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URBAN HEALTH: POLICY AND POLITY

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This note examines selected issues in urban health from a social perspective. In particular, it brings out the key challenges in targeting and planning for the urban poor; their mobilization and participation in improving their health conditions; and in health information and education which plays an important role in changing behaviors not only for seeking health care but also for preventive health.

As the Indian economy grows and globalizes, greater concern is being shown for the health of cities and towns–the 'engines of economic growth'. Long a neglected subject, urban health is back on the development agenda with the Government of India's announcement of a National Urban Health Mission (NUHM) to complement the on-going National Rural Health Mission (NRHM). The draft Framework for Implementation describes the urban health situation in some detail and draws the contours of the proposed Mission.[1] Although national health programs, such as the Reproductive and Child Health Program and the disease control programs (e.g., against vector-borne diseases and tuberculosis, and for immunization), were brought together under the NRHM, their delivery in urban areas is constrained by a paucity of primary health service units.

The NUHM Framework thus proposes the development of new urban health facilities, including primary health centers and health posts, through city plans prepared by Urban Local Bodies (ULBs). It aims to coordinate its efforts with another flagship program of the Government of India–the Jawaharlal Nehru National Urban Renewal Mission (JNNURM), to improve public health services. This policy brief will examine three aspects of the Frameworks proposals through a social lens so that further policy-making and eventual implementation are mindful of promising opportunities and potential pitfalls. These aspects are: NUHMs focus on the urban poor, the suggested interfaces with slum communities, and the role of information, education and communication in urban health. All three concern the crucial need in urban health to reach those who have the worst health, in ways that would improve it.

HEALTHY SLUMS FOR WEALTHY CITIES

Any urban health strategy ought to have a strong focus on the urban poor, wherever they live: in slums or outside them. Their health is critically determined not only by their poverty but also by their living conditions, including the availability of civic amenities such as water supply, sanitation, sewerage, solid waste disposal and other services that determine hygiene and health. It is also affected by their access to health knowledge and care. It is important to address all these dimensions in parallel to create healthier–and–wealthier cities.

Indeed, the NUHM Framework does emphasize the poor, and its proposal to link up with JNNURM recognizes the need for the basic services that underlie health. It has rightly identified urban people living in 'listed and unlisted' slums, and vulnerable groups as the necessary focus of health care. The vulnerable groups include the homeless, beggars, rag-pickers, street children, rickshaw-pullers, manual laborers, construction workers, temporary migrants and others. However, reaching these 'urban people' is a significant challenge. Similarly, providing the poor with adequate amenities under JNNURM and its allied programs–Basic Services for the Urban Poor (BSUP) and Urban Infrastructure Development for Small and Medium Towns (UIDSMT), in a manner that supports significant health improvements, will pose difficulties. Discussed below are some of these challenges.

First is the very large and heterogeneous nature of the urban poor population. There are already over 150 million poor in India's cities; about half the urban population that is projected to reach 540 million by 2026 (see **Policy Note #8**). The urban population includes the migrants, peri-urban dwellers, and 'new towns-people'. Each of these have differing capacities to maintain health, varying needs for care, and unsteady relationships with service providers, authorities and so on, compared to long-time city residents. In contrast with the latter group who may reflect the urban advantage in health over rural areas, the poor in urban slums, squatters and itinerant people are afflicted by the 'urban disadvantage' and require considerable health

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service improvements. Thus, strategies and efforts to improve urban health need to take the diversity of the urban poor into account while planning for the future.

Second, there will be increasing competition between the urban 'rich' and 'poor', and between the bigger and smaller engines of growth, for the resources needed for service improvements. According to a recent report by McKinsey & Co., urban areas will generate 70 percent of India's GDP by 2030, and the urban job market will expand by 230 million people.[2] About 53 percent of urban households will be 'middle class'; the rest will be 'deprived' (15 percent) or 'aspiring' (32 percent). Such changes in spending power, workforce participation, and class composition will escalate demand for the vast range of urban goods and services. In addition, these will put considerable stress on urban infrastructure and service provision. To validate, the McKinsey report estimates that the demand for water supply in 2030 will be 2.3 times that in 2007 and for solid waste management, five times more. In the mega-cities, the scale of services needed is immense and their scope complex, calling for new approaches to service provision and management. Increased concentrations of people could exacerbate problems such as pollution, if left unattended; but with good planning, implementation, and governance, densities could help to reduce the cost of services.

