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Rethinking Urban Health delivery systems in the context of urbanization

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Dr. Manish Priyadarshi has a M. Phil and PhD in urban health from Jawaharlal Nehru University, India; Manish Priyadarshi is a Passionate and Result oriented health professional with more than decade of experience in Health and Health policy, Advocacy, Integrated Program Planning, Research, Documentation, Programme Implementation, Partnership Management, Technical Assistance to National and State Government and Resource Mobilisation. Dr Manish started his career in health as Programme coordinator in 2007 and has worked in every level of providing solutions and leadership in Health sector. As his career progressed, he worked as Consultant (Research and Evaluation), Research Head and Director (Research and Projects) with Government, Corporate and Research Organizations respectively. Dr Manish Priyadarshi, presented papers at National and International conferences on health and allied sectors and member of Young Demographer (Rostock) and Institute of Social Research (Hamburg). Currently, Dr Manish Priyadarshi working as Associate Professor Public health at IIHMR, New Delhi. He teaches the courses- Public health, Health Economics and Organizations Management.

Rethinking Urban Health delivery systems in context of urbanization

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- Concept, need and challenges for Inter-Sectoral action for health (IAH)
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- How Human resources skilling can manage Covid 19 in urban India
- Way forward

Urbanization

- Urbanization is one of the most significant trends of 21st century
- Proportion of Urban population increased from 10.8% in 1901 to 31.2% in 2011 and is expected to increase to 50% in next few decades
- Urban population grew from 91 million to 377 million between 2001 to 2011
- By 2030 it is estimated to increase by more than 200 million
- 3 main factors contributing to this escalating growth rate are:
  - Natural population growth rate (Highest)
  - Net migration
  - Transformation and re-classification of cities and peri-urban areas

Urbanization leading to Vulnerability

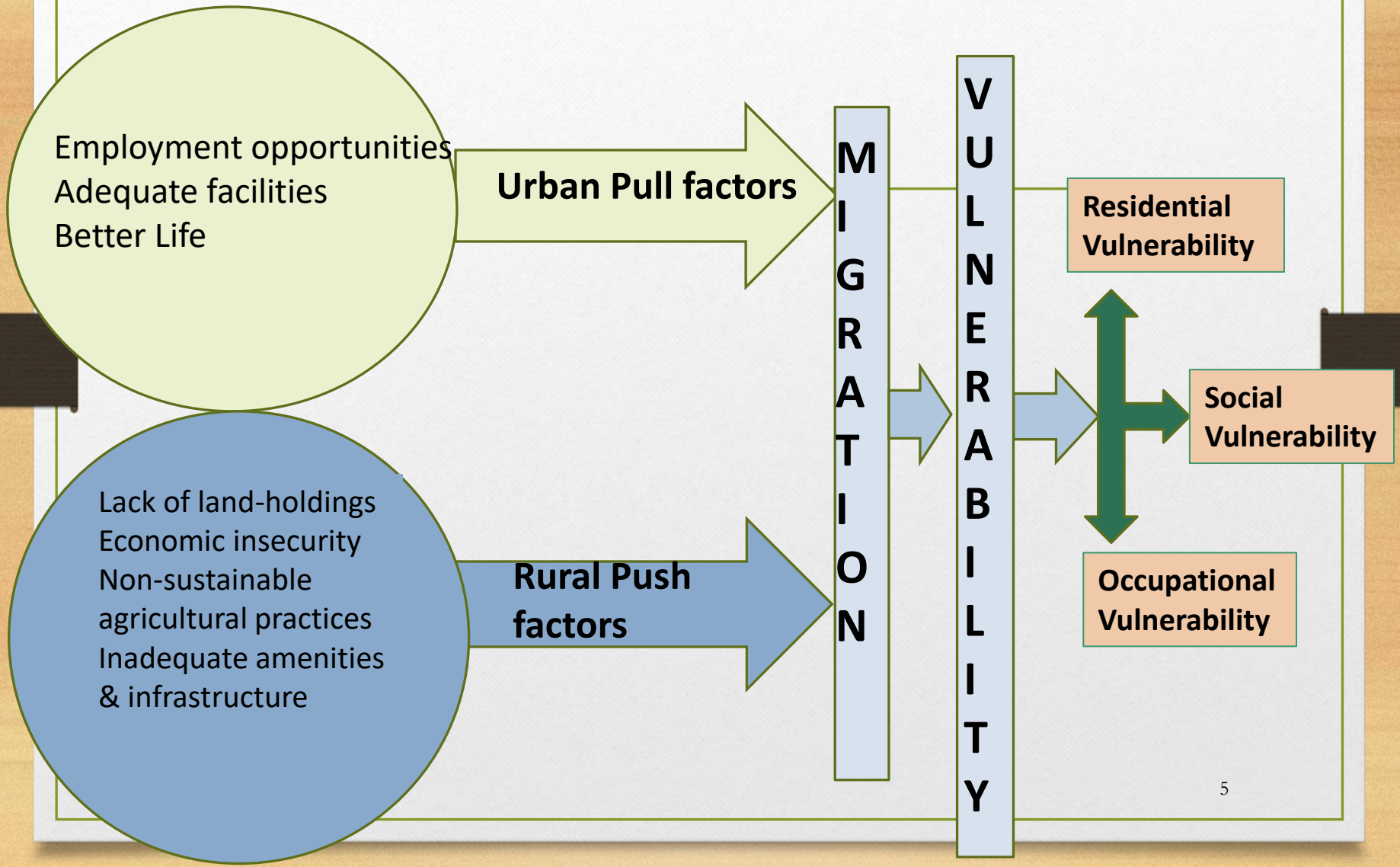
NHM lays special emphasis on improving the reach of healthcare services to vulnerable groups among the urban poor

