were actually thinly disguised fronts for contractors; their poor performance in part undermined the legitimacy of genuine organizations. Other NGOs struggled to develop more participatory engagements with community organizations, but lacked roots firmly based in the urban poor communities. Despite these limitations, in many places inhabitants had the central role in the design and construction of these toilets.

Some women community leaders took on contracts themselves and managed the whole construction process, supported by engineers and architects from SPARC. It took a while for the (usually) illiterate women in each community to develop the confidence to manage this process. As one leader, Savita Sonawane noted, *"In the beginning, we did not know what a drawing or a plinth was. We did not understand what a foundation was or how to do the plastering. But as we went along, we learnt more and more and now we can build toilets with our eyes closed."*[35]

Over time, these women's groups learned how to deal with local government bureaucracies, and this gave them the confidence to deal with other government officials. These groups also kept a close watch on costs. But there were many prejudices against community management that had to be overcome. For instance, when a group of women began to negotiate with shop keepers to obtain materials to build the toilets at the lowest price, they were not taken seriously and had to fetch their husbands. Some government staff did not want to work with organized women's groups because they felt unable to ask these groups for the bribes they usually received from contractors.

Therefore, this case study highlights that urban community groups can and must be centrally involved in improving their own lives and the general conditions of the city in which they live. Communities that have taken steps to change things, to transform their own lives and settlements in various ways, provide powerful examples for other communities, and become the catalysts for other, larger transformations. They can also change the attitudes of city administrators, and the strategies for delivering services and amenities to the poor.

Involving key stakeholders

The health of poor urban communities is influenced by a range of players. The key stakeholders include the Department of Health & Family Welfare, Integrated Child Development Services (ICDS), District Urban Development Authority (DUDA), urban local bodies, NGOs, community groups and charitable organizations. Often, it is observed that these agencies work independently with little or no coordination. Their efforts are likely to be far more effective if synergy can be developed within the activities conducted and approaches adhered to.

[35] cited in Burra et al, 2003

Case Study 3: Multi-stakeholder Urban Health Program in Indore

The Urban Health programs in Indore and Agra have demonstrated that the process of strengthening community capacity either through Link worker or a Community Based Organization (CBO) helps in improving the utilization of services. The IPP-VIII project has also demonstrated that the use of female voluntary health workers viz. Link workers, Basti Sewikas etc. selected from the local community played an important role in extending outreach services to the door steps of the slums which helps in creating a demand base and ensuring people's satisfaction. It was also observed that the collective community efforts played an important role in improving access to drinking water sanitation nutrition services and livelihood.

In partnership with Department of Public Health, the Municipal Corporation of Indore, the District Administration, NGO partners and the local communities, the Indore Urban Health City Program was initiated in March 2003. The program operates with the objective of improving maternal and child health and nutrition among the slum dwellers of Indore.

The partners in the program include:-

- The Department of Health and Family Welfare, Indore and District Health Society, Indore
- District Administration and Municipal Corporation of Indore
- NGOs
- 9 Cluster Coordination Teams
- 90 Community-Based Organisations
- Slum communities
- Charitable organizations, public and private doctors

The first step was to undertake a vulnerability assessment in order to identify and target the most vulnerable slums. With the help of the elected representatives of Indore Municipal Corporation including the Mayor, officials of Department of Health and Indore Municipal Corporation (IMC), the Urban Health Resource Centre (UHRC) undertook the listing, geographical mapping and vulnerability assessment of all listed as well as unlisted slums. This was conducted based on criteria such as:-

- housing conditions
- sanitation facilities
- employment status
- availability and access to public health services

- gender equity

Several of the city's slums had formed community organizations as a result of earlier governmental and non-governmental initiatives. Utilizing the existing Community-Based Organizations (CBOs) and building on their capacity was viewed as a viable strategy to sustain health improvements in slums of Indore.

For instance, in Indore, slum-based health volunteers were trained in improving health awareness and promoting good health practices in their respective areas. Different methods were conducted at the slum level, such as:-

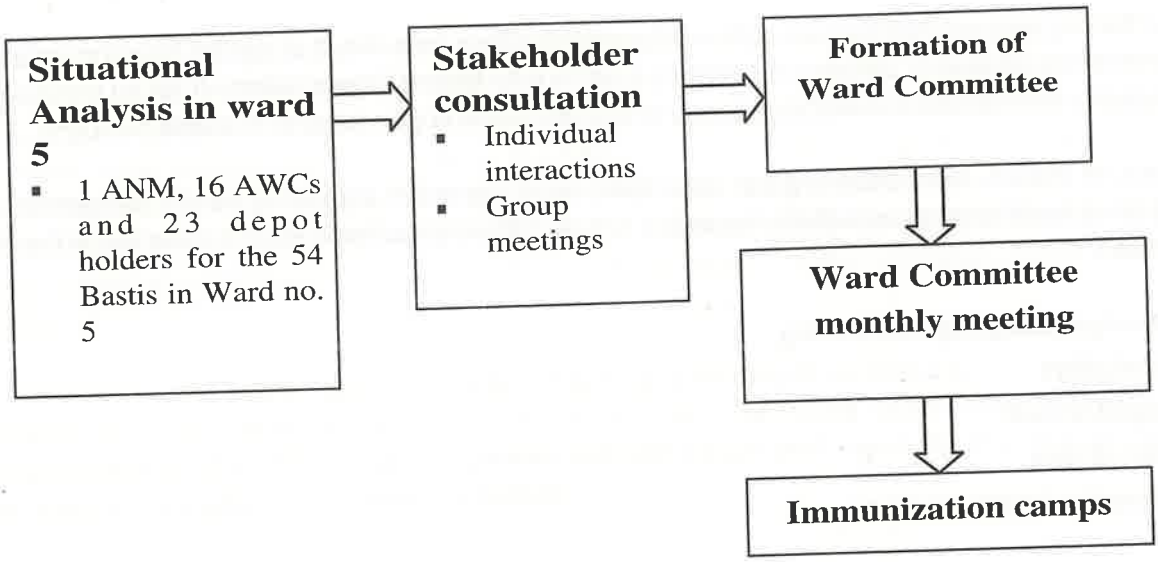
- individual and group counselling
- street plays
- puppet shows
- video shows
- interactive health quizzes

Apart from this, slum groups also have the capacity to forge linkages with public and private sector health providers to provide regular health services in their slums. By facilitating the logistics of organizing monthly health and immunization camps, the CBOs have been successful in increasing the supply of health services to their slums.

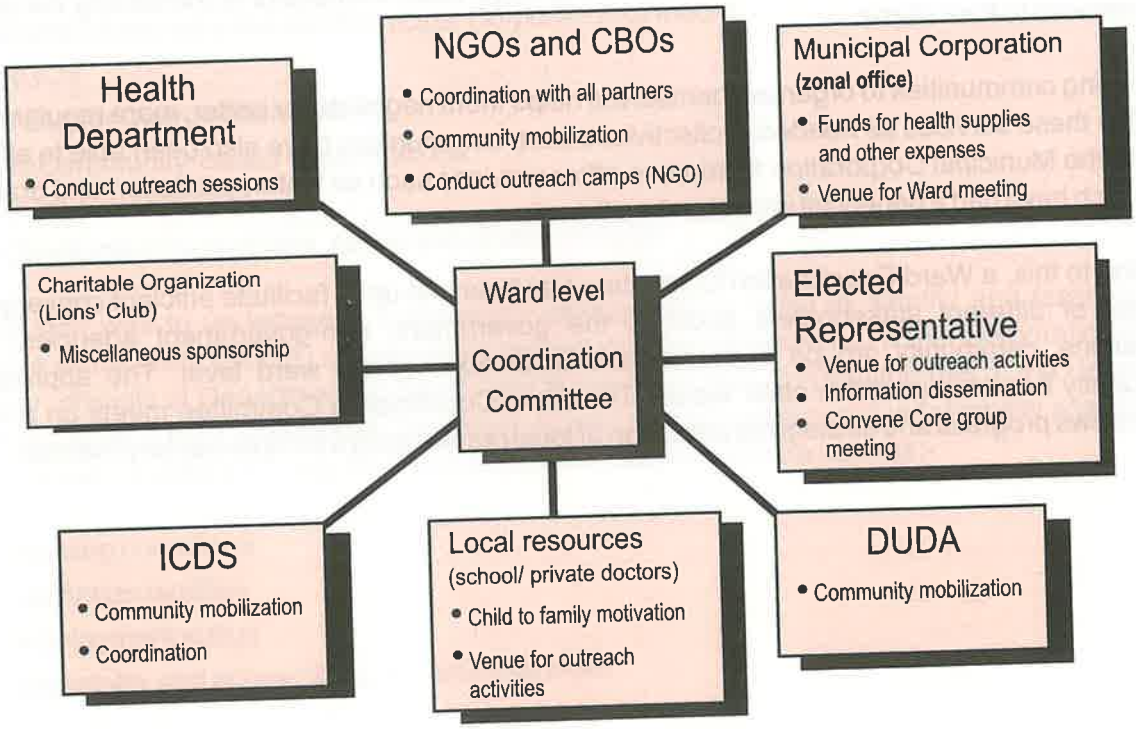
Encouraging communities to organize themselves helps them negotiate for better, more regular services and utilize these services as needed. Collectivized slum communities have also been able to effectively influence the Municipal Corporation to improve other services such as water, sanitation and drainage in slums which have had a beneficial impact on health in slums.

In addition to this, a Ward Coordination Committee has been set up to facilitate efficient convergence of resources of different stakeholders such as the government, non-government agencies, private organizations, community groups and charitable institutions at the ward level. The approach has subsequently been replicated in other wards. The Ward Coordination Committee meets on a monthly basis, reviews progress and strategizes utilization of local resources in a complementary manner.

Flow Chart of the Process of Functioning of the Ward Coordination Model



Components of Ward Coordination Committee[36]



[36] EHP and USAID. 2005

Programme outcomes from 2003 - 2006

The lead NGOs-CBOs, in direct coordination with the Health Department have organised over 50 Maternal and Child Health outreach camps each month. The program has also developed linkages with the private service providers. Approximately 10 ANC camps are organized each month to cover 25 slums where qualified private doctors provide antenatal checkups and advise pregnant women on health and nutrition.

Lessons

From this case study, it suggests that it is possible to reach the most underserved slums of the ward, using the following strategies:-

- discussions with the various stakeholders at the ward level
- situational analysis
- facilitated coordinated collective action (Ward Coordination Committee)
- delegation of responsibilities

This model also points out that in certain situations, that, perhaps, there needs to be a guided effort to be able to utilise fully the available local resources (public and private) to bring about an improvement in health indicators.

Community Health Centre

Case Study 4: Community Health Centre and Outreach Services, St. Stephen's case study, Delhi

St. Stephen's Hospital is one of the oldest hospitals of Delhi. It was established in 1885 by Mrs. Priscilla Winter to serve the underprivileged people especially women who found it difficult to seek medical care from men dominated modern and traditional health care system. For initial 90 years the hospital remained a mother and child care hospital and was popularly known as Zenana Hospital. In 1975 the hospital opened up other specialities. Currently the hospital is one of the largest private multispecialty state-of-the-art hospitals of Delhi. It is popular among the middle class people for its affordable pricing for good quality tertiary and secondary level care. It also offers heavy subsidy or free care to the underprivileged patients. Nearly 30 years back the hospital had recognized that merely by offering the hospital based secondary and tertiary care is not enough. It excludes the poorest of poor from accessing its services and paves way for non needy to exploit the hospital's subsidies. It identified a slum population of Sunder Nagari, East Delhi and adopted it for the outreach services. Initially the community outreach service of the hospital was in the form of a mobile dispensary. In 1983 the hospital built a permanent centre in Sunder Nagari, which is

a large resettlement colony, on a piece of land provided by the government. It continued to provide the primary curative care through a dispensary at the centre.

In 1990 the hospital decided to upgrade the community health department with more professional approach. Noted public health expert and past principal of CMC Ludhiana, Dr. Betty Cowen was asked to develop strategy to make the department truly community based. Entire population was surveyed and covered by the 'Family Folder based Information System'. By the end of 1994, the department was catering to the health needs of 60,000 people in urban slums and resettlement colonies of Sunder Nagari, and surrounding areas in Delhi and 10,000 residents of eight villages in Gurgaon.

Gradually department has grown into a multidimensional community development programme that not only caters to the health needs of the population but also plays very important role in community organization, children's education and women's empowerment. It runs day care centre for 3 to 6 years children from the poorest of poor. After the age of 6, children can join the Child-to-child education that caters up to 18 years of age. The adolescents and youths attend the youth clubs, dance classes and street theatre groups. They are also provided opportunity to attend special health education cum health check-up package of two days, which is organized from time to time. There are vocational training programmes, Self Help Microcredit programmes and Income generation programmes for adult women and young men. For senior citizen the department provides preferential care at its clinics, annual health checkups and free cataract operations. There is a day care centre for senior citizens that offer recreational facility and nutritional hot cooked meal on highly subsidized rates.

Health Services

The department follows the primary health system based on Community Health Volunteers (CHV), ANMs/Multipurpose Health Workers and LHVs/PHN. The population coverage of the health functionaries is as follows:
CHV: 2500
ANM : 7500
LHV: 1 for 4 ANMs

The field team is supported by the postgraduate students of DNB (Diplomate of National Board in Family Medicine) and the faculty. Every household in the area is visited at least once in three months. The family folder based information has been computerized and the field workers have been trained to do the data entry and takeout reports they require for their day to day work.

The Community Health Centre runs out patient services, Ante Natal Clinics, Well baby clinics, DOTS centre and periodic clinics of specialists visiting from the base hospital (St. Stephen's Hospital).

Medicines are dispensed free of cost after a nominal fee of Rs. 5/- for a new registration and Rs. 3/- for an old registration. The ANM has the authority to writing off the registration charges if she thinks the family is too poor to pay the fee. They can also recommend concessions for poor patient if they are referred to the base hospital for secondary or tertiary care. They also work as a bridge between the community and the management for occasional grievances due to overcrowded clinics at the centre.

The centre has very strong referral support from the base hospital. The patients sent from the centre are treated with dignity and care. Most of the patients are treated free of cost as per the recommendations of the centre staff. The centre occasionally refers patients to the neighbouring government hospitals. However, care is taken to write proper referral notes so that they could get proper care. More serious cases are followed up by the doctors and nurses of the centre at the referral hospitals.

The Community Health Department takes up several government and non government assignments related to health and social issues from time to time. It also provides structured and non structured training programmes for various categories of health personnel. The centre is very popular among the community it serves. It is an example of primary, secondary and tertiary care provided by a private sector hospital. If similar kinds of Community Health programmes are run by other hospitals, very large tracts of slums can be covered.

LESSONS TO BE LEARNED

Communities vary widely according to the specific needs of their population, and even more so in terms of existing initiatives and available resources. Outreach strategies, therefore, must be community-specific, not only because health needs vary, but also because people's perceptions and capacities to intervene and implement programmes vary. In centrally designed plans there is little scope for such contextualization and hence decentralized planning and implementation becomes crucial.

Decentralization of health service delivery empowers local governments to manage, control and be accountable for public health services as a core strategy. Using this concept, the Kolkata Municipal Area has managed an innovative and extensive urban health programme since 1986 which has been discussed in the previous lesson.

Experiences over the years suggest that participatory programme initiatives that are designed to build the capacity of people in communities where they are implemented are likely to have a higher chance of success in terms of attainment of programme objectives. As Green (2001) argues, "nothing assures the success of a programme more than to engage the people of a community".

As the SNEHA example shows, programmes that maximize utilization of the existing human resources

base within a community tend to achieve more in terms of community acceptance and participation. This, in turn, also has a significant bearing upon the programme outcomes.

Within an urban health programme, community ownership can often be one of the hardest features to attain. But once it has been achieved, as highlighted in the Pune community toilets case study, it can become a powerful tool to influence policy-holders and bring about a lasting change.

Health has never been easily compartmentalized and thus requires significant intersectoral co-ordination. For any community health programme to achieve significant improvement in health indicators, all key stakeholders need to participate with a sustained level and quality in commitment. The Indore Ward Coordination Model is a particularly successful example of this.