Third, while aiming to collaborate with the JNNURM (including BSUP), which is charged with improving public health amenities, the NUHM proposes a different urban coverage. Effective convergence between the two Missions would certainly be worthwhile but better planning in time and space is essential to effectively reach those with the worst health. The JNNURM intends to provide at least basic level of services to all residents, which could greatly improve urban health, but at a planned slower pace–it will cover 63 cities by 2012 while the NUHM proposes to reach 640 towns (with populations over 50,000) by 2017.[3] What will happen in the towns that will not have the benefit of JNNURM? While many of these are under UIDSMT, there are issues of large financing gap that is likely to constrain investments, and those of shortfalls in capacities to plan, provide, and manage infrastructure and services. To improve urban health, the NUHM will need to work closely with 'its' large number of ULBs to make health a priority. And also, to improve the living conditions of the poor so that the NUHM's proposals for better health care services are not relegated to curing diseases that urban authorities are failing to prevent.

The concept of 'inclusive cities', talked of widely by urban planners today, entails expanding the benefits of urban economic growth and improvements in the quality of life, to a larger number of people–preferably all. In addition to addressing the above concerns, the development of urban health services must be seen in the light of this trend towards inclusiveness and the changes in social dynamics that inevitably accompany significant economic development.

POVERTY AND PRIORITIES

Targeting health services to the urban poor would require micro-planning by the ULBs–a significant challenge (see Box). To illustrate some dimensions, Table 1 presents a few poverty and health-related characteristics of households in eight cities for which representative data are available in the third National Family Health Survey 2005-06.[4] Widespread need is shown by the complete lack of correspondence between and among measurements–for example, between poverty (Column A) and slum dwelling (Column B), and each of these and migration (Column C). The variation in every parameter in just these eight cities points to the complexity of urban health planning, including targeting. Thus, municipalities need to identify their vulnerable populations carefully as well as the determinants of their health, and design suitable approaches and plans to meet them. Further, planning must be done with full knowledge of need and demand which ultimately determine utilization of services and, hence, their cost-effectiveness. The reason for this comment lies in Column D of Table 1: although 100% of the poorest children in Chennai were 'covered' by an *anganwadi* under the Integrated Child Development Services Scheme at the time of the survey, only one-third were actually receiving services (Ref. 4, p. 100).

SPARC–A good example of micro-planning

SPARC (Society for Promotion of Area Resource Centres), a Mumbai-based NGO, provides a good example of what is needed to bring benefits to urban slum and pavement dwellers.[5] SPARC began its work of mobilizing these groups by enumerating, surveying, and mapping them. This information was used to organize targeted population to articulate and collectively solve their problems in the areas of housing, land and basic infrastructure, and to undertake participatory planning. The knowledge served them well in negotiating their rights with government agencies. The Area Resource Centres are spaces where women can bond into collectives to take on settlement-level issues such as water and sanitation and obtain loans to meet health expenses. Construction and management of community toilet blocks have been among their successful interventions. Since 1984, this approach has spread to 70 cities and 20 countries, with SPARC also having supported development of Urban Health Resource Centres (e.g., in Agra). While this experience is one of the bases for NUHM's proposals, it is important to note that SPARC has a highly-committed leadership and immense organizational strengths which have helped it deal with opposition from local public and private interests and achieve good results.