- The three main vulnerable categories as identified by Hashim Committee are:

1. Residential or habitat-based vulnerability
2. Social vulnerability
3. Occupational vulnerability

Definition of vulnerability should accommodate following variable experiences and requirements: All people facing disproportionate burden of ill-health often seen co-terminous with low-incomes, social exclusions, poor housing, risky occupational settings, gender, disability, singleness, age, debilitating ailments and others constitute vulnerability

Migration leading to Vulnerability



Marginalization

Various circumstances of the **urban life marginalize** the urban poor in such a way that they **cannot access services**, and can also not demand their entitlements:

- Inadequacy of resources for all (hence lack of basic services like water, electricity)
- Hazardous living environment (exposure to extreme weather, poor hygiene)
- Exposure to Violence and Crime
- Fear of Eviction from their 'illegal housing'
- Unsafe work environment – in terms of physical safety
- Monetization of Basic needs (in urban areas, every little necessity needs to be purchased, unlike in rural)
- Limited access to social security schemes (mostly they are unable to establish their entitlement and eligibility
- Lack of Social Networks (hence poor social and emotional support)

History of Urban Health Services

- Though many steps were taken at state & central levels, to improve service delivery in urban areas, they were scattered and sporadic
- National Health Policy of 2002 identified the need to organize public health services in urban areas
- MoHFW recommended establishment of 'Urban Health Posts' for 50,000 population, to be located in and around urban slums, with strong linkages with secondary and tertiary level facilities
- World Bank supported India Population Projects (IPPs) Urban Health Posts Maternity Homes and 244 sub-centres were created in Mumbai & Chennai as part of IPP VIII
- Similar health facilities were also established in Delhi, Bengaluru, Hyderabad and Kolkata as part of IPP VIII
- Under various schemes and projects, there was establishment of UHPs, Urban Maternity Centres, Urban Dispensaries, Urban Health and Family Welfare Centres

Introduction to NUHM

- **Approved on** May 1, 2013 as a sub-mission of the National Health Mission (NHM) to strengthen the primary health care system in cities & towns
- **Target Population**: 29.95 Crore urban population (Census 2011)
  - 942 cities/ towns with population above 50,000 (29.69 Crore)
  - 64 District Headquarter towns with population between 30,000 – 50,000 (0.26 Crore)
- **Special focus on**:
  - People living in listed, unlisted slums and other low income neighborhoods
  - All other vulnerable population such as homeless, rag-pickers, street children, rickshaw pullers, and other temporary migrants
- **Implemented by**: Joint implementation by State Health Department and ULBs (either may take the lead, depending upon city population)

Comprehensive Primary healthcare approach

- **Universal access:** No one shall be turned away or refused any health service.
- **Assured minimum package of services**: Delivered as close to home as possible to ensure universal access with quality.
- **Preventive and promotive care:** Enhanced focus on screening of NCDs, early identification of communicable diseases, early outbreak identification and management
- **Effective Gatekeeping:** Reduced patient load at higher facilities by strengthening primary health services
- **Outreach:** Special efforts to identify, reach out to and address health needs of marginalized
- **Reduction in out of pocket expenditure:** Provision of free drugs, diagnostics and consultation
- **Integration:** Collaboration with ULBs and other departments to tackle cross cutting issues