Finally, a decentralized approach towards community-based health delivery systems is crucial since it has the potential to enhance the much-needed aspects of ownership, accountability as well as context-specific planning and implementation. Community outreach services as in the case of St. Stephen's, Delhi show the importance of strong primary level health services that then can lead to further referrals when required.

Enabling those within the community whose needs are greatest to participate equally and meaningfully is no easy task. This chapter outlines a few mechanisms that could facilitate this process but these are by no means the only possibilities. Community participation thrives on innovation and creativity - thus, one must not be limited to merely textbook examples when it comes to devising community-based strategies for urban health.

Review questions

1. Why is community participation important to improving urban health?
2. What are the various mechanisms through which community participation in urban health can take place?
3. What are the challenges of community participation in urban areas as compared to rural areas?
4. Identify criteria used for the geographical mapping / vulnerability assessment of a community.
5. Who are the potential key stakeholders in an urban health programme?

Application questions

1. Create a set of guidelines for "good practice" in programmes involving community groups, which include methods to facilitate effective community participation.
2. From the case studies discussed in the lesson, which of the models do you see as an effective method of community participation for your town/ city? Discuss.

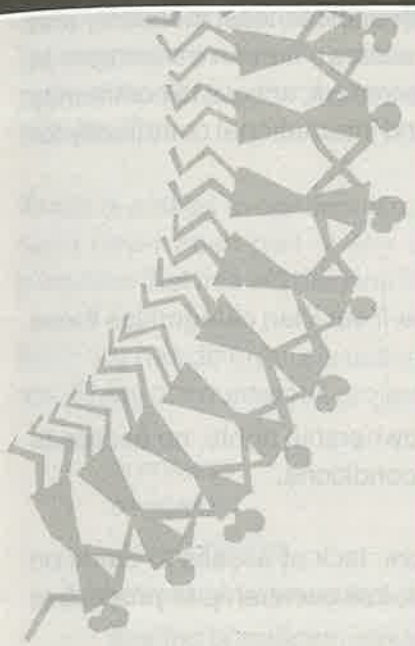
Project assignments

1. Visit an urban locality and map out the existing stakeholders affecting health outcomes of the community. Assess the degree of coordinated collective action and propose strategies to enhance this further. (If helpful, refer to the Indore Ward Coordination Model.)
2. List the functioning community health programmes that exist in a specific urban area. Identify gaps affecting health outcomes and propose suitable community-based strategies that could address these needs.

NOTES

Lesson FIVE

Vulnerable Urban Populations and Health Care



In this lesson we shall discuss:

- Identifying vulnerable populations in urban areas
- The specific health needs of different vulnerable groups
- Impact of illegality on health status
- Current government initiatives for vulnerable urban populations
- Various non-governmental initiatives for vulnerable urban populations
- Operational elements of designing programmes that cater to vulnerable urban groups

WHAT IS VULNERABILITY?

There has been a recent widening of the debates on poverty to include more subjective definitions such as vulnerability. Vulnerability is not synonymous with poverty, but refers to defencelessness, insecurity and exposure to risk, shocks and stress. Vulnerability is reduced by assets, such as human investment in health and education; productive assets including houses and domestic equipment; access to community infrastructure; and claims on other households, patrons, the government and international community for resources at times of need.[37]

Vulnerability in urban context

Vulnerabilities in an urban context also take on specific forms. The 10th Five-Year Plan categorises these vulnerabilities into four types - housing, economic, social and personal.

- Housing Vulnerability: Lack of tenure, poor quality shelter without ownership rights, no access to individual water connection/toilets, unhealthy and unsanitary living conditions.

- Economic Vulnerability: Irregular/casual employment, low paid work, lack of access to credit on reasonable terms, lack of access to formal safety net programmes, low ownership of productive assets, poor net worth, legal constraints to self-employment.

- Social Vulnerability: Low education, lack of skills, low social capital/caste status, inadequate access to food security programmes, lack of access to health services, exclusion from local institutions.

- Personal Vulnerability: Proneness to violence or intimidation, especially women, children, the elderly, disabled and destitute, belonging to low castes and minority groups, lack of information, lack of access to justice.

Vulnerability within the right to health framework, as specified in the Alma Ata Declaration in 1978, is the deprivation of certain individuals and groups due to a lack of access to medical services and the underlying determinants of health such as safe drinking water, nutrition, housing and sanitation etc.[38]

The task of identifying vulnerable groups is compounded by the fact that there are multiple factors affecting vulnerability and more often, it cannot be analyzed in isolation. Prominent factors include stigma and discrimination based on gender, age, caste, class, religion, migrant status and disability. There is also the added complexity that groups and individuals face multiple barriers due to their multiple identities.[39]

[37] Chambers cited by Wratten 1995
[38] Yamin 2005
[39] CEHAT, 2007

For example, in a patriarchal society, a woman with mental illness may face double discrimination for being a woman and also having mental illness.

Specific data on vulnerable populations in India is grossly inadequate. The lack of an index for identifying these groups makes the process particularly difficult. Often there is a large variation within the urban poor population itself. For instance, new migrant groups and squatters form groups with a high degree of mobility.[40]

There is a need to conduct a mapping of vulnerable populations in cities since most of such populations have never been part of any official surveys by the government. The National Urban Health Mission proposes that this will be done in time but it is yet to have materialized.

Each city has different classifications of "vulnerable populations" according to where informal settlements are. There are numerous groups but this chapter will focus on the following vulnerable populations:

- homeless
- beggars
- street children
- women in vulnerable settings - commercial sex-workers
- floating population groups - pavement dwellers, construction workers
- migrants
- elderly poor
- disabled persons
- LGBTs (Lesbian, Gay, Bisexual and Transgendered Individuals)

Illegality is an issue which a number of vulnerable urban groups have to struggle with on a daily basis. For instance, a major issue is that of listed versus unlisted slums. Indian Urban Local Bodies prepare official slum lists and these form the basis of providing basic health services in these slums. These lists are not annually updated and thus, many newly emerged slum clusters remain unlisted. These unlisted slums are often excluded from government and non-government programs. Therefore, official slum status has a significant bearing on the health and overall living standard of slum dwellers.[41]

[40] The Society for the Promotion of Area Resource Centres (SPARC), an NGO working in Mumbai, conducted a study called "We the Invisible" in 1995 which highlighted that is possible to count pavement dwellers – the importance of this is not only for reasons of recognition by the State but rather to create a database of information on such communities and make it available to everyone involved in the process. In other words, they aim to "mobilise people through enumeration".

[41] Agarwal et al., 2009

Focus on Pavement Dwellers - problems of illegality

Pavement Dwellers reside on the pavements or sidewalks of the city. By and large the right to reside on the pavement is not acceptable in the same manner as the right of slum dwellers to reside on lands they have squatted on - because, unlike those lands, pavements belong to the "public" for the use of pedestrians.

Entitlements provided to citizens of India, such as ration cards are denied to pavement dwellers because they were not listed as a separate group who are entitled - often it is assumed they were a part of the "slum" group. Yet with no separate mention in any policy document, they do not have any claims on the policies of government at central, state or at city level. So for instance, an urban ICDS project cannot be extended to pavement dwellers because they are not a "recognized" category.

Without being able to provide a proof of residence, pavement dwellers are not able to acquire ration cards and access safe, nutritious food. They also do not have access to basic public facilities such as toilets and sanitation. These factors perpetuate a cycle between illegality, vulnerability and poor health.

"We the Invisible" (1995) SPARC, Mumbai.

When considering the wider political-economy of vulnerability, contributing sources also include state coercion in the name of beautification of cities, riots, linkages with the criminal world, involvement in the black market economy and heavy dependence on political parties for survival.

Disasters increase vulnerability and lead to heightened rates of morbidity as well as mortality. Disasters, both natural and man-made, cause socio-economic and physical vulnerabilities by affecting livelihoods, housing, food security, health and a range of other factors. One such example is the 2005 floods in Mumbai, which caused a severe epidemic of leptospirosis and led to an estimated 1000 deaths, particularly amongst the slum-dwelling populations in the city.[42]

Hence, when conceptualizing policies and programmes for vulnerable urban groups, a thorough understanding of the mechanisms whereby vulnerability creates disparities in health is essential.

Government initiatives for vulnerable urban populations

The Government of India has introduced various welfare initiatives for the urban poor since Independence. - see Table 1. With regard to vulnerable populations, the Urban Basic Services for the Poor scheme launched in 1990 was particularly significant. It targeted Scheduled Castes /Scheduled Tribes and other minorities, Below Poverty Line (BPL) households in slums, undeveloped settlements on

[42] Government of Maharashtra, 2005

city outskirts, pavement dwellers and street children. Its initiatives included community mobilization on mother and child health issues, primary non-formal education, rehabilitation of destitute / disabled people, provision of clean drinking water and low cost sanitation.

Government Welfare Initiatives for the Urban Poor since Independence

Year of Introduction	Scheme	Target Beneficiary	Objective
1975	Integrated Child Development Services (ICDS)	Children between 0-6 years	Integrated package giving holistic non-formal pre-school education, supplementary nutrition, immunization for children, water and environmental sanitation
1981	Low Cost Sanitation (LCS)	For liberation of scavengers	Conversion of all existing dry latrines numbering 50 lakh units unto low-cost pour flush sanitary latrines and 100 per cent liberation of scavengers on "whole town" coverage basis
1985	Universal Immunization Programme (UIP)	Infants and pregnant women	Immunize 85% infants by 1990 Immunize 100% pregnant women by 1990
1986	Support for Training and Employment Programme for Women (STEP)	Marginalised, assetless rural women and urban poor with special focus on SC / ST households	Integrated development, training and upgradation of skills in agriculture, handicrafts etc Also mobilizing women in viable groups, arranging for support services like health check-ups, mobile crèches, nutrition education etc
1990	Urban Basic Services for the Poor (UBSP)	Most vulnerable populations, e.g. SCs/STs and minorities. BPL households in slums, undeveloped settlements on city outskirts, pavement dwellers, street children. Slums in 250 towns in 36 districts in 23 states.	Integration between provision of social services under UBS (1986) and physical amenities under Environmental Improvement of Urban Slums (1972). Community mobilization, mother and child health, primary non-formal education, rehabilitation of destitute / disabled, provision of clean drinking water, low cost sanitation etc. Creation of an Urban Poverty Alleviation Fund in each municipality combining the funds available under different schemes.

Source: Ramanathan Foundation(2002) - Urban Poverty Alleviation in India

More recently, the National Urban Health Mission (NUHM) is being conceptualised by the Government of India to meet the health challenges of urban populations and aims to cover over 400 cities. It has brought about a specific focus on improving the reach of health care services to the vulnerable urban poor, falling in the category of destitute, beggars, street children etc. For instance, in its list of key strategies, there is mention of "prioritizing the most vulnerable amongst the poor ". This support would be through a city specific strategy with a cap of 10% of the city budget.

These programmes have not been fully operationalised as yet. It can also be argued that these initiatives do not take into full consideration the specific health needs of each vulnerable population in particular urban contexts. Most of these vulnerable populations are currently being covered by health services provided by NGOs. The health status of these groups and examples of programmes designed for them have been elaborated upon in the next section.

SPECIFIC NEEDS OF VULNERABLE URBAN POPULATIONS AND RELEVANT PROGRAMMES

1. The Homeless

Urban homeless are the most marginalized category even within the urban poor populations. They constitute anywhere between 100 million and one billion of the global population. This broad range is the consequence of the many variant definitions of what constitutes a 'homeless' person - a person with no shelter whatsoever; one with shelter that is very insecure (e.g. squatter settlements); one with shelter that is temporary (including pavement dwellers and refugee camps).

Homeless people on city streets are invisible to public policy, though they are visible daily to policy makers as they drive the same city streets. Homeless women, men and children share the cities virtually as non-citizens. Many die unmourned in the bitter winter cold, the merciless summer heat or in the deluge of the monsoons. They are forced to live and sleep each night under the open sky. Life for them is an unremitting struggle against hunger, loneliness, sickness.[43]

The bitter winter often proves to be a messenger of death. In 2002, the police found 3040 corpses of homeless people defeated by Delhi's harsh winters. 400 of these were victims of a single cold wave. The onus lies entirely with the government to build a comprehensive policy to support the city's most marginalised residents, but the governance amnesia across the nation has been acute.

'Houseless people', of all age-groups, are defined by the census as those who do not live in 'census houses' i.e. a structure with roof. Enumerators are instructed to observe possible locations where the houseless populations are likely to congregate: roadside, pavements, drainage pipes, under staircases, or in the open, temple-mandaps, platforms, welfare institutions. [44]

[43] Commissioner's of the Supreme Court (2008)
[44] Census of India, 1991

Based on this restricted vision, in 2001, the census enumerated 1.94 million homeless people, of whom almost three-fifths live in villages and remaining 0.78 million live a precarious existence in India's cities and towns. However, these numbers are likely to be gross underestimates, because people without a home tend to be a highly invisible especially to officialdom. In Chennai city, a civil society survey in 2003 was able to list twice the official estimate of homeless people (i.e. 40,500 persons from 11,000 households) and also revealed that 83 percent of them are dalit. The largest majority of homeless people sleep on pavements and sidewalks, under ledges of shops and homes, in market corridors, at bus-stands and railways stations, outside places of worship often in daily danger to their lives from rash and drunken drivers. In some cities, single women seem to prefer shrines, children bus stands and railway stations and families pavements.

Homelessness itself is perceived to be a crime. Homeless families are wary of both the government and the middle class, particularly because both perceive homeless people of any age and gender to be vaguely dangerous and intractably on the wrong side of the law. Homeless people are taken as illegal elements who need to be weaned out of the city. Due to the above reason police brutality and harassment is more common for homeless people.

Worse still, vagrants, mentally ill itinerants, 'illegal' squatters, pavement dwellers, are all considered 'guilty' of violating penal statutes or those whose entire enforcement is at the mercy of the police and the junior magistracy. Across India, large numbers of homeless people are routinely rounded up by the police. This is done usually to fulfil targets of 'preventive detention' as proactive measures to maintain civic peace under Sections 109 and 151 of the Criminal Procedure Code, 1973. Homeless people then languish for long periods in the jail, because they are too poor, asset less and without legal aid or literacy, to secure bail. Even apart from their acute need for shelter, their daily efforts of survival are hindered at every step by their absolute 'illegality' of existence. At the heart of the problem are existing laws and policies of regulating urban land, which systematically exclude the poor from building or acquiring legal shelter. As a result, even all self-help efforts of the poor to live are condemned by law to the twilight zones of illegality.[45]

Lack of public services

The urban homeless people often have little and troubled access to even the most elementary public services much of which people who are privileged to live on homes take for granted. Worse still, everything that they can use has to be paid for - every visit to the toilet, every bath - must be paid for, in cash, immediately. The wider range of services, including healthcare, education and law and order, on the grounds of cost and discriminatory practices, remain a distant dream.

The Centre for Equity Studies survey revealed that 45 percent of homeless respondents pay for to relieve themselves in public toilets. Drinking water, often not potable and erratic in supply, is however available

[45] Commissioner's of the Supreme Court (2008)

free at roadside taps. In Chennai, however, women complained that they have to wait at public taps for long, until other more authorized citizens including even slum dwellers, fill their needs before homeless people get their turn.

Even the night shelters sometimes charge a fee. In Delhi, the Municipal Corporation runs 12 night shelters with a total capacity of 2,500. But the occupancy rate is minimal as each person has to pay Rs 6 for 12 hours, but the basic facilities like toilets, blankets, mats, clothing and sense of safety are rarely available or are in terrible disrepair.

Homeless life can therefore be paradoxically costly. Especially in urban areas, the costs of living are higher than rural areas as all essential items including food, rent, energy, transport, water from private vendors, and sanitation from pay-as-you-use facilities have to be purchased. Poor people's capacity to meet these needs is purely dependent on having a secure to live preferably close to their work, their capacity to sell their labour for money, and their ability to draw on and use social support systems - all of which are prohibitively difficult for homeless people.