The requirement for integrated planning also emerges from Table 1. Column E shows the low percentages of the poorest quartile of urban households that have access to their own toilet. According to the India Human Development Survey 2005 (IHDS), fewer than 40 percent of households in the

three poorest quintiles (i.e., bottom 60 percent) in urban areas of the country had indoor piped water, while 72 percent of the richest quintile did.[6] There was also a significant difference between urban areas of 'low income' and 'high income' states. In the poorer states, less than one-third of households had indoor piped supply while in the richer ones, over 40 percent did. The availability of flush toilets followed a similar pattern. The survey established the relationship between these amenities and minor illnesses: households without indoor piped water had 134 episodes of minor illness per 1,000 people in the 30-day reference period, compared with 92 in households with such supply. Similarly, there were more episodes in households without flush toilets (131) than in those with (100). As poor people and areas have lower service levels and worse health than the better off, their health needs begin with preventive public health services.

Table 1. Some Characteristics of Urban Households and of the Poorest Quartile of Urban Households in Eight Cities, 2005-06

	Percent of Urban Households			Percent of				
	Who are poor	Who are slum dwellers	With men migrants	0-6 year-old children living in slums covered by *anganwadi*	Poorest households using own 'Improved' toilets	Poorest women employed in previous 12 months	Poorest households using government health facilities	Poorest children under-weight
	A	B	C	D	E	F	G	H
Delhi	14	20	57	26	5	27	29	46
Meerut	16	43	37	18	20	40	6	44
Kolkata	14	33	31	64	6	45	39	32
Indore	12	20	29	49	14	59	29	57
Mumbai	8	56	45	55	3	27	42	46
Nagpur	21	34	27	90	26	42	24	45
Hyderabad	13	18	51	61	24	47	40	37
Chennai	7	18	52	100	8	52	63	43

Compiled from Reference 4

Currently, in most states, ULBs [Municipal Corporations, Municipal Councils, Nagar (Town) Panchayats, and Notified Area Committees], Public Health Engineering Departments (PHEDs) or specialized agencies are charged with delivering environmental health services. PHEDs have been hard pressed to provide even basic environmental health services in most cities, often unable to service slums and informal settlements for legal, financial or managerial reasons. Under the new Missions, in the spirit of good micro-planning, ULBs could begin to meet the needs of the poor by implementing services in recognized slums as well as unrecognized colonies where living conditions are bad. It is important to recognize that wealthy cities need to be more inclusive to be healthy.

The core of the NUHM is the expanded health system proposed for urban areas, focusing on primary care services (which include some preventive measures such as immunization). However, attention is inadequate for core public health functions, including disease surveillance; prevention and (early) response to epidemics; promotion of public and personal hygiene; and such. Further, most ULBs have inadequate capacities in the provision of health care, calling for better coordination of environmental health improvements with planning, implementation, and management of health facilities and services. To reap the potential and necessary synergies, integrated micro-planning as discussed above, coordination between the professional agencies engaged in implementation at the local level (e.g., ward), developing environmental services based on health priorities, and establishing health facilities in tandem would be most useful. Involving the poor in planning, managing and monitoring these related services would be a complementary way of ensuring that appropriate priorities are set and met. The next section discusses whether the 'community involvement' proposed by NUHM is appropriate to this crucial task.

APPLYING AN 'URBAN SOCIOLOGY'

City dwellers in India today are more heterogeneous and mobile than ever, and this is likely to increase as the economy develops unevenly across the country, between rural and urban areas, and across states. Today's migrants to the city are somewhat different from those of yesteryear–they come from farther away as road and rail networks expand; they may barely speak the language of their adopted city, are less connected to kin and clan flows, and are perhaps poorer than before as the 'push' of rural landlessness, joblessness, indebtedness, and such

accelerates.[7] At the same time, transport links and mobile phones facilitate continued contact with their rural origins and the time taken to assimilate urban ways of life may be extended. Another significant difference is that women are now migrating to cities for reasons other than 'relocation due to marriage' [see, for example, Reference 8]. On the one hand, women are 'modernized' by entry into the labor force; while on the other, they are up against the violence of tradition as domestic relationships are strained by urban life.