- **Continuity of Care: C**ontinued care through referral and follow ups

Package of primary healthcare services

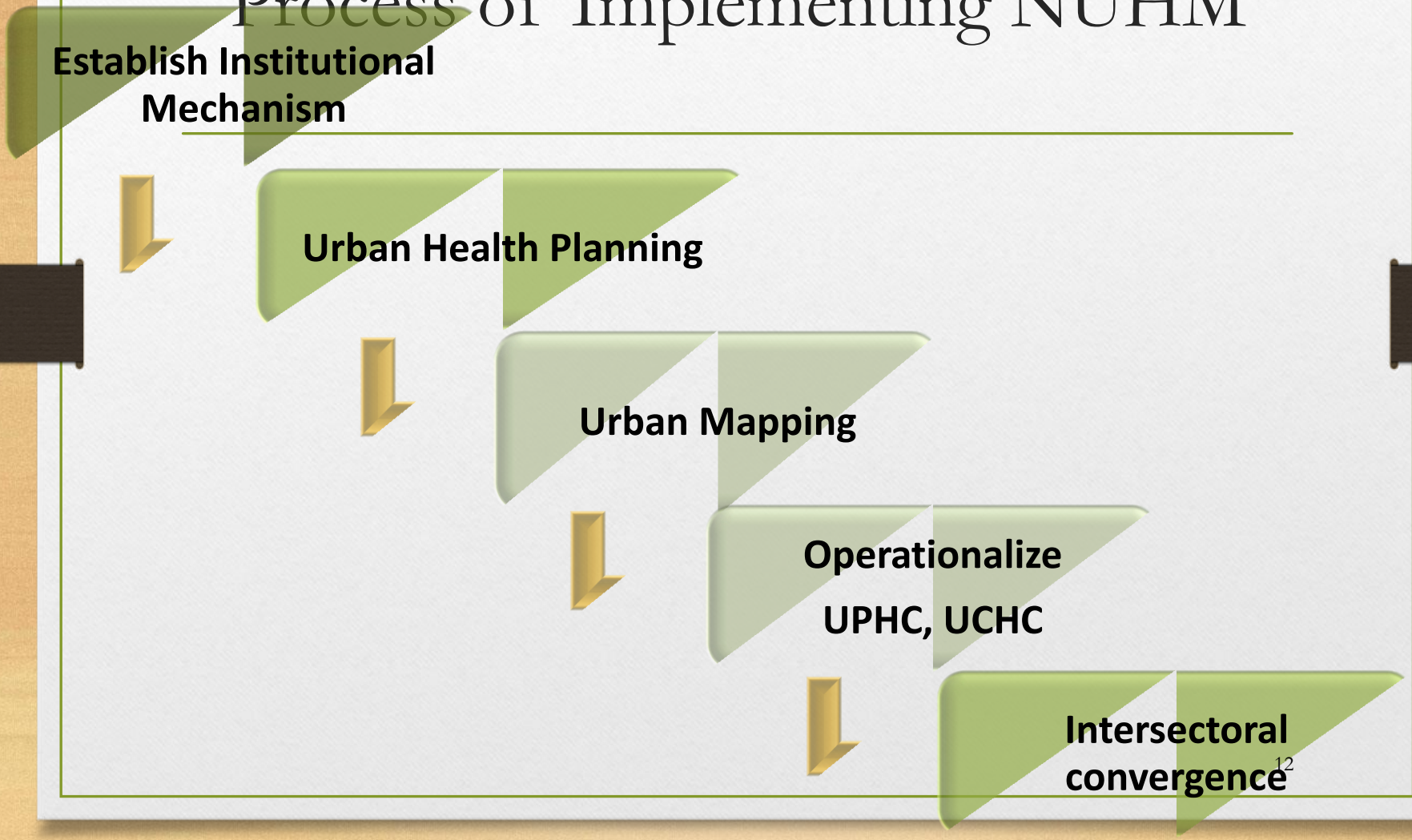
- Under the **Comprehensive Primary Healthcare Service Package**, following services are essential:

- Care in pregnancy and child-birth.
- Neonatal and infant health care services
- Childhood and adolescent health care services including immunization.
- Family planning, Contraceptive services and Other Reproductive Health Care services
- Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments
- Management of Communicable diseases: National Health Programmes
- Prevention, Screening and Management of Non-Communicable diseases
- Screening and Basic management of Mental health ailments
- Care for Common Ophthalmic and ENT problems
- Basic oral health care
- Geriatric and palliative health care services
- Trauma Care (that can be managed at this level) and Emergency Medical services

Service delivery structure of NUHM

Population Served	Health Facility/Worker
2.5 lakh population (5 lakh for metros)	1 UCHC (30-50 bedded in-patient facility, 100 bedded in Metros for 5 lakh population)
50,000 population	1 UPHC (OPD facility)
10,000 population	1 ANM
1000-2500 population (200-500 households)	Community Health Volunteer (ASHA)
250-500 Population (50-100 households)	Mahila Aarogya Samiti

Process of Implementing NUHM



NUHM implementation

3 models identified by TRG* based on the roles played by State & ULBs in providing urban health services:

Model 1	Model 2	Model 3
▪ State → 100% ▪ ULBs → Minimal ▪ Municipal Health Officer in charge of non-medical services ▪ Examples: HP, Bihar, Small towns (< 2 lakh population)	▪ State → Major ▪ ULBs → Minor ▪ State: District hospital, Medical colleges. Examples: Bhubaneshwar ▪ ULBs: Urban Health Dispensaries, Health Posts, Health Volunteers	▪ State → Minimal ▪ ULBs → Major ▪ State: Municipal corporations ▪ ULBs: Metropolitan: Example: Mumbai, Calcutta, Chennai, Bangalore, Ahmedabad, Delhi Non-Metro: Madurai, Pimpri

*__TRG:__ Technical Resource Group on NUHM in 2013, a committee formed by MoHFW to give recommendations on NUHM strategies.

Establishing institutional mechanism:

Key Steps

1. Appointing Additional Mission Director, NUHM
2. Expansion of SHS (State Health Society)
3. Expansion of DHS (District Health Society)
4. Establishing CHS (City Health Society)
5. Establishing Urban Health Cell/Unit within State Program Management Unit (SPMU) & District PMU and setting up City Program Management Units
6. Convergence with ULBs & Urban stakeholders

Expansion: Means Inclusion of members from other urban stakeholders such as Municipal Administration, Water, Sanitation, Social Welfare etc.