Survey of homeless people

Last year, more than half the people surveyed by the Centre for Equity Studies reported that work is not available on a regular basis. In Delhi, Chennai and Patna more than three-fifths held the same opinion. Only in Madurai, where the dominant occupation is begging, did 90 percent of homeless people report regular earnings.

"100 per cent of respondents in every city reported major health problems in the past year, and 56 per cent were advised hospitalization but did not go to hospital. They found the government hospitals unwelcoming and discriminating because of their unclean, unwashed bodies. In addition, it was too expensive, from the costs of medicines to the sometimes illegal charges stated by the public health practitioners."

Source: Mander, H. 2008. Living Rough: Surviving City Streets. A Study of Homeless Populations in Delhi, Chennai, Patna and Madurai
(340 respondents were interviewed between October 2007 and October 2008 - this was supplemented by life histories of 30 of these respondents, as well as focus group discussions.)

Hunger in city streets

The availability of food to urban homeless people is mixed. The quantities may be (but are not always) sufficient. The quality however uniformly tends to be monotonous, elementary, often of poor nutritional

value and (in the nature of their existence) unhygienic. It is indeed the search of food which has led many to the streets.

Sufficiency of the food seems far more important to the homeless than the nutritional content. Except those with families in the streets, they rarely get home cooked food. Many buy cooked food, sometimes from humble eateries on the pavements themselves. Homeless people are forced to depend extensively on external sources for their food - through purchase, foraging, or receiving food in charity.

Many who live by soliciting alms, eat only what they get as charity and save all the cash they are given as alms to send back to their village. At times, they have to be content with only one meal, but usually they are able to manage two half meals a day. Leprosy patients in Madurai, Patna were found to depend upon stale leftovers that they are given as they beg in the day. But at night, they try to set up a makeshift stove between two bricks, and boil some hot rice.[46]

A short exploratory study in 2010 by PHRN in collaboration with CES explored the nutritional status of homeless adults in Delhi. Some major findings that came up from the study were:

- People depending solely on charity had no income
- People depending sporadically on charity had less income then those who only purchased cooked meals
- People who did not have any earnings the previous day also recorded spending on food (26%, i.e. 50 respondents)
- Absolute lack of fruits and milk in the diet (only three persons had fruits in their diet and only four persons had milk in their diet). No protective food in the diet.
- The intake of vegetables predominantly consists of potatoes.
- More than 50% of all women and all men belonged to the Normal category of BMI classification.
- In both the categories of BMI classification -overweight and underweight -there are more women than men
- There is a significantly more number of underweight in the NGO run night shelter as compared to MCD night shelter (Nizamuddin).
- The average income of the people was below the prescribed minimum daily wage.
- The income of the women was substantially lower than that of the men, on computation women earn 50% less than men.

Prasad, V., S. Haripriya and S. Jacob (2010), Food Security of the Homeless in Delhi: A Study of the Nutritional Status and Dietary Intakes of Adult Homeless Persons in New Delhi, Working Paper, PHRN and CES.

[46] Commissioner's of the Supreme Court (2008)

2. Beggars

Beggars in urban areas constitute one of the most vulnerable populations, particularly since they have little in the way of legal rights. They have very limited access to healthcare and furthermore, lack of proper housing facilities, clothing, water, sanitation and nutrition makes them more susceptible to various diseases. Exposure to harsh weather conditions such as intense monsoons and bitter cold, especially in cities of Northern India, increases their vulnerability and can even lead to death. Lack of proper night shelters for the homeless also makes them more prone to abuse on streets - this is especially true for women and children.

Case Study: Saroja Devi

Alighting from the passenger train at the New Delhi railway station nearly 30 years ago, it was not long before Saroja Devi found her way to Hanuman temple and its bedraggled unsteady collective of forlorn women. Her daughters and she lived mainly by begging and selling flowers.

She longed for some stability, some permanence, some dignity. Therefore, when a woman slumlord offered to sell her a shanty in a slum not far from Hanuman Mandir, she readily gave her remaining savings, a few thousand rupees. She moved into a shanty with her children, and continued to sell flowers outside the temple.

But one day, government bulldozers arrived and razed the entire slum settlement. It was government land, she was told. They were illegal squatters with absolutely no rights. The woman who had sold her the shanty disappeared. Saroja could never find her again. She took with her the life savings of many dispossessed people.

So Saroja Devi returned to the temple courtyard, and its community of the luckless. The ensuing years were the worst in her life. First, her elder daughter had jaundice. She managed to admit her to the government hospital ward one day, but she died the next day. It was not long before her younger daughter fell from a tree, which she had climbed to pluck its jamun fruit. The child lingered in agony with broken limbs and festering wounds in the overcrowded public hospital for six months. Her mother did all she could to try to save her life, but she died.

Source: Harsh Mander, Frontline, May 18, 2003.

There are existing government initiatives for beggars such as the Beggars' Homes. However, Dr. Asha Banu Soletti and Mr. Mohd. Tarique of the Tata Institute of Social Sciences (TISS), Mumbai described these as unhygienic and crowded spaces. They report that there is a lack of water supply, few activities to

keep people physically and mentally active and little in the way of clothing or health care provision.

The Bombay Prevention of Begging Act, 1959, outlines medical examination, provision for medicines and referral for those who fall sick in Beggars' Homes. However, in practice very little is done. The supply of medicines is poor and medical examinations are rarely carried out. A lack of funds affects referrals and also there is a shortage of staff to escort the patients to healthcare facilities. In addition, despite recommendations of the medical officers, there have been no regular psychiatrists or mental health nurses appointed.[47]

Soletti and Tarique argue for the urgent need to improve conditions within Beggars' Homes and have started initiatives such as Koshish.[48]

Example: Koshish

Koshish is a field action project of Tata Institute of Social Sciences, Mumbai, which was initiated in 2006. It aims to address the issues of beggary, destitution and homelessness in a holistic manner combining the basic services such as food, healthcare, legal assistance. Moreover, what distinguishes the Koshish initiative from Beggars' Homes is that it also makes efforts towards rehabilitation through measures such as vocational training and guidance.

The project is working in partnership with various governmental and non-government organizations to develop a comprehensive policy framework that would address destitution and homelessness in urban India.

From the above example, certain principles can be derived about programmes for this section of vulnerable urban populations. Early intervention and prevention are crucial in combating the vicious cycle of homelessness and destitution. Initiatives such as those incorporating vocational guidance enable people who are homeless to achieve maximum self-reliance and independence. In addition, responses which might prevent instances of homelessness often lie outside the homelessness service system itself. Such responses may include increasing the supply of affordable housing and addressing the causes of domestic and family violence.

3. Street children

Urban poverty has a direct impact on the mortality and morbidity of children. NFHS-III data reports that the under-five mortality rate among urban poor at 72.7 is higher than the urban average of 51.9. More that 50% of these children are underweight, and almost 60% of the children do not receive full

[47] JSA, 2007

[48] Alongside this, in collaboration with another NGO called Saki, TISS has also started a manufacturing unit at the Beggars' Home in Chembur. Those who work in the unit receive a stipend that is deposited into an account in their name.

immunization within the first year.[49] In addition, poor environmental conditions coupled with high population density makes them susceptible to diarrhoeal diseases, malaria, asthma and tuberculosis.

Street children form an important sub-category of vulnerable populations. Often with no families to support them, many run away from home due to abuse or other reasons such as failing in class or the attraction of a big city, particularly to Mumbai with its glamour of the film industry. Living on the streets exposes them to varied forms of abuse that ranges from physical to sexual, which, needless to say, has a significant psychological impact.

Studies (Finkle, Hoare and Brown) have found that these children tend to go into a process of "shutdown" through the sheer trauma of the experiences they have faced at a young age. These develop into a set of behavioural characteristics which include:

- distraction, disinterest and forgetfulness
- irresponsibility in planning for the future
- isolation and detachment
- muted emotional response and inability to form relationships
- lack of energy / fatigue
- lack of interest in hygiene and loss of appetite
- often lost in a world of day-dreaming and imaginary friends
- engaging in risky behaviours - including unprotected sex[50]

Often these children resort to beggary or other menial jobs as a livelihood. They may also get involved in street gangs and crime.

The *Juvenile Justice Act 1986* is the primary legal framework for juvenile justice in India. This act was amended in 2000 and is now known as the Juvenile Justice (Care and Protection) Act.

The preamble to the Act reads:

"An Act to consolidate and amend the law relating to juveniles in conflict with law and children in need of care and protection, by providing for proper care, protection and treatment by catering to their development needs, and by adopting a child-friendly approach."

This Act makes provision for the rehabilitation of children through various institutions. These include special homes, children's homes and shelter homes.

[49] NFHS, 2005-06
[50] Ehsaas Modules for Railway Children, written by Vikramjeet Sinha for Saathi.

It must be borne in mind that in certain cases, street children may not wish to be rehabilitated. Thus, each case needs to be taken in turn and considered what action would be in the best interests of the child.

Substance abuse is also high among these children, particularly alcohol, cannabis and opium. A cross-sectional study conducted in Mumbai amongst adolescent street boys showed the following findings:

Of 163 street boys, 132 (80.98%) were substance abusers. The most common reasons for substance abuse or the perceived functions of substance use mentioned by participants were peer pressure (62.1%), experimentation (36.3%) or to boost self-confidence (28.7%). Almost three-quarters (70 %) of all substance users wanted to quit and about 40% had tried to quit.[51]

Strategies to deal with substance abuse

WHO (2005) recommends that early diagnosis and treatment forms the key approach to deal with substance abuse. Health promotion and specific intervention can also have a major impact that is equivalent. A combination of approaches is most likely to be of greatest benefit to communities.

One particularly innovative method is to use peer-to-peer strategies for drug abuse prevention. This focuses on the involvement of same age or background educators to challenge certain "unhealthy" norms, beliefs or practices. It has been proven to be an effective way of sharing knowledge as the educators are better able to relate to the context in which they are operating in. It is also based on real experiences and thus viewed as more credible.

The five key characteristics of a good peer-to-peer programme are as follows:

1. culturally appropriate
2. understanding of developmental psychology of young people at various stages
3. accuracy in the information provided
4. based on experiential learning, including practising communication, negotiation and refusal skills
5. ongoing support, training and planning activities for educators

Source: United Nations Office on Drugs and Crime

Therefore, these children have a number of crucial health needs which range from the psychical to the psychological. Healthcare for this group is seldom catered for, as few government programmes target street children specifically. However efforts have been made by some NGOs, such as Prayas to address this group and their pertinent health needs.

[51] Gaidhane et al, 2008

Example: Prayas

Prayas was started in 1988 and now operates in seven states, reaching out to 50,000 street children through its services. The children served by Prayas include rag pickers, shoeshine boys, street vendors, beggars and children trafficked for different forms of child labour including domestic help. Prayas believes that in order to give the child an opportunity for holistic development, economic empowerment and capacity building of communities needs to be simultaneously undertaken. Specific initiatives for children include provision of clothing and shoes, basic nutrition, mid-day meals, counselling and health care. In addition, through clinics and 24 hour primary health centres, Prayas supports those who cannot afford healthcare. Weekly health camps also spread awareness in the communities.

From the above example, it can be learnt that the two main intervention principles that should be considered when dealing with street children are protection and participation. These two aspects are not mutually exclusive since protection is dependent on children's participation, if it is to succeed. This includes enabling children to exercise their right to information so that they can make decisions, to the best of their capabilities, about their own interests and subsequently have their views heard.

West (2003) recommends a set of guidelines for "good practice" in programmes for street children:

1. Cases must be managed carefully to ensure that project work is based on the reality of children's lives and circumstances, rather than well-meaning assumptions.
2. Programmes should not be limited to street-based interventions or to the provision of shelters, since children's life "on the streets" may also involve other places such as brothels, factories, squatter homes etc.
3. The nature of provision created for street children must be safe, offer protection and enable their personal development.
4. The ways in which children move on from the street, with respect to possible reunification with family as well as their future lives, must be taken into account.
5. It must not be overlooked that street children's lives are not static. These children respond to opportunities, constraints, coercion and undoubtedly change as they grow older.[52]

4. Women in vulnerable settings: commercial sex-workers

Commercial sex is illegal in India, but some groups put the figure of women involved in this industry in the country at close to 2 million. With no clear data available, it is estimated that around 80% of the women have been forced into it. The perpetuation of this phenomenon can be attributed to factors such as growing poverty, increasing urbanization, migration, and widespread unemployment. Physical and

[52] West, 2003

sexual violence is a part of these women's lives and often health needs are neglected. Many of these women suffer from diseases that incur from unhygienic living conditions and lack of proper food and care.

Debate on legalization of commercial sex

Supporters

- Believe that legalisation of commercial sex work is in the best interests of all, particularly since it will continue to exist in society regardless.
- Argue that in countries where commercial sex is regulated; the spread of sexually transmitted infections (STIs), is reduced through the encouragement of safer sex practices and regular STI testing.
- Argue that legalization is a step in reducing sex industry abuses since it will make the environment marginally safer.
- Argue that criminalizing the sex industry fosters black market conditions. In these black markets, no government regulation exists, and no rule of law can exist either. Therefore, the likelihood of abuse, violence, and rape is increased.

Opponents

- Cite that commercial sex work is immoral
- Argue that the women involved in this industry are likely to be exposed to abuse, exploitation, harassment etc
- Argue that it is a cause of the trafficking and exploitation of women
- Argue that even if testing for STIs is mandatory, there is the issue that it can take up to 12 weeks for an HIV infected person to produce enough antibodies for a test to find them HIV-positive. This delay puts large numbers of people at risk if commercial sex is legal and practiced freely.

A large proportion of these women also suffer from sexually transmitted infections, particularly HIV / AIDS. Tackling the high prevalence rates amongst this group is a major area of concern. Since these women are exposed to multiple sexual partners and often do not have the choice of using contraception, they are acutely vulnerable. The genital anatomy of women put them at a particular disadvantage since research has revealed that transmission of HIV from males to females is significantly higher than the other way around. Furthermore, in the absence of effective treatment (antiretroviral drugs), the transmission rates of all children born to HIV positive women can be up to 25%.[53] These children have to deal with the burden of potentially being orphaned at an early age, not to mention the stigma and discrimination of being associated with HIV / AIDS.

[53] Coovadia, 2004

Example: Committed Communities Development Trust (CCDT), Mumbai - HIV/AIDS project

CCDT's Project Roshni (A Ray of Light) was started in 2003 and provides healthcare, counselling, and day care services to HIV-infected women in the red light area of Kamathipura, Mumbai. CCDT works with almost 6500 women involved in commercial sex in this area.
Most of the brothels are no more than small rooms crowded with beds, often separated by curtains only. Some of the women live on the pavements; in huts made of scrap wood and plastic. The children of these women live on the streets along with their mothers, constantly exposed to violence and even sexual exploitation. The age group of the women ranges between 8 years and 65 years. More than 8% of the clients visiting the VCCTCs (Voluntary Confidential Counselling & Testing Centres) in Kamathipura have tested positive for HIV.
Activities:

- Day care facilities for women living with HIV/AIDS.
- Psycho-social support through counselling and support-group activities.
- Medical care, including care of the terminally ill, through referral linkages with private and public healthcare facilities.
- Events for sensitising the community on the care and support needs of women living with HIV/AIDS and for addressing stigma and discrimination.

A significant achievement of the project has been the contribution of peer educators or sakhis who are women from the community itself. These women have a much better understanding of community dynamics and have been very successful in providing health related information to the community. They also offer valuable insights into the problems faced by women in commercial sex work. This has resulted in many women insisting on using condoms with their "clients". One of the future challenges is to involve the men from this community in the prevention and awareness-raising of HIV/AIDS.