The size and composition of urban populations (and sub-populations) have a strong bearing on how people interact with each other and with 'others', including authorities, service providers, and neighbors. While Indian cities are often the locus of attempts to 'lose' caste, they often 'cement' ethnic, caste, religious, linguistic, and cultural affinities (as do cities worldwide). However, social and economic fragmentation may undermine social capital, constraining people from drawing together and even resulting in daily conflict. For example, 'fights' over water, garbage disposal, etc. are not uncommon in urban neighborhoods, including in slums. The concept of 'community' in urban areas thus needs to be purposively constructed to overcome the fissiparous tendencies of mixed neighborhoods. Community committees or slum-dwellers' organizations may function well if there are strong common interests and goals that are perceived to be equitable and achievable.

These are some of the contexts in which one must view the NUHM's proposals for community organizations such as women's self-help groups (SHGs, savings and credit groups of 10-20 women) and *Mahila Arogya Samitis* (women's health committees for 20-100 slum households). Such associations have worked in some cities (such as Agra and Indore, cited by the NUHM document) to help families meet emergency health expenses, or support preventive/ promotive health activities. However, the NUHM expects them to perform many additional roles including: promoting change in community health and hygiene behavior, facilitating community risk pooling, 'proactive community action in partnership with ULBs' to improve health-related services, stimulating health services through demand, and monitoring them at the community level. Such expectations of poor women living in slums must take into account not only the diversity discussed above but also, importantly, the triple burden women face of earning, bearing and rearing children, and managing the stresses of urban life. In the eight cities in NFHS-3, the employment levels of the poorest quartile of women (Table 1, Column F) compared favorably with that of men (not shown in the table; around 30 percent in three cities, approximately 40 percent in another three cities, and between 50–60 percent in two cities). At the same time, the proportion of women in the poorest income quartile who had experienced spousal violence ranged from one-quarter in Mumbai to about two-thirds in Indore, Meerut and Chennai. In four cities, women living in slum areas were affected twice or more as much as women in non-slum areas.

Indeed, data show that women's ability to 'associate' varies considerably. In the 22 states covered by the IHDS, over 60 percent of women in four states were members of at least one organization (caste, religious and social associations being most frequent), but in the remaining 18 states fewer than 40 percent joined any organization (including SHGs and *mahila mandals*).[6] Membership was lower in urban areas than in villages (24 percent in metro cities, 34 percent in other urban areas, 35 percent in less-developed villages, and 42 percent in developed villages), and particularly low (under 20 percent) in the north, northwest and central India. Further, membership does not mean active participation nor certain benefit.

While mobilizing women around common concerns helps in group formation, in the context of NUHM there is a sizeable lacuna in the capacity to do so. Domestic violence is indeed an issue around which women's self-help or health groups could be mobilized, but even in the best conditions, creating effective groups is a matter of painstaking nurturing and support. It is unlikely that the USHA, the proposed urban health activist modeled on the rural ASHA, could fulfill this role. Further, vesting critical health actions in such groups is tantamount to a deferred and then patchy health care. It would also take a very long time to set up the *Swasthya Chowkis* (health posts with an Auxiliary Nurse Midwife and Male Community Worker for 10,000 people) and 'doctor-manned' Primary Health Centers proposed by NUHM. Relevant lessons from the 60-year history of the rural health system are: establishing pyramidal systems based on population norms is akin to 'running to stay in place'; that there are never enough trained and motivated staff to deliver quality health services; and that people do not follow planners' routes to health care! Thus, in lieu of developing a whole new primary health structure, the NUHM would do well to encourage states and ULBs to invest in improving the access of the poor to and quality of care at existing secondary facilities. Also, ULBs should focus on strengthening population based public health interventions and working with local residents (female and male, organized or not) who would prioritize and oversee them. Harnessing the services of private providers and organizations through payments for appropriate services provided to the poor is another way to rationalize available health care.