Legacy Management

Legacies of health services (previously hired health workforce, health facilities, health programs and projects need to be properly managed while rolling out NUHM

State Governments

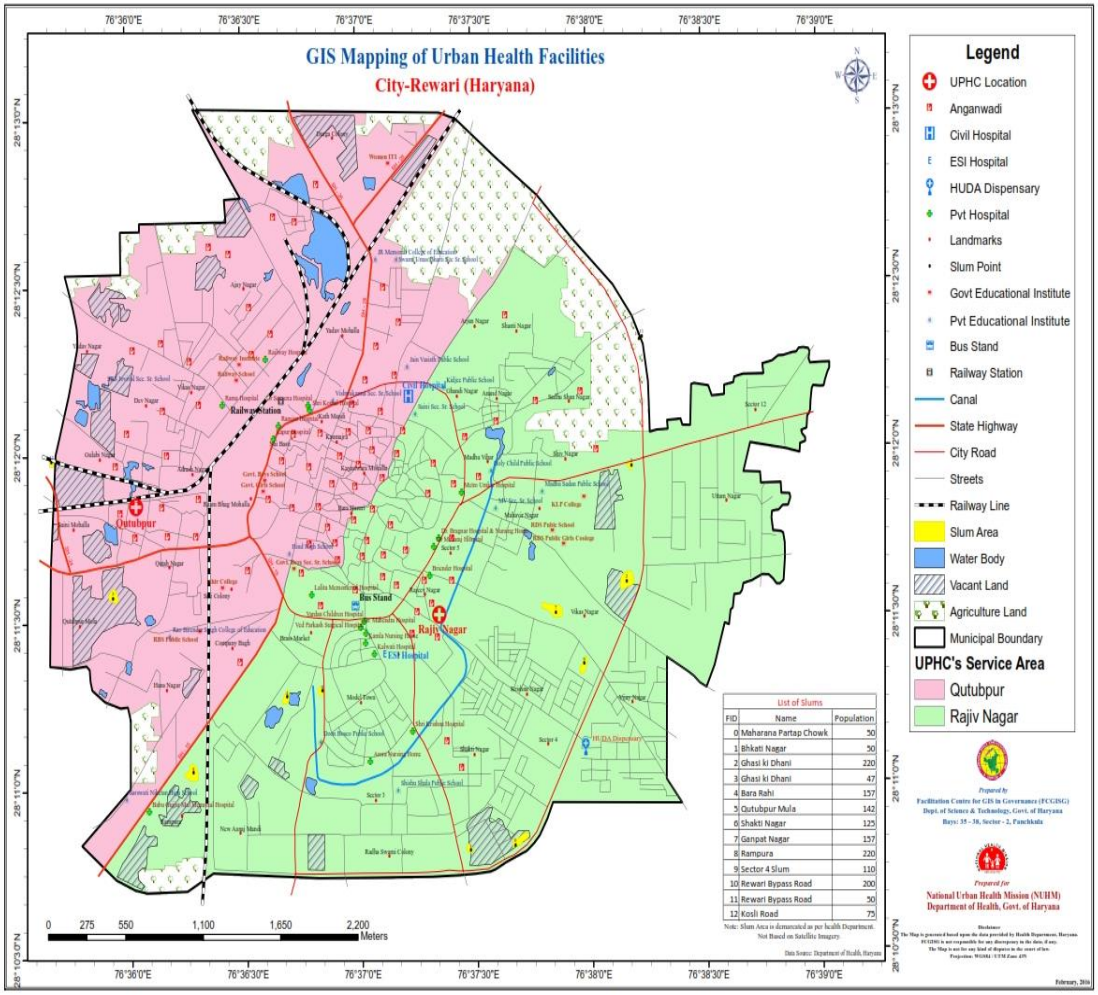
- Must devise a plan for legacy management
- Proper absorption of existing workforce, dispensaries, secondary hospitals, health posts, link workers, MMUs into formal NUHM framework
- Minimization of redundancy, duplication or loss of role clarity
- Clear re-allocation of job descriptions with training & supervisory changes
- Legacy management is an important exercise for externally funded projects particularly those yielding good results

City Mapping

Mapping is geo-spatial distribution of vulnerable populations, physical structures, social relationships and issues of access to health care.

It helps to understand the availability & distribution of:

- Resources
- Services (and gaps therein)
- Health Needs
- Vulnerable groups and their needs



Mapping makes urban poor and vulnerable **visible** to the health system!

Sample GIS Map of Rewari city (Haryana)

OBJECTIVES OF URBAN HEALTH MAPPING

- Identify & map vulnerable groups (slums, mobile population), infrastructure, environmental features
- Understand health issues, needs and coping mechanisms
- Barriers faced by poor and marginalized in accessing health services
- Locate health care services, their accessibility and responsiveness