Source: CCDT website

On the basis of a review of current best practice in interventions with commercial sex workers, WHO (2009) suggests that observation of the following general principles contributes to effectiveness and sustainability:

- Adopting a non-judgemental attitude;
- Ensuring that interventions do no harm;
- Ensuring that rights to privacy, confidentiality and anonymity are respected;
- Respecting sex workers' human rights and according them basic dignity;

- Respecting sex workers' views, knowledge and life experiences;
- Involving sex workers, and, where appropriate, other community members in all stages of the development and implementation of interventions;
- Recognizing that sex workers are usually highly motivated to improve their health and well-being, and that sex workers are part of the solution;
- Building capacities and leadership among sex workers in order to facilitate effective participation and community ownership;
- Recognizing the role played in HIV transmission by clients and third parties, i.e. targeting the whole sex work setting, including clients and third parties
- Recognizing and adapting to the diversity of sex work settings and of the people involved.[54]

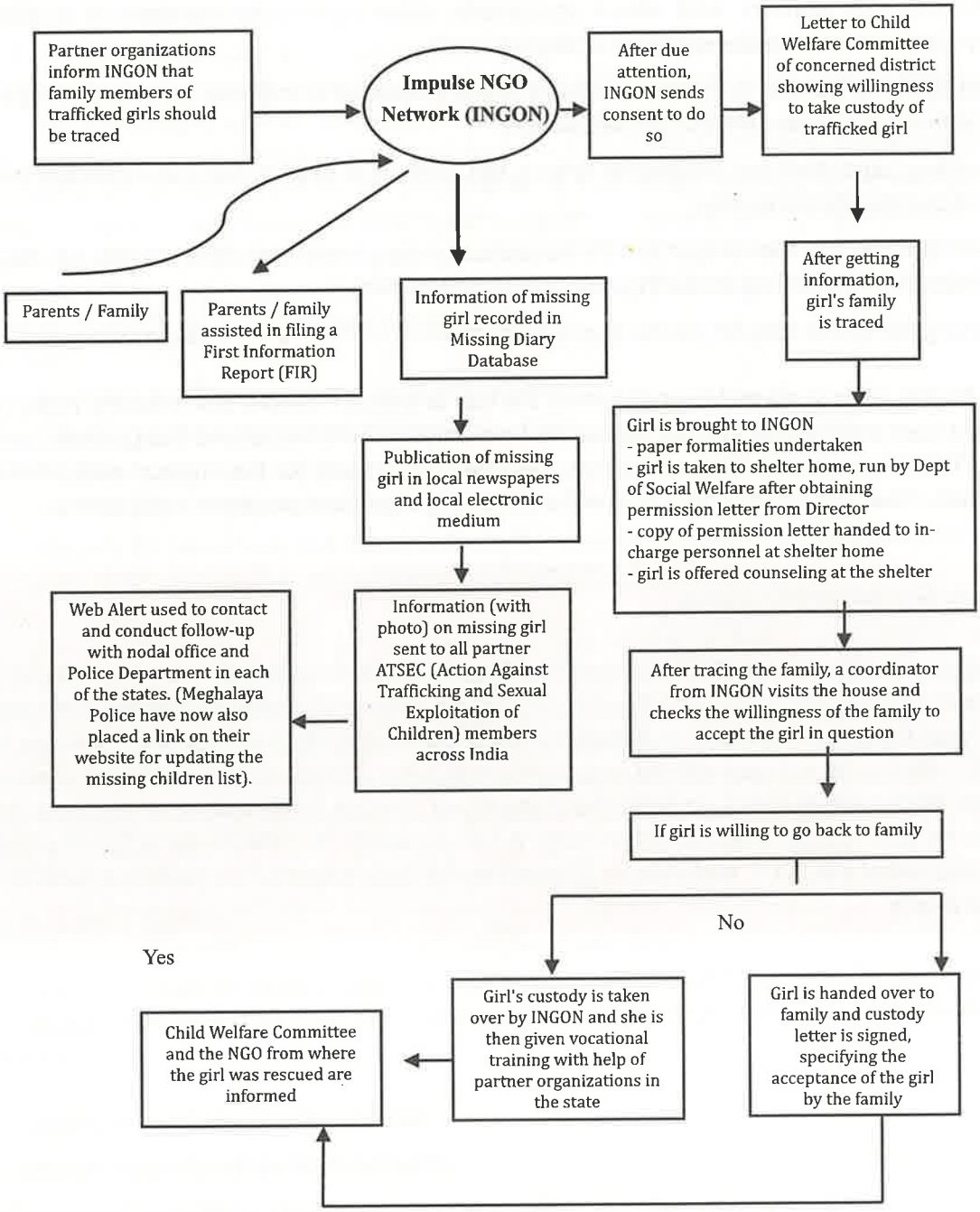
Although the big cities such as Mumbai remain the hub of the commercial sex industry, many girls are in fact brought from other states in India, as well as from countries like Nepal and Bangladesh, and sold into the trade. There is currently little assistance from the government for the support and rehabilitation of these women. However, several NGOs have been making significant progress in this arena.

Example: Impulse NGO Network

The Impulse NGO Network (INGON) based in Meghalaya works with trafficked women and children who are forced into sex work and labour. Its President, Hasina Kharbhih, pioneered the "Meghalaya Model" (see Diagram 1), which brings together State governments, law-enforcing agencies, the legal fraternity, the media and civil society organisations to keep a check on the trafficking of women and children. Moreover, it seeks to build the capacity of various stakeholders to address the issue collectively and ensure positive networking. It has received recognition as a "good practice" by UNDP and Ashoka in 2007, and also the Government of India which is now drafting it out to become a national model.

[54] WHO, 2009

Meghalaya Model



Source: National Commission for Women, New Delhi

Based on the above, one can draw out certain guidelines to deal with the issue of human trafficking:

- Identification of trafficked persons and traffickers
- Ensuring an adequate legal framework - for anti-trafficking and also for protection of trafficked persons
- Ensuring an adequate law enforcement response - particularly sensitizing law enforcement officials to their primary responsibility to ensure the safety and immediate well-being of trafficked persons
- Protection and support for trafficked persons - through cooperation with NGOs, ensuring that trafficked persons are provided with adequate shelter, primary health care, access to information and legal representation
- Preventing trafficking - for instance, strengthening the capacity of law enforcement agencies to arrest and prosecute those involved in trafficking as a preventive measure
- Special measures for the protection and support of child victims of trafficking
- Coordination between States and regions - such as developing cooperation arrangements to facilitate the rapid identification of trafficked persons including the sharing of information in relation to nationality / state of origin e.g. Meghalaya Model

5. Migrant groups: construction workers and their children

The construction industry is the single largest employer of migrant labourers in Indian cities. There are approximately 35 million men and women who work in this sector. Most migrant labourers are illiterate and are only able to speak their native language. Their lives are characterized by insecurity of wages, dangerous working conditions, and lack of access to any kind of welfare. Due to their migratory status, construction workers tend to live on construction sites in appalling conditions, often housed in makeshift shanties.[55]

To add to this, the estimated 50 million children of these workers are even more vulnerable. Due to their parents' perpetual low-income, uncertain jobs that necessitate frequent shifts, infants hardly begin or complete their set of required immunizations. These children are often left on their own to fend for themselves. They suffer from malnutrition, accidents, and countless health problems. They are also marginalized from formal schooling, day-care centres or any sort of support system.[56]

These children are often put to income-earning work at a young age. Girls tend to work as domestic help in neighbouring residential buildings. Girls are also expected to manage all the chores at home. Their low skills sets and low income earning capacity leads to possible further exploitation and early marriage. Thus, the cycle of vulnerability is perpetuated.

[55] JSA, 2007
[56] Ibid.

The migrant population usually does not get registered in any municipal electoral roles and consequently they fall through the cracks. Another major problem for migrant communities is access to healthcare - this stems from an inability to provide a proof of residence as well as language barriers. Malcolmson (2003) also argues that "health service gatekeepers", in the form of negative attitudes of health care providers and staff, can act as an obstacle for these vulnerable groups to access health care.[57]

The immediate needs of this group are:

- Coverage by all facilities to be extended to this group, especially of Health Posts
- Ratification of Construction Workers' Act - through this, construction workers are expected to benefit from collection of 1 per cent cess on cost of construction. They would also get welfare benefits such as accident assistance, pension benefits, family pension, funeral assistance, loan and advances for construction of house, group insurance, financial assistance for education of children, medical expenses for treatment, maternity benefits, marriage benefits and loans.[58]
- ICDS (Integrated Childhood Development Scheme) coverage to be extended for nutrition of children of construction workers
- Follow up mechanism for seasonal migration - this is vital because the health needs of migratory groups are often not given the required attention because of the high mobility of these groups.[59]

There are various organizations, such as Mobile Crèches, which attempt to provide basic healthcare and education for construction workers' children.

Example: Mobile Crèches

Mobile Creches was set up in 1969 in response to the needs of migrant constructions workers, who move from site to site with their children and their belongings.

By 1996, The Building and Other Construction Workers Act, stipulated the establishment of crèches such as these at all large construction sites with 50 or more women.

Mobile Creches now serves an average of 5000 children in a year, and functions in Delhi, Noida, Gurgaon, Mumbai and Pune. Along with this growth in numbers of children, there has been a parallel growth in field staff. The branches in Mumbai and Pune are, as of April 1, 2007, are being run as independent organizations called Mumbai Mobile Crèches and Tara Mobile Crèches.

[57] Malcolmson, 2003
[58] The Hindu 2009
[59] JSA, 2007

Mobile Creches provides health care services to children in the age-group of 0-12 years. The children are divided into three age-groups:

- 0-2 years: sometimes includes infants as young as 1 month old
- 3-5 years : the Balwadi section for pre-school children
- 6-12 years : the non-formal education (NFE) section for children who are either not attending school or are being equipped to join the formal schooling system.

Great emphasis is laid on preventive care. This includes the following:

- Immunization - although the schedule cannot always be followed due to migrancy of labour
- Regular supplementary nutrition
- Special diet for malnourished and sick children and adults
- Care for pregnant and lactating women
- Health and nutrition education for parents and children at the centre

The above example demonstrates that this intervention rests on the foundation of child development principles. That is, care and attention during the early years of a child are crucial for his or her physical, mental, emotional and social growth. Furthermore, the migratory nature of their life must fully be taken into consideration for all interventions, whether it be nutrition and healthcare, age-appropriate learning or school admission and support.

6. Elderly poor

In India, the population of elderly people is growing rapidly and is emerging as a serious concern for policy planners. According to the 2001 Census, there are over 76.6 million people over the age of 60 years, constituting 7.2 per cent of the population. Vulnerability amongst the elderly is partly due to an increased incidence of illness and disability but also due to the extent of their economic dependence on spouses, children and other family members. This lack of independence has a significant impact on their access to food, clothing and healthcare. In urban areas, the individualistic nature of life can amplify social isolation and thus put older people further at risk of ailing health.

The special nutrition and care needs of this group need to be taken into careful consideration. Age-related sensory changes include a decline in sight and peripheral vision, hearing, smell and taste. The losses are neither total nor rapid, but they do affect nutritional intake and health status. Also, as one ages, one can experience a loss of body mass. Reduced muscle mass includes skeletal muscle, smooth muscle and muscle that affects vital organ function. Cardiac capacity may be reduced and cardiac function impaired

by chronic diseases such as atherosclerosis, hypertension or diabetes. Changes also occur in the kidneys, lungs and liver, and in one's ability to generate new protein tissue. In addition, aging can slow the immune system's response in making antibodies. Aging can also cause bone density, resulting in more frequent fractures or even osteoporosis.

Poor nutrition is also associated with some of the changes above. The slowing of the normal action of the digestive tract plus other general changes reduce the effectiveness of digestion and hence, on nutrition. In the aging process, digestive secretions diminish markedly, although enzymes remain adequate.

Among the basic needs of the elderly, healthcare remains the highest unmet need. A National Sample Survey from 1998 reports that common aliments among the elderly include cough and blood pressure, piles, heart disease, urinary problems, diabetes and cancer. Providing healthcare to the elderly is a huge burden for poor households, especially in cases of chronic diseases which require life-long medications. This is highlighted by the fact that about 29 per cent of the elderly populations in India are estimated to have received no medical attention before death.[60]

The current health status of older people in poor urban populations is that there are no special schemes and there is limited access to various facilities. Often, they are restricted by age in being unable to take out insurance policies - even if they succeed, the focus is on hospitalization whilst chronic and ambulatory care are not covered.

A report from the 2007 JSA Consultation on Access to Healthcare of Vulnerable Groups in Mumbai states that there is a lack of sensitization among allied specialists and also little professional regulation of private sector. The report also finds that there is no uniformity in standard of care.

However, certain civil society organizations, such as HelpAge India are implementing advocacy programmes that aim to improve policies for elderly people.

Example: HelpAge India

HelpAge India is the leading advocate for Older People's rights. Their mission is speak out on behalf of the country's elderly population to enable them to live lives of dignity, independence and self-fulfilment.

HelpAge aims to influence policy interventions at state and national level to bring about positive changes in the lives of elderly people. For instance, they have made a recommendation to the government that social pensions should incorporate health insurance. At present social pensions are allocated at Rs 200 a month for older citizens below the poverty line. It is proposed that the

[60] NSSO, 1991

government should add an increased sum of Rs 50 per month towards health insurance, which can be paid to General Insurance Corporation or the National Insurance Corporation of India so that senior citizens in the lower economic strata can be covered for universal health insurance. This will help provide both social and health security for the elderly poor.

Also, HelpAge aims to increase awareness of issues concerned with ageing and thus promote more sensitive attitudes in society. Through its programmes of livelihood support, old age homes, cancer/Alzheimer's projects as well as their helpline, the organisation offers crucial support structures for the elderly poor.

Therefore, when designing programmes for the elderly poor in urban areas, it is important to consider their particular health-care and nutrition needs; thereby planning and implementing appropriate and context-specific interventions.

7. Disabled persons

Disability can include poor vision, hearing impairment and locomotor impairment, to name a few. According to the 2001 Census, the total number of disabled people in India is close to 21.9 million. Of these - 48.55 % have visual disabilities; 27.87 % have movement disabilities.[61]

The stigma attached to disabilities means that there is much discrimination in accessing appropriate health care and exercising rights to employment, housing and education. Among those who are disabled, women, children and the elderly are the most vulnerable.

The Persons with Disabilities, Equal Opportunities, Protection of Rights and Full Participation Act, commonly referred to as the PWD Act, came into force on February 7, 1996. (For full details of the Act, see Annexure). It does go some way in outlining measures for early detection of disabilities as well as aiming to ensure affirmative action for and non-discrimination of disabled people, particularly in the areas of education and employment.

Studies have shown that persons with disabilities are twice as likely to delay necessary health care; three times more likely to go without required health care; four times more likely to have special needs not covered by health insurance (Chatterjee & Sheoran, 2007). Health care providers may not fully understand disability and its relationship to overall health. Often it has been observed that disabled people do not get the respect they deserve and so healthcare centres remain inaccessible to them.[62]

NASEOH is a particular example of an NGO that focuses on the community-based rehabilitation of disabled persons.

[61] CEHAT, 2007
[62] JSA, 2007

Example: The National Society for Equal Opportunities for Handicapped (NASEOH)

NASEOH creates comprehensive rehabilitation opportunities for disabled persons so as to facilitate integration into the mainstream of the society. Its wide range of programmes include education, vocational training, employment, providing aids and appendages, counselling and various empowerment projects. It aims to target differently-abled persons and provide an interface between people and community; to start conversation on various issues of disability not only for the person, but also for the family and the community.

Interventions may vary according to age-dependent needs but there are some common themes across the life cycle.

1. Focus on the inclusion, visibility and rights of disabled people.
2. Specialised services, e.g. orthopaedics and rehabilitation, as a condition for full participation - thus efforts must be taken in terms of staff training, capacity building and monitoring quality of care.
3. Special consideration should be given to:
    - The development of community-based services for disabled people.
    - Programmes which emphasise the development of public awareness concerning the rights of disabled people, and the promotion of positive attitudes towards disabled people in the community.
    - Initiatives which increase the capacity of the disabled people to help themselves and each other, through the development of skills in needs identification, planning, decision-making, and project management.
4. All programmes, whether centre-based or community-based, must have the principle of economic, social and cultural integration built into the plan.
5. Programmes should lead to the empowerment of disabled people. Therefore, disabled people should be involved in designing, planning, and implementing programmes which affect them, as far as possible, at every stage.
6. Programmes should strive for an equitable distribution of resources, regardless of type of disability, age, gender, religion, or political affiliation.