EDUCATION FOR HEALTH

Most likely, secondary health facilities will continue to be the mainstay of urban health care for some time, given the limited number of cities that would improve health-related services under JNNURM/ BSUP and UIDSMT, and the low capacity of ULBs to expand health care. However, data from the 2004 National Sample Survey (NSS) show that only 25 percent of the poorest urban quintile sought out-patient treatment from a government health facility, just 2–3 percent more than those in the other four quintiles.[9] The remaining 75 percent of the poorest approached private providers. The data in Table 1, Column G, are not

comparable to NSS data but show the variation among cities in utilization of government health facilities by the poor. The main reasons for not using a government facility are well known: inconvenient timings, long waits, poor quality, and unmanageable distances. All these problems are amenable to correction, roughly in the order listed.

The NUHM Framework makes a large number of suggestions to improve services at extant facilities and establish additional ones, as well as to induct local private practitioners into pro-poor provision. Facility and service planning, standard setting, Citizens' Charters, and the other proposals would all be useful. In addition, to address the above constraints in the use of government services, individual facilities need to improve their patient flow systems, maintenance of equipment, organization of available doctors and staff as well as their behaviors. Bringing about these relatively low-cost improvements, beginning with the 'poorest' facilities, would make a difference. But this is not enough.

A sociological lens compels at least one significant observation. In order to improve the efficiency of health facilities, broad-based 'behavior change communication' (BCC) is essential–both to reduce the need for health care by improving hygiene and health practices and to encourage timely and rational use of services. The visible squalor of urban areas, both rich and poor–garbage, muck, choked drains and cowpats to name a few offenders–is the creation of people who need to be educated about the consequences of their unhealthy and anti-social actions, and motivated to change them. Even in the face of inaction by local bodies, people manifest a dependence on authorities (for example, to provide cleaning services), leading to 'wrong action' (such as throwing their refuse in the street). Also, data and anecdotes are rife on the delays in seeking health care and of inappropriate consultations.

Therefore, it is highly important to educate urban dwellers, rich and poor, for better all-round health behavior (preventive health actions as well as rational use of curative care). This can readily be done in urban areas because of the multiple communication channels available–TV, radio, illustrated print material, schools, public spaces, community groups, and health providers (who need education themselves). Previous significant efforts at BCC, however, necessitate a caution. For example, in five of the eight cities discussed above (Delhi, Meerut, Kolkata, Hyderabad and Chennai), under 15 percent of women in the poorest quartile had a functional knowledge of AIDS [Ref. 4, p. 108]. Only if BCC is done effectively–i.e., reaching the right people with the right messages, clearly and frequently enough to actually change their behavior–will the 'improved' government health facilities be properly utilized, and the poor saved from excess morbidity and the burden of out-of-pocket expenses on health care. Better information is needed even inside health facilities to reduce the costs to the poor of seeking health care. There is no substitute for a more informed and educated society for better health.

POLICY PRESCRIPTIONS

Three key policy recommendations can be summarized from the above social exploration of urban health.

First, greater and urgent attention must be accorded to ensuring availability of the environmental services that underlie health, particularly water, sanitation and clean spaces, to the poor in slums and on the streets (regardless of the legal status of slums).[1] Participatory and holistic micro-planning and coordination of implementation are some other essentials.

Second, 'urban sociology' suggests that very careful consideration must be given to the construction of social capital while promoting local organizations to improve health. The difficulties faced by poor urban women suggest that those with the want may not be the ones with the time or other wherewithal to form community groups for health. This raises the need for such organizations to be 'incentivized' to work for the larger community.

Third, any effort to improve urban health must give pride of place to providing simple education for health through every available means for all urban dwellers to improve their hygiene practices and use of health care. Public health and BCC must together redress the current gross imbalance in health interventions–inadequate preventive health on the one hand, and huge expenses on curative care, on the other.

[1] Access to food, which is also a top priority–on which the NUHM Framework is silent, despite acknowledging the high malnutrition of urban areas (illustrated in Table 1, Column H)–is the subject of another policy note.

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