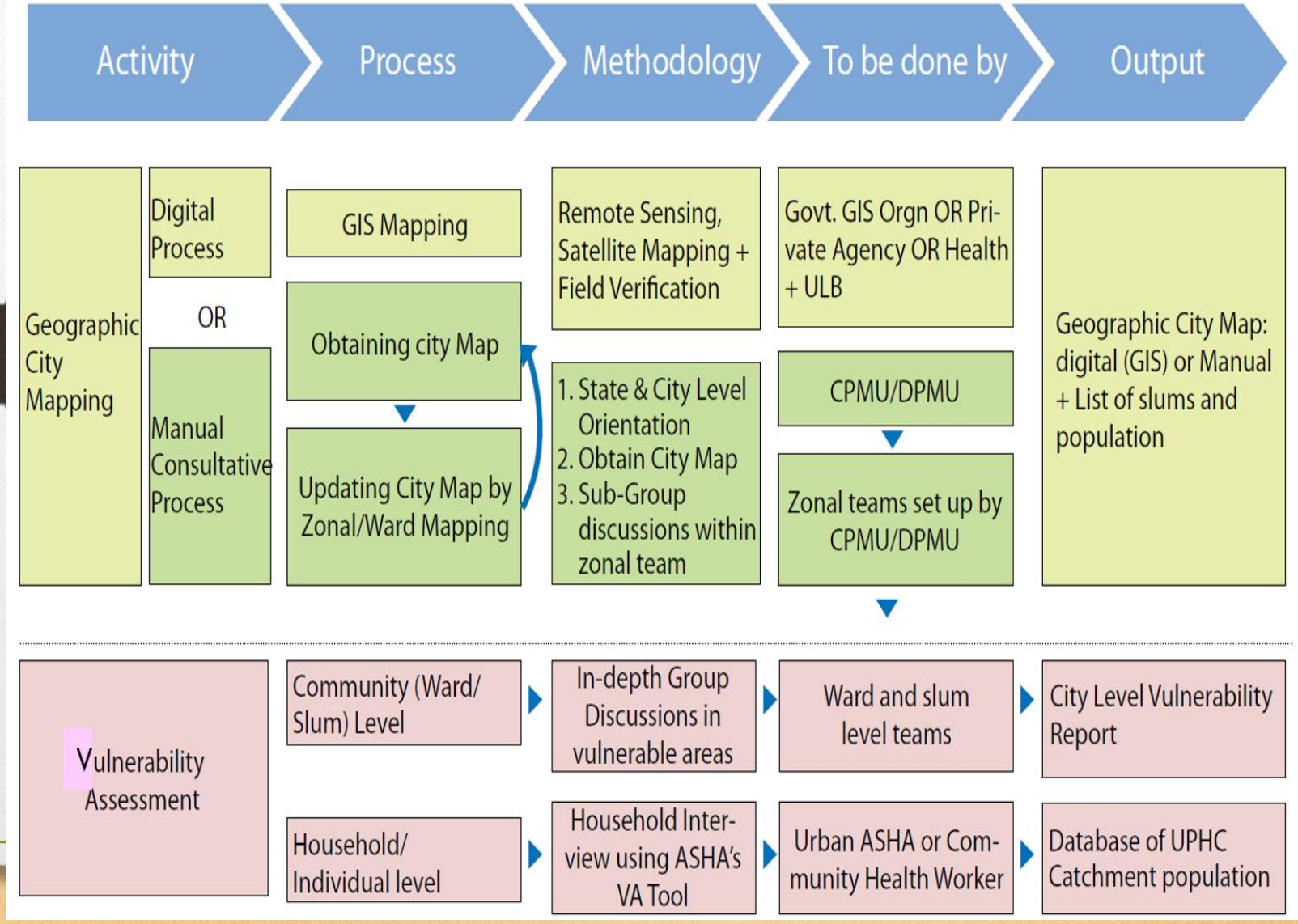
TYPES OF MAPPING

City Mapping	UPHC Catchment area Mapping	Vulnerability Assessment Mapping
▪ Health facilities ▪ Notified/un-notified slums ▪ Anganwadi Centers ▪ Educational institute (Public and private) ▪ Major landmarks ▪ Agricultural land ▪ Water bodies	▪ To be done by ANM, ASHA, PHM, supervised by MO ▪ Covers area catered by the UPHC ▪ Shows locations of slum and vulnerable pockets ▪ Areas under each ANM ▪ Major landmarks	• Done at 2 levels: • Slum level assessment (team of Urban ASHA, ANM, PHM, RKS, ULB members) • Household level assessment (ASHA, ANM) [Registration of families at UPHC may also be done during this process]