8. People with mental illness

Mental illness is an oft neglected area in India. Stigma about mental illness is significant and has various detrimental consequences, including denial of equal opportunity and participation in society. Symptoms of mental illness are interpreted by some along religious lines. Families feel a need to hide facts from

others because of a fear of rejection by the community, as well as concerns about harming marriage opportunities. Faith healers and rituals are seen as the readily available option of choice, rather than appropriate treatment and support.

Those with mental illness living on the streets are a particularly vulnerable group since they may not have the family support system that can act as a crucial safety net. This leaves them exposed to further psychological, physical and emotional abuse.

It has been argued that institutional care is the first step to facilitate recovery of homeless mentally ill persons. However, a CEHAT report (2007) states that people with mental illnesses in institutions face severe human rights violations. In special homes and asylums, there are cases where they have been denied basic food and clothing, whilst facing physical and emotional abuse.[63]

Debate on need for institutionalization

For:

- Custodial care of individuals who do not have any other support
- Specialised care of those who are perceived to be incapable of taking care of themselves
- Based on the premise that it is better to isolate people with mental illness from society
- Has become a shifting paradigm - reflects prevailing societal values related to the social perceptions of mental illness

Against:

- Institutional isolation of a person with a mental illness is a form of discrimination
- Perpetuates unwarranted assumptions about people with disabilities and their ability to participate in community life
- Can diminish the quality of life of persons with mental illness by severing connections to family and other social contacts as well as limiting economic independence

An alternative school of thought amongst mental health practitioners is that rehabilitation is a better route to follow. Several studies have shown that there is a link between effective mental health rehabilitation, length of relapse duration and shorter inpatient stays (Moller and Murphy, 1997). The focus of rehabilitation tends to be the social, cognitive, and occupational disabilities that accompany psychological illness. Four types of assistance are often provided:

- Social skills training
- Cognitive remediation - attempts to help people improve their performance through practice and rehearsal
- Helping people to engage in purposeful activity e.g. vocational skills, employment etc
- Providing support in the person's environment

[63] CEHAT, 2007

Mental health rehabilitation issues

- Confusion over terminology
  Rehabilitation is a widely used term but rarely has it found meaning in practice (Mohan, 2005). This has given birth to many misconceptions and false practices under the name of mental health rehabilitation.
- Lack of a rehabilitation framework

  Till recently, mental health was a poorly developed and grossly underfunded area in India. Although there have been attempts by institutions such as National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore there is a general absence of guiding principles for service delivery of mental health in India. There is a dire need for rethinking of existing practices and policy development to build this framework further.
- Absence of resources

  Even in the District Mental Health Programme allocation, rehabilitation is given the least preference and is allied with services imparted at the institutional level. In addition, there is a lack of government coordination over this issue.
- Training

  A major hurdle in providing rehabilitation services is a lack of trained professionals and furthermore, training is restricted to a few institutions e.g. NIMHANS etc. More funds are required to be allocated to the bridge the gap between demand and supply.
- Monitoring and evaluation

  The process of rehabilitation in mental health is complex and has a broad spectrum of inter and intra sectoral dependency - as observed from the first day of treatment to last day of resettlement of client. It is important to collate information on the progress of the person undergoing treatment, the performance of the rehabilitation services and also on the prevalence / incidence of mental disorders. Such data tools and record keeping procedures need to be developed for all service delivery organizations working in the mental health sector.

Source: Sinha, H. 2008. "Issues and Challenges of Rehabilitation of Mentally Ill Persons in India".

The current situation in India is that there are 42 mental hospitals in the country with a bed availability of 20, 893 in the government sector and another 5096 in the private sector. This is not sufficient to provide care for an estimated 1,02,70, 165 people with severe mental illness and 5,12,51,625 with common

mental disorders.[64] Psychiatric medicines are supplied only in a few primary health centres, community centres and district hospitals. Services such as child guidance and rehabilitative services are available only in a few mental hospitals. Moreover, several states do not even have mental hospitals.[65]

Mental illness has been considered in the aforementioned Persons with Disabilities Act but there is no reference to any provision to be set aside for people with mental illness. The Act also does not assure the right to treatment.

Efforts are being made by NGOs such as The Banyan in implementing programmes with a more community-based approach to ensure care and treatment for women with mental illness living on the streets.

Example: The Banyan

The Banyan is an NGO that started work as a shelter and transit home for homeless women with mental illness who had left their homes across the country and ended up on the streets of Chennai. One of the organisations' core beliefs is that these women need to receive timely assistance and then as and when appropriate, be rehabilitated into mainstream society. The Banyan model of care is as follows:

1. An individual is referred to The Banyan by a volunteer, police etc.
2. A social worker and a health worker brings the individual to the shelter home.
3. Basic needs of food and hygiene are tended to.
4. Enquiries about details on family and place of residence are made to the individual.
5. Steps are taken towards rehabilitation - if possible, repatriation with the family is sought.
6. A social worker is assigned to the individual - who starts case documentation and carries out psychological, physical, social and skill assessments. Then, together with the individual, a treatment and rehabilitation plan is drawn up.
7. Treatment takes the form of medical, recreational (daily activities, social interaction etc) and therapeutic (including occupational therapy and vocational training) care.
8. Once the individual feels ready, the process of re-integration is set into motion with visits to the family as well as links made with local NGOs, local police, a local doctor, the head-man/woman of the area and other prominent members to enable effective follow-up.

The Banyan follow-up team stays in touch with former residents by making home visits, phone calls and by postal communication. "After Care" services include an Outpatient Clinic that provides the rehabilitated residents with free psychiatric consultation, lifelong free medication and follow-up as well as an allowance of Rs. 200 / month to encourage regular pick-up of medicines.

[64] CEHAT, 2007
[65] Mental Health in India, 2006

Thus, there are a number of models of service provision for people with mental illness, especially in a homeless context.[66] According to Timms (1996), these can be broadly classified as:

i. Primary outreach: where staff make first initial approach to potential patients;
ii. Secondary outreach: where initial contact is made by a voluntary agency which initiates or provides the venue for subsequent contact with a psychiatric team;
iii. Residential stabilization: special housing and support arrangements are made for homeless patients, especially following episodes of hospital care.

In addition, as Breakey (1987) outlines, certain desirable service characteristics can also be set out:

- Rapid response
- Willing and tolerant - informal and non-stigmatising
- Capable of linking mental health services and accommodation
- Comprehensive - dealing with a range of social needs
- Continuous - good flow of information within and between services
- Collaborative - part of a wider service network
- Responsive to context and changing circumstances[67]

9. LGBTs (Lesbian,Gay,Bisexual and Transgendered Individuals)

A crucial contributory factor which heightens vulnerability is stigma and discrimination. One group which faces a great deal of stigma and discrimination are LGBTs (lesbian, gay, bisexual and transgendered individuals).

- Lesbian - refers to women who identify themselves or who are characterized by others as having the primary attribute of female same-sex desire
- Gay - describes people who are attracted to members of the same sex
- Bisexual - refers to people who can experience sexual, emotional, and affectional attraction to both their own sex and the opposite sex
- Transgender - non-identification with, or non-presentation as, the sex (and assumed gender) one was assigned at birth. It does not imply any specific form of sexual orientation - transgender people may identify as heterosexual, homosexual, bisexual or asexual.

People who have same-sex sexual preferences were, until recently, considered criminals in India. They are often ridiculed and ostracized by their own families - they are left with limited support structures or networks that provide them with conditions of care and assistance.[68]

[66] Timms, P. 1996
[67] Breakey, 1987
[68] CEHAT, 2007

Case Study: Manjude

"I was born as a male in a Muslim family in Khanpur (in central Ahmedabad). In my teenage years, I suddenly started behaving like a girl swaying my hips and giggling along with other girls. I had the desire to wear women's clothes and also noticed hormonal changes in my body. My family was shocked and took me to tantriks and soothsayers to cure me, but to no avail. Ultimately I decided to run away from home to the temple town of Bahucharaji, where I performed the ritual of castration and was admitted into the society of hijras."

Now Manjude resides at Kharwadi slum, on the eastern bank of the Sabarmati river, as a group of 15 devotees of the Goddess Bahucharaji. They go off to work early in the morning - begging, collecting alms or offerings at times of marriage and childbirth. But they are forced to live in social exclusion. The society refuses them regular work and all basic rights like access to the Public Distribution System, amenities etc.

To compensate for exclusion from society, the hijras have developed a strong network of solidarity. They never turn to the non-hijra society for any support, other than when begging. For example, when admitting new entrants into the fold, they castrate them in an elaborate religious ritual spread over days. The initiated persons suffer from infections, inflammations and boils but they refuse to seek any medical help. They say, "We apply hot oil as a medication for about a month and a half, the rest will be taken care of by the divine Bahucharaji. What can any doctor do?"

Source: D'Costa, W. & Das, B. 2002. "Life and Living of the Vulnerable in Ahmedabad City".

The needs of LGBTs are often excluded from various health policies and programmes. The National AIDS Prevention and Control Policy is one of the few to recognize sexual minorities and homosexuality but only when identifying "high risk behaviors" in the HIV / AIDS discourse. According to the UNAIDS, criminalizing homosexuality leads to an increase in the stigma and discrimination they face, which can increases the chances of HIV infection. Although, the recent Supreme Court ruling (July 2009) to decriminalize homosexuality is a progressive step, negative attitudes persist in society, partly due to perceptions of causes of HIV / AIDS. These are compounded by marginalization on the basis of other attributes, not only of sexual preferences and behaviours, but also due to gender and migrant status.[69]

The National AIDS Control Organization (NACO) and UNAIDS places the figure of HIV-affected people in India between 2.3- 3.1 million in 2009. Vulnerability to HIV / AIDS is increased by the lack of power of individuals to minimize their risk to exposure, for instance through lack of awareness. Currently, there are hardly any support systems available for people living with HIV / AIDS. For instance, a HIV positive individual may sometimes also have to deal with the additional stigma of being homosexual. Negative

[69] Ibid.

attitudes from health professionals generate anxiety and fear and as a result, many do not seek treatment for HIV. In addition, a lack of awareness may result in people living with HIV / AIDS not accessing test centres and thus not even knowing their HIV positive status.

Though a significant number of non-governmental organizations are working on this issue, they all point to the fact that they cannot reach out to a huge section of the population who are stigmatized on account of their sexual identity and choose to remain hidden from surveillance programmes. This creates an enormous problem not only in providing services to people living with HIV / AIDS but also in increasing awareness about the disease.

Example: Humsafar Trust

The Humsafar Trust was set up in 2004 by a group of self identified homosexual men to reach out to the MSM (men who have sex with men) population in Mumbai. During later years, their programme expanded to targeting transgenders, lesbians and bisexuals as well.

The Humsafar Trust's work has four main components:

- community work
- outreach into the gay and MSM groups
- advocacy on gender and sexuality issues
- research into sexuality and gender issues

By having services like a drop in centre, telephone counseling line and free workshops, this organization has created a gathering place and educational centre for the homosexual and transgendered population. The main mission of this group is to educate and empower society to seek informed safer practices for better sexual health.

Thus, based on the above example as well as frameworks such as the Yogyakarta Principles (2007),[70] one can derive certain principles of intervention for LGBTs. Health systems need to fully recognize the rights of LGBTs, thereby designing and implementing services that cater to their specific health needs. These health-related rights include:

- Right to control one's health and body
- Right to sexual and reproductive freedom
- Right against forced medical treatment
- Right to a system of health that offers equality of opportunity in attaining the highest standard of health, especially including HIV / AIDS prevention and treatment

[70] The Yogyakarta Principles on the Application of Human Rights Law in Relation to Sexual Orientation and Gender Identity (launched on March 26, 2007) were drafted by experts from 25 countries representative of all regions of the world. These principles detail the obligation of states to respect, protect and fulfil the human rights of all persons regardless of their sexual orientation or gender identity

CONCLUSION

It has been learnt that the most vulnerable pockets of people in urban settings are often not included in official slum lists. Thus, there is a dire need to identify and plot vulnerable populations in each city, so as to efficiently target resources.[71] The violation of the right to health for vulnerable groups may result from contextual factors and patterns of systematic discrimination but also due to a lack of government action to fulfill its minimum core obligations. There needs to be a special focus on the population groups considered most vulnerable in urban settings whilst designing and implementing urban health progammes. These programmes should seek to abide by the following principles:

- Be based on equality
- Be free from discrimination
- Include the participation of beneficiaries in the decision-making process
- Provide prompt referral and treatment in the primary care of the specific health needs of these vulnerable groups
- Improve the health infrastructure so as to better provide these services
- Develop human resources for health
- Establish national policies and legislations that promote the health and welfare of vulnerable groups
- Sensitize and educate the public about the needs of and challenges faced by these groups
- Provide care in the community
- Link with other sectors e.g. water, sanitation, other aspects of urban development

[71] The Indore Ward Coordination Model has demonstrated well that holding discussions with stakeholders at the ward level and using situational analysis facilitates coordinated collective action, which helps to reach under-served areas and vulnerable populations in the ward.

Review Questions

1. List two kinds of vulnerabilities and illustrate each with an example
2. Name one government initiative for the urban poor and state its main objectives
3. What are any three behavioural characteristics that may be noticed amongst street children?
4. Outline the debate on the legalisation of commercial sex
5. Define the terms - lesbian, gay, bisexual and transgender

Application Questions

1. Discuss in detail how the 'invisibility' of certain urban poor communities contributes to heightening their vulnerability. Explain using examples.
2. Examine how a lack of convergence between government bodies i.e. State Health Department, Municipal Corporation Health Bodies, etc. as well as various sectors e.g. housing, sanitation etc. affects the health outcomes of vulnerable urban populations.
3. Compile a set of guidelines for 'good practice' in programmes for the elderly poor, that takes in to full consideration their health and specific needs
4. Cull out actionables when preparing a District Health Action Plan (DHAP).

Project Assignment

1. Identify a particular vulnerable group in an area that you know (it can be a group not covered in the chapter). Conduct interviews, focus group discussions etc. to understand their specific health needs. Design a programme that would address these needs by taking a context specific approach.
2. Conduct a focus group discussion with women living in a slum community on:
   a) their own understanding of health issues
   b) their experiences in attempting to access health care
3. You are asked to organise a one day HIV/AIDS awareness-raising event in a poor urban community. Draw up a detailed schedule of events and activities that would tackle issues of stigma and discrimination and emphasise the care and support needs of people living with HIV/AIDS.

Lesson SIX

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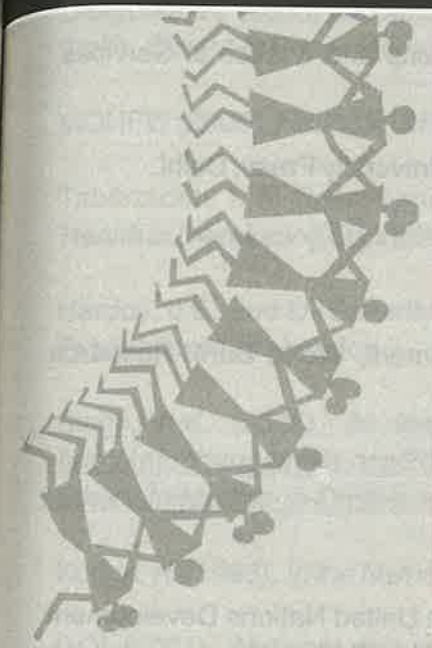

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Annexure ONE

Lesson 1 - First 100 Cities

#	City	Urban Status	Total Popul.	Slum Popul.	% Slum Popul.	District	State/UT	JNN URM City
1	2	3	4	5	6	7	8	9
Cities with a population of 40 lakhs plus as per 2001 census								
1	Greater Mumbai	M.Corp.	11,914,398	6,475,440	54.06	Mumbai (Suburban) and Mumbai	Maharashtra	yes
2	Delhi Municipal Corporation (U)	M.Corp.	9,817,439	1,851,231	18.74	In all 9 districts	Delhi *	yes
3	Kolkata	U.A. P	4,580,544	1,485,309	32.43	Kolkata	West Bengal	yes
4	Bangalore	M.Corp.	4,292,223	819,873	18.88	Bangalore	Karnataka	yes
5	Chennai	M.Corp.	4,216,268	430,501	10.01	Chennai	Tamil Nadu	yes
Cities with a population of 10 lakhs plus but below 40 lakhs as per 2001 census								
6	Ahmedabad	M.Corp.	3,515,361	473,662	13.47	Ahmadabad	Gujarat	yes
7	Hyderabad M.Corp	M.Corp.	3,449,878	626,849	18.17	Hyderabad and Rangareddi	Andhra Pradesh	yes
8	Pune	M.Corp.	2,540,069	492,179	19.38	Pune	Maharashtra	yes
9	Kanpur	M.Corp.	2,532,138	367,980	14.53	Kanpur Nagar	Uttar Pradesh	yes
10	Surat	M.Corp.	2,433,787	508,485	20.89	Surat	Gujarat	yes
11	Jaipur	M.Corp.	2,324,319	368,570	15.86	Jaipur	Rajasthan	yes
12	Lucknow	M.Corp.	2,207,340	179,176	8.12	Lucknow	Uttar Pradesh	yes
13	Nagpur	M.Corp.	2,051,320	737,219	35.94	Nagpur	Maharashtra	yes
14	Indore	M.Corp.	1,597,441	260,975	16.34	Indore	Madhya Pradesh	yes
15	Bhopal	M.Corp.	1,433,875	125,720	8.77	Bhopal	Madhya Pradesh	yes
16	Ludhiana	M.Corp.	1,395,053	314,904	22.57	Ludhiana	Punjab	yes
17	Patna	M.Corp.	1,376,950	3,592	0.26	Patna	Bihar	yes
18	Vadodara	M.Corp.	1,306,035	186,020	14.24	Vadodara	Gujarat	yes
19	Thane	M.Corp.	1,261,517	351,065	27.83	Thane	Maharashtra	
20	Agra	M.Corp.	1,259,979	121,761	9.66	Agra	Uttar Pradesh	yes
21	Kalyan-Dombivali	M.Corp.	1,193,266	34,860	2.92	Thane	Maharashtra	
22	Varanasi	M.Corp.	1,100,748	137,977	12.53	Varanasi	Uttar Pradesh	yes

23	Nashik	M.Corp.	1,076,967	138,797	12.89	Nashik	Maharashtra	yes
24	Meerut	M.Corp.	1,074,229	471,581	43.90	Meerut	Uttar Pradesh	yes
25	Faridabad	M.Corp.	1,054,981	490,981	46.54	Faridabad	Haryana	yes
26	Haora	M.Crop.	1,008,704	118,286	11.73	Haora	West Bengal	
27	Pimpri Chinchwad	M.Corp.	1,006,417	123,957	12.32	Pune	Maharashtra	
Other Capital Cities with Reported Slum Population								
28	Srinagar	M.C.	894,940	137,555	15.37	Srinagar	Jammu & Kashmir	yes
29	Ranchi	M.Corp.	846,454	74,692	8.82	Ranchi	Jharkhand	yes
30	Guwahati	M.Corp.	808,021	8,547	1.06	Kamrup	Assam	yes
31	Chandigarh	M.Corp.	808,796	107,125	13.24	Chandigarh	Chandigarh *	yes
32	Trivandrum	M.Corp.	744,739	11,817	1.59	Thiruvanan -thapuram	Kerala	yes
33	Bhubanes -war	M.Corp.	647,302	71,403	11.03	Khordha	Orissa	yes
34	Raipur	M.Corp.	605,131	226,151	37.37	Raipur	Chhattisgarh	yes
35	Dehradun	M.Corp.	447,808	91,939	20.53	Dehradun	Uttaranchal	yes
36	Pondicherry	M	220,749	31,129	14.10	Pondicherry	Pondicherry *	yes
37	Agartala	M.Cl.	189,327	29,949	15.82	West Tripura	Tripura	yes
38	Shillong	M	132,876	86,304	64.95	East Khasi Hills	Meghalaya	yes
39	Port Blair	M.Cl.	100,186	16,244	16.21	Andamans	Andaman & Nicobar Islands*	
Cities with higher slum population as per 2001 census								
40	Aligarh	M.Corp.	667,732	304,126	45.55	Aligarh	Uttar Pradesh	
41	Jabalpur	M.Corp.	951,469	275,662	28.97	Jabalpur	Madhya Pradesh	Yes
42	Vijayawada	M.Corp.	825,436	263,393	31.91	Krishna	Andhra Pradesh	Yes
43	Ghaziabad	M.Corp.	968,521	258,255	26.66	Ghaziabad	Uttar Pradesh	
44	Amravati	M.Corp.	549,370	233,712	42.54	Amravati	Maharashtra	
45	Warangal	M.Corp.	528,570	229,661	43.45	Warangal	Andhra Pradesh	
46	Amritsar	M.Corp.	975,695	229,603	23.53	Amritsar	Punjab	Yes
47	Madurai	M.Corp.	922,913	221,338	23.98	Madurai	Tamil Nadu	Yes
48	Gwalior	M.Corp.	826,919	209,769	25.37	Gwalior	Madhya Pradesh	
49	Malegaon	M.Cl.	409,190	208,202	50.88	Nashik	Maharashtra	Yes
50	Burhanpur	M.Corp.	194,360	193,725	99.67	East Nimar	Madhya Pradesh	

51	Shahjah -anpur	M.B.	297,932	185,602	62.30	Shahjahanpur	Uttar Pradesh	
52	Solapur	M.Corp.	873,037	180,882	20.72	Solapur	Maharashtra	
53	Tiruchira-ppalli	M.Corp.	746,062	178,410	23.91	Tiruchirappalli	Tamil Nadu	
54	Siliguri	M.Corp.	470,275	175,012	37.21	Darjiling and Jalpaiguri	West Bengal	
55	Visakhap -atnam	M.Corp.	969,608	170,265	17.56	Visakhap -atnam	Andhra Pradesh	Yes
56	Guntur	M.Corp.	514,707	170,007	33.03	Guntur	Andhra Pradesh	
57	Rajkot	M.Corp.	966,642	166,030	17.18	Rajkot	Gujarat	Yes
58	Nizamabad	M	286,956	164,447	57.31	Nizamabad	Andhra Pradesh	
59	Saharanpur	M.B.	452,925	161,971	35.76	Saharanpur	Uttar Pradesh	
60	Jhansi	M.B.	383,248	158,482	41.35	Jhansi	Uttar Pradesh	
61	Asansol	M.Corp.	486,304	158,324	32.56	Barddhaman	West Bengal	Yes
62	Bareilly	M.Corp.	699,839	156,001	22.29	Bareilly	Uttar Pradesh	
63	Nellore	M	378,947	155,505	41.04	Nellore	Andhra Pradesh	
64	Jodhpur	M.Corp.	846,408	154,080	18.20	Jodhpur	Rajasthan	
65	Kota	M.Corp.	695,899	152,588	21.93	Kota	Rajasthan	
66	Salem	M.Corp.	693,236	151,577	21.87	Salem	Tamil Nadu	
67	Aurangabad	M.Corp.	872,667	147,776	16.93	Aurangabad	Maharashtra	
68	Durgapur	M.Corp.	492,996	147,006	29.82	Barddhaman	West Bengal	
69	Navi Mumbai	M.Corp.	703,947	139,009	19.75	Thane	Maharashtra	
70	Quthbullapur	M	225,816	138,952	61.53	Rangareddi	Andhra Pradesh	
71	Jalandhar	M.Corp.	701,223	134,840	19.23	Jalandhar	Punjab	
72	Akola	M.Cl.	399,978	134,812	33.70	Akola	Maharashtra	
73	Allahabad	M.Corp.	990,298	126,646	12.79	Allahabad	Uttar Pradesh	Yes
74	Dindigul	M	196,619	121,762	61.93	Dindigul	Tamil Nadu	
75	Kurnool	M.Corp.	267,739	121,165	45.25	Kurnool	Andhra Pradesh	
76	Morena	M	150,890	120,652	79.96	Morena	Madhya Pradesh	
77	Ujjain	M.Corp.	429,933	120,330	27.99	Ujjain	Madhya Pradesh	Yes
78	Ajmer	M.Cl.	485,197	120,315	24.80	Ajmer	Rajasthan	Yes
79	Uluberia	M	202,095	119,490	59.13	Haora	West Bengal	
80	Bhiwandi	M.Cl.	598,703	115,996	19.37	Thane	Maharashtra	
81	Rajahmundry	M.Corp.	313,347	112,388	35.87	East Godavari	Andhra Pradesh	
82	Khandwa	M.Corp.	171,976	111,844	65.03	East Nimar	Madhya Pradesh	
83	Bilaspur	M.Corp.	265,178	110,336	41.61	Bilaspur	Chhattisgarh	

84	Hubli -Dharwad	M.Corp.	786,018	108,709	13.83	Dharwad	Karnataka	
85	Korba	M.Corp.	315,695	108,616	34.41	Korba	Chhattisgarh	
86	Eluru	M	189,772	105,111	55.39	West Godavari	Andhra Pradesh	
87	South Dumdum	M	392,150	104,534	26.66	North Twentyfour Parganas	West Bengal	
88	Panipat	M.Cl.	261,665	102,853	39.31	Panipat	Haryana	
89	Titagarh	M	124,198	102,363	82.42	North Twentyfour Parganas	West Bengal	
90	Machilip -atnam	M	183,370	99,868	54.46	Krishna	Andhra Pradesh	
91	Dewas	M.Corp.	230,658	98,250	42.60	Dewas	Madhya Pradesh	
92	Bikaner	M.Cl.	529,007	98,035	18.53	Bikaner	Rajasthan	
93	Panihati	M	348,379	97,706	28.05	North Twentyfour Parganas	West Bengal	
94	Farrukhabad -cum -Fatehgarh	M.B.	227,876	97,390	42.74	Farrukhabad	Uttar Pradesh	
95	Tiruvottiyur	M	211,768	95,120	44.92	Thiruvallur	Tamil Nadu	
96	Ramagundam	M	235,540	94,929	40.30	Karimnagar	Andhra Pradesh	
97	Cuttack	M.Corp.	535,139	93,910	17.55	Cuttack	Orissa	
98	Dhule	M.Cl.	341,473	93,288	27.32	Dhule	Maharashtra	
99	Hapur	M.B.	211,987	90,977	42.92	Ghaziabad	Uttar Pradesh	
100	Rohtak	M.Cl.	286,773	90,609	31.60	Rohtak	Haryana	

Annexure TWO

Lesson 2

Health of the Urban Poor in India Key Results from the National Family Health Survey, 2005 - 06

Key Indicators for Urban Poor in India from NFHS-3 and NFHS-2	Urban Poor	Urban Non Poor	Overall Urban	Overall Rural	All-India	Urban Poor NFHS-2 (1998-99)
Marriage and Fertility						
Women age 20-24 married by age 18 (%)	51.5	21.2	28.1	52.5	44.5	63.9
Women age 20-24 who became mothers before age 18 (%)	25.9	8.3	12.3	26.3	21.7	39.0
Total fertility rate (children per woman)	2.80	1.84	2.06	2.98	2.68	3.78
Higher order births (3+ births) (%)	28.6	11.4	16.3	28.1	25.1	29.5
Birth Interval (median number of months between current and previous birth)	29.0	33.0	32.0	30.8	31.1	31.0
Maternal Health						
Maternity care[1]						
Mothers who had at least 3 antenatal care visits (%)	54.3	83.1	74.7	43.7	52.0	49.6
Mothers who consumed IFA for 90 days or more (%)	18.5	41.8	34.8	18.8	23.1	47.0#
Mothers who received tetanus toxoid vaccines (minimum of 2) (%)	75.8	90.7	86.4	72.6	76.3	70.0
Mothers who received complete ANC[2] (%)	11.0	29.5	23.7	10.2	15.0	19.7
Births in health facilities (%)	44.0	78.5	67.4	28.9	38.6	43.5
Home deliveries (%)	56.0	21.5	32.6	71.1	61.4	56.5
Births assisted by a doctor/nurse/LHV/ANM/other health personnel (%)	50.7	84.2	73.4	37.4	46.6	53.3
Anaemia among women						
Women age 15-49 with anaemia (%)	58.8	48.5	50.9	57.4	55.3	54.7
Child Health & Survival						
Child immunization and vitamin A supplementation[3]						
Children completely immunized (%)	39.9	65.4	57.6	38.6	43.5	40.3
Children receiving measles immunization (%)	52.6	80.1	71.8	54.2	58.8	35.3
Children left out from UIP (Children not receiving DPT 1) (%)	29.5	9.8	15.6	27.0	24.0	35.0
Children dropping out from UIP (DPT 1 to DPT 3) (%)	19.1	13.2	15.3	22.6	20.7	21.2
Child feeding practices						
Children under 3 years breastfed within one hour of birth (%)	27.3	31.5	30.3	22.4	24.5	17.7
Children age 0-5 months exclusively breastfed (%)	44.7	38.6	40.7	48.6	46.4	44.3
Children age 6-9 months receiving solid or semi-solid food and breast milk (%)	56.2	66.1	63.1	54.7	56.7	52.7
Nutritional status of children						
Children under 3 years who are stunted (%)	25.2	33.2	39.6	50.7	48.0	52.5
Children under 3 years who are underweight (%)	49.8	26.2	32.7	45.6	42.5	48.0
Anaemia among children						
Children under 3 years with anaemia (%)	79.8	59.0	63.0	71.5	69.5	79.0
Childhood diseases and treatment [4]						
Children who had diarrhoea in the last 2 weeks (%)	8.9	8.9	8.9	9.0	9.0	22.0
Children with diarrhoea in the last 2 weeks who received ORS (%)	24.9	36.3	32.6	23.8	26.0	25.6
Children with diarrhoea in the last 2 weeks taken to a health facility (%)	55.1	69.0	64.5	58.2	59.8	66.3

Health of the Urban Poor in India Key Results from the National Family Health Survey, 2005 - 06

Key Indicators for Urban Poor in India from NFHS-3 and NFHS-2	Urban Poor	Urban Non Poor	Overall Urban	Overall Rural	All-India	Urban Poor NFHS-2 (1998-99)
Children with fever in the last 2 weeks (%)	15.1	13.5	14.0	15.1	14.9	29.1
Children with acute respiratory infection in the last 2 weeks (%)	6.1	4.4	5.1	6.0	5.8	20.8
Children with acute respiratory infection in the last 2 weeks taken to a health facility (%)	76.1	79.4	78.1	66.3	69.0	65.3
Mortality[5]						
Neonatal Mortality	34.9	25.5	28.7	42.5	39.0	45.5
Infant Mortality	54.6	35.5	41.7	62.1	57.0	69.8
Under-5 Mortality	72.7	41.8	51.9	81.9	74.3	102.0
Family Planning (Currently Married Women, age 1549)						
Current use						
Any modern method (%)	48.7	58.0	55.8	45.3	48.5	43.0
Spacing method (%)	7.6	19.8	16.9	7.2	10.1	4.6
Permanent sterilization method rate (%)	41.1	38.2	38.9	38.1	38.3	38.4
Unmet need for family planning						
Total unmet need (%)	14.1	8.3	10.0	14.6	13.2	16.7
a. For spacing (%)	5.7	4.1	4.5	6.9	6.2	8.5
b. For limiting (%)	8.4	4.2	5.2	7.2	6.6	8.2
Environmental Conditions						
Households with access to piped water supply at home (%)	18.5	62.2	50.7	11.8	24.5	13.2
Households accessing public tap / hand pump for drinking water (%)	72.4	30.7	41.6	69.3	42.0	72.4
Household using a sanitary facility for the disposal of excreta (flush / pit toilet) (%)	47.2	95.9	83.2	26.0	44.7	40.5
Median number of household members per sleeping room	4.0	3.0	3.3	4.0	3.5	3.5
Infectious Diseases						
Prevalence of medically treated TB (per 100,000 persons)	461	258	307	469	418	535
Women (age 15-49) who have heard of AIDS	63.4	89.1	83.2	50.0	60.9	42.1
Prevalence of HIV among adult population (age 15-49)	0.47	0.31	0.35	0.25	0.28	na
Educational Attainment and Schooling						
School attendance 6-17 years (male) (%)	61.3	83.7	77.1	74.7	75.4	67.3
School attendance 6-17 years (female) (%)	59.2	83	76.1	62.9	66.4	61.4
Women age 15-49 with no education (%)	49.8	13.7	22.0	49.7	40.6	60.9
Access to Health Service						
Children under age six living in enumeration areas covered by an AWC (%)	53.3	49.1	50.4	91.6	81.1	na
Women who had at least one contact with a health worker in the last three months (%)	10.1	5.8	6.8	14.2	11.8	16.7$