Rationalize the location of Health Facilities, MMUs, outreach

Ensure adequate service delivery to vulnerable poor

Flow chart of city mapping & vulnerability assessment



Urban Health Planning

A convergent action leading to holistic approach

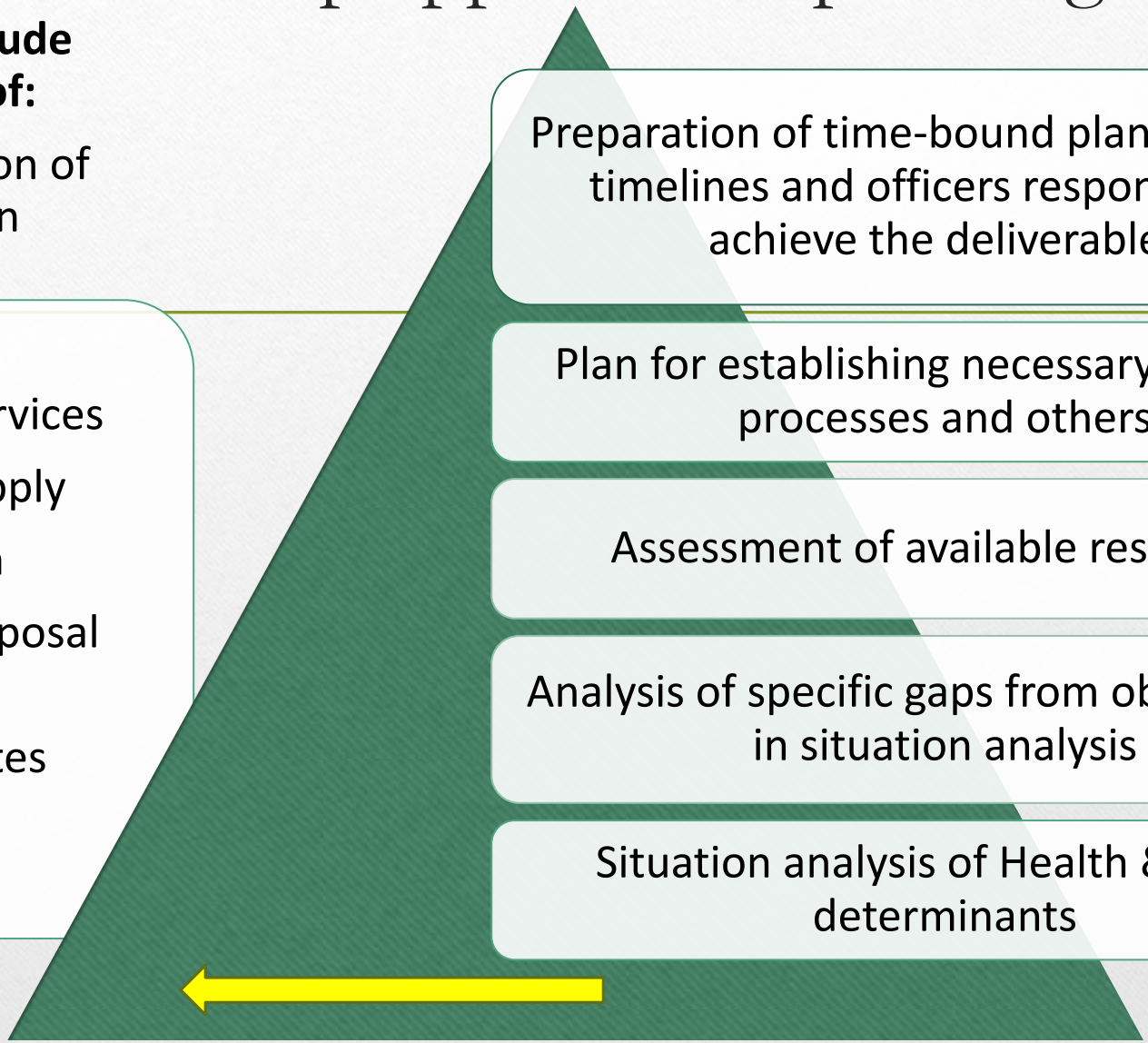
Objectives of Urban Health Planning

- Prevention of ill-health
- Strengthening of primary health facilities
- Ensure access to primary health service through outreach, awareness and efficient Asha and ANMs
- Identification and strengthening of multi-directional referral linkages
- Address specific urban health issues of the city like malaria, heat stroke, road safety, pollution and water quality

Bottom-up approach to planning

Should include analysis of:

- Distribution of population
- Health indicators
- Health services
- Water supply
- Sanitation
- Waste disposal system
- Other states specific issues



UTILIZING MAPPING FOR PLANNING PROCESS

The Mapping Process, as explained before, is the foundation of good planning. Mapping data can be used for the following:

- **Identifying site** for UPHC, Health Kiosk, MMUs, and their catchment areas
- **Organizing Outreach** UHND and Special Outreach sessions
- **Planning for Community processes** (population allocation to ASHAs, helping ASHA understand needs of her population, formation of MAS groups)
- **Public private partnerships** (understanding the need for a PPP, which private/NGO partners are available through stakeholder analysis)
- **Convergence** (Mapping process brings together multiple stakeholders)
- **Disease Surveillance** (understand which areas to focus on for which outbreaks)
- **Planning for Referral transport**

WHY CONVERGENCE?

- Health problems are Multi-casual in nature with factors outside the control of health sector
- Health Sector alone cannot ensure good health outcomes
- Urgent need to systematically aligning of all sectors together with health sector
- Highlighted as an urgent need by World Health Organization, and at Alma Ata Declaration, as a pre-requisite for Primary Healthcare Approach

We need to build partnership with institutions and actors both in the health and across other related areas, to tackle various determinants of health, in a holistic and integrated manner.

TYPES OF CONVERGENCE

Intersectoral Convergence

- Bringing together different sectors
  - Water
  - Sanitation
  - Waste management
  - Nutrition
  - Education
  - Housing
  - Roads and Transport

Inter-departmental Convergence

Bringing together departments/ divisions within health

- TB
- Vector Borne Diseases
- Non-Communicable Diseases
- HIV/AIDS
- Maternal and Child Health
- Family Planning etc.
- Communicable Diseases

ESTABLISHING INTERSECTORAL CONVERGENCE

Ways of overcoming challenges & establishing sustainable convergence mechanism

- Designing systematic process of collaboration
- Forming multi-stakeholder teams and committees at various levels
- Participatory planning involving all stakeholders
- Conducting joint workshops
- Advocacy
- Mutually benefitting process
- Shared goal setting
- Trust building
- Cross cutting information sharing & evaluation systems
- Integrated workforce development

3 BROAD TYPES OF MULTI-SECTORAL ACTIONS

1. Supporting actions within single sectors that form their core business and have positive or negative implications for health

2. Health sector supports cross sectoral policies to address issues that drive disparities

3. Identifying, promoting, and co-financing actions that require collaboration between two or more sectors (inter-sectoral work) to produce joint or "co-benefits"