1. For the most recent live birth; 2. CompleteANC includes three ANC visits, two TT injections and 90 doses of IFA; 3. For the last 2 births before the survey within the age group of 12-23 months; 4. For children under age of five years; 5. Rates are calculated for the five-year period preceding the survey.
na: not available; # NFHS 2 figure is for women who received 90+ IFA; @ NFHS 2 figure is for children under three years; $ NFHS 2 figure is for women who receive visit of a health/ family planning worker in the 12 months prior to the survey

Annexure THREE

Slum and Non-slum data for eight cities, Study by IIPS, Mumbai - Lesson 2

Slum/nonslum indicators from NFHS-3	CHENNAI			DELHI			HYDERABAD			INDORE		
	SLUM	NON SLUM	TOTAL	SLUM	NON SLUM	TOTAL	SLUM	NON SLUM	TOTAL	SLUM	NON SLUM	TOTAL
Marriage and fertility												
Total fertility rate (children per woman 15-49)	1.7	1.6	1.6	2.5	2.0	2.1	1.9	1.7	1.8	2.2	2.0	2.0
Women age 15-19 who were already mothers or pregnant at the time of the survey (%)	12.6	4.3	5.9	11.8	3.1	4.9	7.4	5.6	5.9	6.2	7.7	7.3
Median age at first birth for women age 25-49	20.6	22.3	21.9	19.9	22.2	21.9	19.8	21.0	20.8	20.6	21.3	21.1
Family planning (currently married women age 15-49)												
Current use												
Any method (%)	72.3	67.5	68.4	56.4	69.3	66.9	64.5	66.6	66.2	68.8	71.4	70.9
Any modern method (%)	70.0	66.4	67.1	50.5	57.9	56.5	63.2	65.5	65.1	66.7	66.3	66.4
Female sterilization (%)	64.9	53.5	55.7	26.9	20.9	22.0	55.1	54.0	54.2	44.9	39.9	40.9
Male sterilization (%)	0.0	0.3	0.2	1.4	0.6	0.8	1.7	2.1	2.0	2.7	1.6	1.8
IUD (%) 2.8	5.7	5.2	3.1	5.5	5.0	1.1	2.9	2.6	1.9	2.7	2.5	
Pill (%) 0.1	0.5	0.5	4.1	4.5	4.4	2.3	2.7	2.6	4.4	4.1	4.1	
Condom (%)	1.9	6.4	5.5	14.7	26.0	23.9	2.9	3.7	3.6	12.6	18.1	17.0
Unmet need for family planning												
Total unmet need (%)	6.5	6.7	6.6	13.3	5.8	7.2	8.9	7.3	7.6	8.4	7.7	7.9
Unmet need for spacing (%)	4.0	4.5	4.4	5.0	2.7	3.1	3.6	5.0	4.7	4.5	3.7	3.8
Unmet need for limiting (%)	2.5	2.1	2.2	8.3	3.1	4.1	5.3	2.3	2.9	3.9	4.1	4.0
Childhood mortality (in the last 5 years)												
Infant mortality rate	31.7	11.3	16.3	50.9	37.7	40.8	22.9	27.7	26.9	63.2	27.3	34.9
Under-five mortality rate	40.5	11.3	18.6	66.8	41.5	47.7	25.8	29.6	28.9	72.7	38.5	45.8
Maternal and child health												
Maternity care (for births in the last 5 years)												
Mothers who had at least 3 antenatal care visits for their last birth (%)	98.7	100.0	99.7	58.5	79.5	75.1	90.5	91.4	91.2	83.9	85.1	84.9

Mothers who consumed IFA for 90 days or more when they were pregnant with their last child (%)	49.0	58.1	56.0	22.6	45.9	41.0	46.7	54.3	53.0	37.2	41.1	40.3
Births assisted by a doctor/nurse /LHV/ANM/other health personnel (%)	98.8	100.0	99.7									
Institutional births (%)	97.5	99.6	99.1	33.4	68.4	60.1	88.7	92.8	92.1	76.4	73.4	74.1
Mothers who received postnatal care within 4 hours of delivery for their last live birth (%)	72.1	72.6	72.4	29.2	43.5	40.5	51.5	61.8	60.0	50.5	59.2	57.4
Child immunization and vitamin A supplementation												
Children 12-23 months fully vaccinated (BCG, measles, and 3 doses each of polio and DPT) (%)	89.2	74.1	77.7	51.7	67.0	63.2	53.3	62.4	60.8	73.7	76.4	75.7
Children 12-23 months who have received BCG (%)	100.0	98.1	98.6	79.8	89.0	86.7	93.3	97.0	96.4	95.0	100.0	98.7
Children 12-23 months who have received 3 doses of polio vaccine (%)	93.8	87.0	88.7	74.2	80.7	79.1	68.9	76.2	75.0	86.2	90.9	89.7
Children 12-23 months who have received 3 doses of DPT vaccine (%)	100.0	90.7	93.0	65.2	74.3	72.0	75.6	83.2	81.8	81.2	89.1	87.1
Children 12-23 months who have received measles vaccine (%)	95.4	94.4	94.7	67.4	81.7	78.1	74.4	82.2	80.8	81.2	78.2	79.0
Treatment of childhood diseases												
Children with diarrhoea in the last 2 weeks who received ORS (%)	42.1	62.5	54.7	38.5	26.5	29.4	36.8	66.7	61.4	44.8	58.5	55.1
Children with diarrhoea in the last 2 weeks taken to a health facility (%)	42.1	75.0	62.4	64.1	73.5	71.2	89.5	71.4	74.6	72.4	70.7	71.1
Children with acute respiratory infection or fever in the last 2 weeks taken to a health facility (%)	90.5	90.0	90.2	73.9	94.4	90.2	*	*	*	80.0	100.0	84.5
Child feeding practices and the nutritional status of children												
Children under 5 years breastfed within one hour of birth (%)	61.6	48.1	51.2	18.1	22.7	21.7	21.8	28.6	27.4	31.7	28.4	29.1
Children under 5 years who are stunted (%)	27.6	24.8	25.4	50.9	37.9	40.9	32.4	32.0	32.1	39.6	30.6	32.5
Children under 5 years who are wasted (%)	22.8	17.6	18.8	14.5	15.6	15.3	11.1	9.1	9.4	34.0	27.6	28.9
Children under 5 years who are underweight (%)	31.6	20.6	23.1	35.3	23.9	26.5	26.0	18.4	19.8	49.6	36.7	39.3

Nutritional status of adults (age 15-49)												
Women whose body mass index (BMI) is below normal (%)	9.3	6.3	6.8	21.2	12.8	14.4	20.9	20.8	20.8	33.0	23.0	25.0
Men whose body mass index (BMI) is below normal (%)	11.6	10.3	10.5	22.4	13.0	15.1	25.2	21.0	21.7	25.9	19.8	21.1
Women who are overweight or obese (%)	33.5	40.6	39.2	20.3	28.9	27.3	31.4	33.9	33.4	19.4	23.1	22.3
Men who are overweight or obese %	17.8	24.8		10.5	20.0	17.9	21.9	25.1	24.5	8.8	15.0	13.7
Anaemia among children and adults												
Children age 6-59 months who are anaemic (%)	72.2	59.9	62.8	71.4	51.6	56.2	59.0	53.1	54.3	59.8	53.4	54.7
Women age 15-49 who are anaemic (%)	50.5	51.4	51.2	47.8	43.5	43.1	54.6	48.9	49.9	42.9	39.8	40.4
Men age 15-49 who are anaemic (%)	14.7	12.8	13.2	22.1	16.5	17.8	13.2	12.0	12.2	11.7	10.4	10.6
Knowledge of HIV/AIDS												
Women age 15-49 who have heard of AIDS (%)	97.7	98.9	98.7	80.9	92.1	90.0	85.6	89.9	89.1	90.2	95.4	94.3
Men age 15-49 who have heard of AIDS (%)	97.1	99.1	98.7	95.9	98.3	97.8	97.4	97.1	97.2	98.2	99.8	99.5
Women who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	52.2	58.1	57.0	60.6	80.3	76.7	46.3	47.5	47.3	75.8	85.0	83.1
Men who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	79.8	85.6	84.5	89.5	95.3	91.3	68.0	65.9	66.2	90.1	96.7	95.3
Women's empowerment												
Currently married women who usually participate in household decisions (%)	54.8	54.3	54.4	52.7	52.2	52.3	53.7	48.2	49.1	54.1	42.8	45.0
Women who have ever experienced spousal violence (%)	65.5	38.8	43.9	28.8	13.5	16.5	31.1	27.2	27.9	38.9	46.3	44.7
Household characteristics												
Average household size	3.9	3.7	3.8	4.6	4.5	4.5	4.5	4.8	4.7	4.6	4.7	4.7
Percent Hindu	82.7	83.5	83.3	83.3	85.7	85.2	68.3	66.7	67.0	89.5	76.6	79.2
Percent Muslim	6.4	5.5	5.6	15.8	7.2	8.9	28.0	27.8	27.8	7.7	12.6	11.6
Percent SC	34.7	15.6	19.1	36.4	11.7	16.7	12.8	10.8	11.2	25.3	13.2	15.6
Percent ST	0.9	0.5	0.6	1.7	1.1	1.3	4.0	2.3	2.6	3.1	2.2	2.4
Percent OBC	61.4	72.1	70.1	19.2	11.9	13.4	34.2	29.8	30.6	34.6	35.5	35.3

Percentage of households that:												
Have electricity	94.4	98.4	97.6	98.2	99.7	99.4	96.2	98.9	98.5	99.3	99.0	99.1
Have an improved source of drinking water	83.5	92.4	90.8	94.1	92.0	92.4	98.1	99.7	99.4	98.7	99.0	98.9
Have no toilet facility	2.8	0.3	0.7	19.1	2.6	6.0	1.7	0.8	1.0	1.8	5.8	5.0
Live in a pucca house	83.2	91.4	89.9	86.3	97.6	95.3	93.2	94.9	94.6	89.6	84.5	85.5
Have a television (colour or black and white)	76.2	87.5	85.4	21.9	16.8	17.9	77.5	80.8	80.2	85.1	85.6	85.5
Have a BPL card	4.4	2.3	2.7	5.4	1.4	2.2	30.4	22.4	23.9	10.3	5.5	6.4
Use adequately iodized salt	47.0	68.6	64.7	67.4	91.2	86.4	70.7	73.7	73.1	89.8	90.5	90.4
Education												
Women age 15-49 who have no education (%)	22.1	14.1	15.6	40.9	17.5	22.0	26.2	18.9	20.2	23.5	19.3	20.1
Men age 15-49 who have no education (%)	9.5	4.3	5.3	22.4	7.6	10.6	14.7	11.9	12.4	9.1	6.6	7.1
Children age 6-10 attending school (%)	97.4	99.2	98.8	80.0	92.1	89.1	87.2	89.6	89.1	91.7	91.9	91.8
Children age 11-14 attending school (%)	86.9	92.7	91.5	68.8	88.8	84.2	78.2	82.5	81.8	81.5	86.5	85.4
Employment												
Percent of women age 15-49 currently employed	40.8	35.5	36.5	24.1	21.8	22.2	30.1	22.7	24.0	33.6	28.5	29.5
Percent of men age 15-49 currently employed	87.8	83.6	84.4	85.9	79.0	80.5	80.9	76.7	77.4	85.2	82.2	82.8

Slum/nonslum indicators from NFHS-3	KOLKATA			MEERUT			MUMBAI			NAGPUR		
	SLUM	NON SLUM	TOTAL	SLUM	NON SLUM	TOTAL	SLUM	NON SLUM	TOTAL	SLUM	NON SLUM	TOTAL
Marriage and fertility												
Total fertility rate (children per woman 15-49)	1.6	1.2	1.4	3.0	2.6	2.8	1.9	1.4	1.7	1.9	2.0	1.9
Women age 15-19 who were already mothers or pregnant at the time of the survey (%)	8.7	6.9	7.7	9.2	2.0	5.6	9.8	2.9	6.7	7.0	3.6	5.0
Median age at first birth for women age 25-49	20.1	22.8	21.9	20.3	21.8	0.5	21.5	23.3	22.2	20.3	22.6	21.7
Family planning (currently married women age 15-49)												
Current use												
Any method (%)	71.6	79.5	76.9	57.9	64.9	61.8	54.5	63.9	58.5	69.6	72.4	71.4
Any modern method (%)	47.8	44.6	45.6	50.5	55.3	53.2	51.4	61.1	55.5	68.3	70.2	69.6
Female sterilization (%)	29.7	22.2	24.6	26.3	22.1	24.0	38.2	40.4	39.1	57.1	45.3	49.4
Male sterilization (%)	0.3	0.1	0.2	0.3	0.5	0.4	0.1	0.1	0.1	0.7	1.7	1.4
IUD (%) 1.0	1.6	1.4	3.1	3.3	3.2	3.5	7.7	5.3	1.4	6.2	4.5	
Pill (%) 8.0	9.8	9.2	1.7	4.6	3.3	2.8	1.9	2.4	2.6	3.6	3.3	
Condom (%)	8.2	10.7	9.9	18.3	24.3	21.6	6.6	11.0	8.4	6.0	12.8	10.4
Unmet need for family planning												
Total unmet need (%)	6.3	3.3	4.3	12.9	8.9	10.7	15.4	7.6	12.1	6.5	4.5	5.2
Unmet need for spacing (%)	3.0	1.9	2.3	5.5	3.4	4.3	5.9	3.7	5.0	4.2	2.5	3.1
Unmet need for limiting (%)	3.3	1.3	2.0	7.4	5.6	6.4	9.5	3.9	7.1	2.4	2.0	2.1
Childhood mortality (in the last 5 years)												
Infant mortality rate	35.1	69.2	54.8	72.3	57.0	64.1	28.5	32.4	29.9	39.0	40.9	40.1
Under-five mortality rate	45.4	72.9	61.3	86.7	63.9	74.6	40.9	39.9	40.5	46.6	42.2	43.9
Maternal and child health												
Maternity care (for births in the last 5 years)												
Mothers who had at least 3 antenatal care visits for their last birth (%)	81.4	89.5	86.3	60.5	60.8	60.6	90.4	92.9	91.2	80.8	94.5	89.3