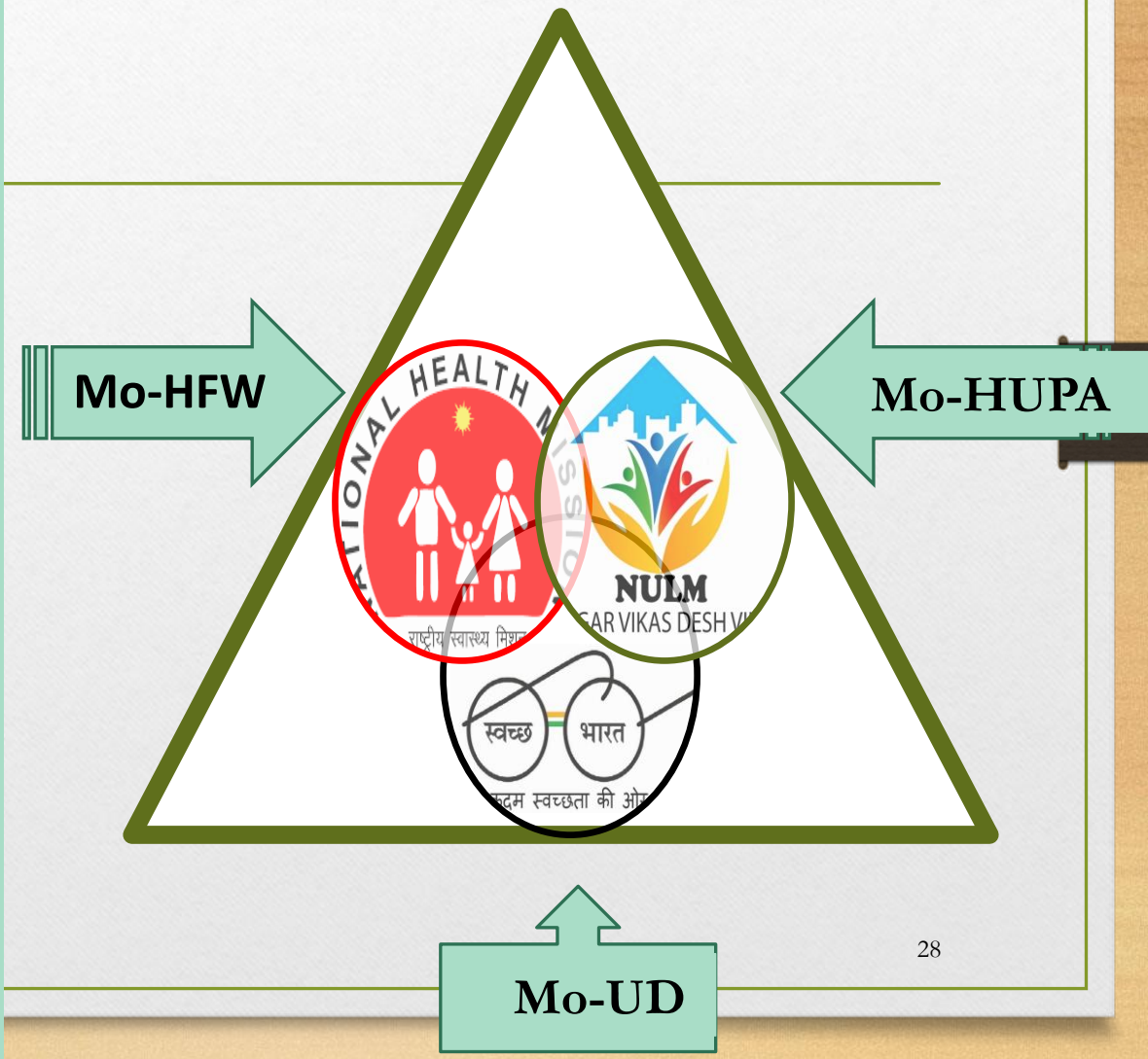
Joint ownership of convergent actions

MAJOR CONVERGENCE PLATFORM

Collaborative implementation of:

- National Urban Health Mission (NUHM)
- National Urban Livelihoods Mission (NULM)
- Swachh Bharat Mission (SBM)
- At National, State, City & Ward Levels

- Ultimate objective of all three Missions is same: well-being of urban population in a prosperous, healthy and hygienic environment



VARIOUS CONVERGENCE STRUCTURES

(EXAMPLES)

SNo	Partner 1	Partner2	Type	Coordinated Actions
1	West Bengal UHC	wards and higher level	Formal	Smooth Health service delivery
2	Mysuru Health Department	ULB	Informal Coordination	City urban health planning by forming City Urban Health Committees
3	Chhattisgarh Health & ICDS	ULBs, Schools, elected officials	Formal coordination	Promoting health seeking behavior, infrastructure & monitoring of developmental inputs (including WASH)
4	Pune Health Department	UCD-Pune, ICDS, JNNURM and PMC Eng. Deptt.	Formal	Addressing issues both health & beyond like: stray dogs, traffic jams and electricity connections
5	Nutrition committee Madhya Pradesh	Neighborhood committees under SJSRY and ward committees under JNNURM	Informal coordination	Potential for being leveraged for health purposes as well

Urban Health challenges- post covid 19

- Increase in NCDs; Diabetes and Hypertension, are the most common diagnosed medical condition at urban primary care practices. (leading risk factor in attributable disability-adjusted life-years (DALYs) in India 2013- Global burden of Disease)
- Urban India has a high concentration of health-care providers, yet, not everyone has easy access to health care. (the situation changed after COVID 19 as patients deferred their treatments)
- Male patients load is more than 50%(possible reasons poverty, migration and financial stability)