Mothers who consumed IFA for 90 days or more when they were pregnant with their last child (%)	39.0	43.3	41.6	21.7	35.3	63.6	27.3	30.7	28.5	24.4	46.7	38.3
Births assisted by a doctor/nurse/ LHV/ANM/other health personnel (%)							82.2	92.5	85.7	80.8	86.8	84.4
Institutional births (%)	80.1	91.5	86.7	35.1	55.6	46.1	83.3	91.2	86.0	77.7	85.2	82.3
Mothers who received postnatal care within 4 hours of delivery for their last live birth (%)	45.7	51.9	49.4	24.9	39.7	32.9	41.7	57.3	47.2	50.9	61.2	57.3
Child immunization and vitamin A supplementation												
Children 12-23 months fully vaccinated (BCG, measles, and 3 doses each of polio and DPT) (%)	63.4	70.8	67.6	35.1	50.0	42.9	68.8	72.5	69.8	57.3	75.6	68.6
Children 12-23 months who have received BCG (%)	91.5	93.8	92.8	63.1	83.0	73.5	97.5	97.5	97.5	93.3	96.2	95.1
Children 12-23 months who have received 3 doses of polio vaccine (%)	77.5	87.5	83.2	92.8	89.0	90.8	81.3	85.0	82.3	70.7	83.3	78.5
Children 12-23 months who have received 3 doses of DPT vaccine (%)	76.1	77.1	76.6	46.8	53.0	50.1	75.0	80.0	76.5	74.7	85.9	81.6
Children 12-23 months who have received measles vaccine (%)	74.6	85.4	80.7	45.0	61.0	53.4	87.5	90.0	88.2	78.7	89.7	85.5
Treatment of childhood diseases												
Children with diarrhoea in the last 2 weeks who received ORS (%)	52.6	40.0	46.3	14.3	22.5	18.7	52.0	45.5	50.3	40.0	52.0	45.9
Children with diarrhoea in the last 2 weeks taken to a health facility (%)	57.9	40.0	48.9	71.4	69.0	70.1	88.0	72.7	83.9	77.5	80.0	78.7
Children with acute respiratory infection or fever in the last 2 weeks taken to a health facility (%)	73.1	90.9	81.1	82.3	88.0	84.2	*	*	*	70.6	80.0	75.6
Child feeding practices and the nutritional status of children												
Children under 5 years breastfed within one hour of birth (%)	27.7	23.8	25.3	5.5	7.0	6.3	50.0	71.1	57.5	47.7	50.3	49.3
Children under 5 years who are stunted (%)	32.6	23.1	27.5	46.2	41.6	43.8	47.4	41.5	45.4	47.5	26.5	34.7
Children under 5 years who are wasted (%)	16.8	14.0	15.3	9.4	9.5	9.5	16.1	16.4	16.2	18.1	15.5	16.5
Children under 5 years who are underweight (%)	26.8	15.6	20.8	26.3	30.3	28.4	36.1	25.8	32.6	41.7	28.4	33.6

Nutritional status of adults (age 15-49)												
Women whose body mass index (BMI) is below normal (%)	20.8	13.5	16.1	22.0	18.9	20.3	23.1	21.4	22.4	35.5	27.6	30.6
Men whose body mass index (BMI) is below normal (%)	22.6	18.6	20.1	25.5	20.7	22.9	25.6	22.7	24.5	41.4	31.2	34.9
Women who are overweight or obese (%)	25.0	32.3	29.8	24.6	33.5	29.6	25.1	30.4	27.4	13.5	22.8	19.3
Men who are overweight or obese (%)	15.3	19.6	18.0	16.0	21.0	18.7	16.4	21.0	18.2	9.5	15.5	13.3
Anaemia among children and adults												
Children age 6-59 months who are anaemic (%)	54.7	55.3	55.0	68.8	66.7	67.7	50.2	46.9	49.1	71.1	58.4	63.0
Women age 15-49 who are anaemic (%)	52.3	56.8	55.2	40.1	48.4	44.7	46.0	47.9	46.8	48.7	51.8	50.6
Men age 15-49 who are anaemic (%)	17.2	22.0	20.2	12.3	14.3	13.4	10.9	13.2	11.8	16.6	15.8	16.1
Knowledge of HIV/AIDS												
Women age 15-49 who have heard of AIDS (%)	83.3	93.7	90.1	72.1	83.4	78.4	92.5	95.6	93.9	86.5	92.3	90.2
Men age 15-49 who have heard of AIDS (%)	93.2	97.9	96.2	96.3	96.5	96.4	98.9	99.1	99.0	94.9	98.0	96.9
Women who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	49.8	67.0	61.1	50.0	65.4	58.6	63.9	76.3	69.3	55.6	72.3	66.2
Men who know that consistent condom use can reduce the chances of getting HIV/AIDS (%)	77.0	81.2	79.7	87.9	88.0	88.0	91.0	94.1	92.3	79.8	88.9	85.6
Women's empowerment												
Currently married women who usually participate in household decisions (%)	38.4	43.8	42.0	53.7	60.6	57.6	58.0	57.2	57.6	47.4	59.3	55.2
Women who have ever experienced spousal violence (%)	37.1	23.1	27.9	49.8	27.9	38.0	25.2	16.5	21.4	36.9	18.2	25.0
Household characteristics												
Average household size	4.5	4.0	4.2	5.6	5.2	5.4	4.6	4.4	4.5	4.9	4.4	4.6
Percent Hindu	63.5	85.5	78.3	68.2	67.5	67.8	70.6	73.6	71.9	64.2	72.8	69.9
Percent Muslim	34.3	12.0	19.3	30.5	28.3	29.2	18.1	12.0	15.4	15.2	8.1	10.5
Percent SC	13.9	10.4	11.6	25.8	9.1	16.3	10.8	11.3	11.0	25.7	14.8	18.5
Percent ST	0.1	0.1	0.1	0.2	0.4	0.3	2.1	1.2	1.7	10.7	6.2	7.7
Percent OBC	2.6	1.9	2.1	42.7	35.9	38.9	15.6	13.6	14.7	33.3	37.2	35.9

Percentage of households that:												
Have electricity	94.7	98.7	97.4	90.6	95.9	93.6	99.5	99.0	99.3	92.7	95.6	94.6
Have an improved source of drinking water	96.5	99.8	98.7	100.0	100.0	100.0	100.0	100.0	100.0	95.1	92.1	93.1
Have no toilet facility	1.4	0.0	0.5	18.4	3.0	9.6	1.6	0.3	1.0	12.5	6.9	8.8
Live in a pucca house	90.9	96.0	94.3	78.0	89.4	84.4	97.1	98.0	97.5	69.6	89.5	82.7
Have a television (colour or black and white)	70.0	85.1	80.2	73.3	81.3	77.8	77.9	88.6	82.6	72.5	85.8	81.3
Have a BPL card	7.0	5.4	5.9	1.4	0.5	0.9	2.5	1.5	2.1	29.8	8.2	15.5
Use adequately iodized salt	89.5	94.2	92.6	59.2	73.2	67.1	82.9	88.5	85.4	15.4	46.9	36.1
Education												
Women age 15-49 who have no education (%)	33.3	14.4	20.7	36.4	24.5	29.8	19.3	13.1	16.5	17.8	10.6	13.2
Men age 15-49 who have no education (%)	19.4	8.9	12.6	18.4	14.8	16.5	6.7	4.4	5.7	7.5	5.3	6.1
Children age 6-10 attending school (%)	79.6	88.3	84.6	76.1	78.2	77.2	96.4	97.7	96.9	95.7	95.2	95.4
Children age 11-14 attending school (%)	68.7	85.5	78.3	70.4	75.8	73.2	89.7	94.5	91.7	87.1	98.8	88.7
Employment												
Percent of women age 15-49 currently employed	30.2	30.7	30.5	30.1	23.2	26.2	32.9	35.0	33.8	32.2	24.9	27.6
Percent of men age 15-49 currently employed	85.1	82.1	83.2	85.6	81.7	83.5	83.8	75.6	80.5	85.1	78.0	80.6

Annexure FOUR

Lesson 5 : Persons with Disabilities Act, 1996

➢ Prevention and Early Detection of Disabilities

The appropriate Governments and the local authorities shall-

(a) Undertake or cause to be undertaken surveys, investigations and research concerning the cause of occurrence of disabilities;

(b) Screen all the children at least once in a year for the purpose of identifying "at-risk" cases;

(d) Provide facilities for training to the staff at the primary health centers;

(e) Educate the public through the pre-schools, schools, primary health Centers, village level workers and anganwadi workers;

(f) Create awareness amongst the masses through television, radio and other mass media on the causes of disabilities and the preventive measures to be adopted;

➢ Education

The appropriate Governments and the local authorities shall-

(a) Ensure that every child with a disability has access to free education in an appropriate environment till he attains the age of eighteen years;

(b) Endeavor to promote the integration of students with disabilities in the normal schools;

(c) Promote setting up of special schools in Government and private sector for those in need of special education

(d) Endeavor to equip the special schools for children with disabilities with vocational training facilities.

➢ Employment

The appropriate Governments and local authorities shall by notification formulate schemes for ensuring employment of persons with disabilities, and such schemes may provide for-

(a) The training and welfare of persons with disabilities;

(b) The relaxation of upper age limit;

(c) Regulating the employment;

(d) Health and safety measures and creation of a non-handicapping environment in places where persons with disabilities are employed;

(e) The manner in which and the person by whom the cost of operating the schemes is to be defrayed; and

(f) Constituting the authority responsible for the administration of the scheme.

➢ **Affirmative Action**

The appropriate Governments shall by notification make schemes to provide aids and appliances to persons with disabilities.

The appropriate Governments and local authorities shall by notification frame schemes in favor of persons with disabilities, for the preferential allotment of land at concession] rates for-

(a) House;
(b) Setting up business;
(c) Setting up of special recreation centers;
(d) Establishment of special schools;
(e) Establishment of research centers;
(f) Establishment of factories by entrepreneurs with disabilities

➢ Non-discrimination

Establishments in the transport sector shall, within the limits of their economic capacity and development for the benefit of persons with disabilities, take special measures to-

(a) Adapt rail compartments, buses. Vessels and aircrafts in such a way as to permit easy access to such persons;
(b) Adapt toilets in rail compartments, vessels, aircrafts and waiting rooms in such a way as to permit the wheel chair users to use them conveniently.

The appropriate Governments and the local authorities shall aim to provide for-

(a) Ramps in public buildings;
(b) Braille symbols and auditory signals in elevators or lifts;
(c) Braille symbols and auditory signals in elevators or lifts;
(d) Ramps in hospitals, primary health centers and other medical care and rehabilitation institutions.

No establishment shall dispense with or reduce in rank, an employee who acquires a disability during his service. No promotion shall be denied to a person merely on the ground of his disability:

➢ **Research and Manpower Development**

The appropriate Governments and local authorities shall promote and sponsor research, inter alia,, in the following areas-

(a) Prevention of disability;

(b) Rehabilitation including community based rehabilitation;
(c) Development of assistive devices including their psychosocial aspects;
(d) Job identification;
(e) On site modifications in offices and factories.

➢ **Recognition of Institutions for Persons with Disabilities**

The State Government shall appoint any authority, as it deems fit to be a competent authority for the purposes of this Act. Save as otherwise provided under this Act, no person shall establish or maintain any institution for persons with disabilities except under and in accordance with a certificate of registration issued in this behalf by the competent authority:

Annexure FIVE

Lesson 5: Response of State governments for shelter homes for homeless

S.No.	State	Response on Shelters	Response on other issues raised
1	Maharashtra		4351 AAY cards out of 16,168 AAY cards in Mumbai have been given to the homeless
2	Rajasthan		One residential school for children of people living on streets (beggars and *"avanchit vritiyon")* 2008-09 in Kota for 160 children. No community kitchens They have also sent details of old age, widow and disability pensions in their response
3	Gujarat	Junagadh: No temporary shelters; 3 permanent shelters Gandhinagar: No shelters Vadodara: Mahanagar Seva Sadan has responded saying shelters, kitchens and AAY *"does not fall under its purview"*	**Junagadh: 4** community kitchens; 1322 out of 6086 homeless people have been given AAY cards **Gandhinagar:** No community kitchens or AAY cards
4	Orissa	No temporary shelters 49 old age homes (of this urban is 9) "State is contemplating to set up night shelter in five places - Bhubaneshwar, Cuttack, Rourkela, Berhampur and Sambalpur in PPP mode"	As community kitchens they have reported 16583 AWCs where emergency feeding programme is running in KBK districts No AAY cards
5	Ministry of Food and Consumer Affairs		Responded saying they need more time and will write back after "due examination"

6	Chhattisgarh	In one letter it says 2800 permanent shelters and in another 11,175 shelters	
7	West Bengal	There are NO temporary/permanent shelters for homeless	NO community kitchens or AAY cards distributed to homeless in the state
8	Delhi Developme nt Authority	Expert group may be constituted to identify sites for night shelters "As per development norms of MPD 2021 at least 550 to 600 shelterless can be accommodated on a 1000sq.m plot size on a long term basis. Therefore on every 5 lakh population one plot of night shelter will be required" "DDA is duty bound to plan and cater to the public needs of providing shelter and identify available places for providing night shelters...duty bound to abide by orders issued by this Hon'ble Court"	
9	Madhya Pradesh	State Government issued orders to all commissioners, Municipal Corporations etc. on 4.02.2010 for making arrangements for night shelters for the homeless people - one per 1 lakh, water, light, toilet, blankets, arrangements for investigations of health and treatment, locker facility, separate for men and women.	This order also states that urban bodies with the co-operation of working social organisations should make arrangements for supply of food on reasonable rates Survey of homeless should be completed within six months
10	Tamil Nadu	CS held a meeting to discuss Commissioners' letter They will come up with an Action Plan for ensuring food and shelter for the homeless in urban areas esp. in Chennai.	Integrated Programme for Street children which provides residential care (covering 2500 children) Various pensions for the old, widows, disabled, destitute

			One saree/dhoti twice a year to all pensioners Pensioners permitted to eat nutritious meal in children centres or get free grain.
11	Gujarat	In the four cities of Ahmedabad, Vadodara, Surat and Rajkot where there are more than 5 lakh population in the state, there are already some "Ren Basera" being run, apart from old age homes and beggar homes. However, the numbers don't look adequate at all	They have mentioned some programme under Gujarat SSA and NCLP in the cities where they are providing residential care and meals. Again numbers look highly inadequate
12	Himachal Pradesh	There are no reported shelterless in urban areas, also no metropolitan towns, only Shimla with population of 1.42 lakhs which has 5 labour hostels and a Rehan Basera	
13	Uttarakhand	3 towns have more than one lakh population, there are 3 night shelters already operational in these 3 towns State government has also directed local bodies, after SC order, to provide land free of cost for the establishment of additional night shelters and also to submit proposals for upgradation of existing shelters	
14	Kerala	Kerala has night shelters in all cities with more than one lakh population. Further special homes for children, aged and disabled, beggars, mentally challenged separately for men and women	Night shelters for street children in 9 districts and 574 orphanages run by NGOs

Source: Commissioner's Office (2009)

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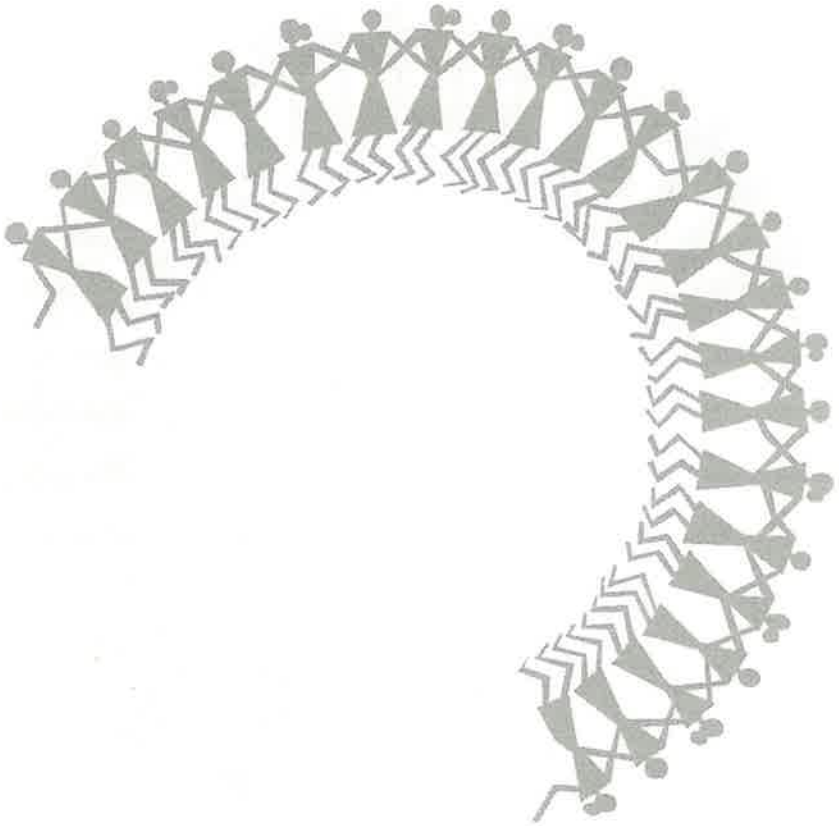

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