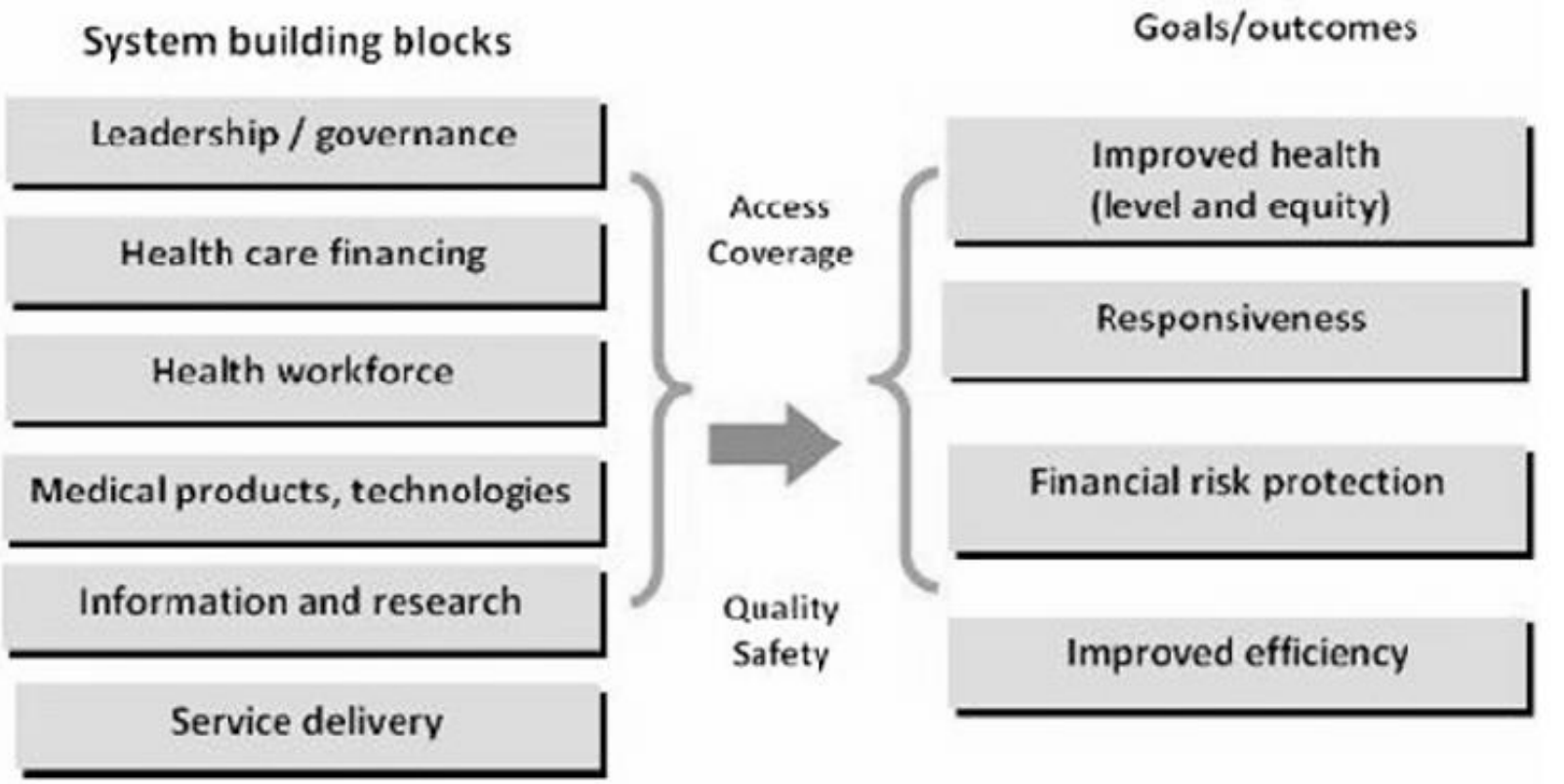
UH challenges

- National surveys show that reports of ailments increase with age, only 7–9% of the visits recorded by Salvi and colleagues. The situation worsens with geriatric care is severely HIT by COVID 19 Pandemic.
- Methodological problems of patient care in Urban Poor.(informal sector contribution)
- Large Proportion of Slums Are Uncounted, Invisible
- Weak referral mechanisms
- Low access of health services to the poor & High usage of hospitals for minor ailments.
- Multi-Dimensional Vulnerability

Opportunities for UH

- Growing recognition of the problem among government agencies Growing interest among donors
- Large presence of experienced and interested NGOs in urban areas
- Increased financial allocation and investment in slum development and health programs
- Growing body of urban-poor-specific research and data

WHO-Health system framework



http://www.wpro.who.int/health_services/health_systems_framework/en/

“Health workforce Transition”

- The SDGs therefore provide the comprehensive framework to make the transition from a **more disease-based and curative focus**, to a **more integrated and preventive approach.**
- It will also provide the reference for **tracking development progress** (*Integrated Care*) in the coming decades.

Health and Human resource management for urban health- Post COVID 19

- Govt. and organizations have started focusing on scenarios for planning and taking necessary operational responses to ensure Health service continuity post-COVID-19.
- Govt. and organizations need to focus on building Communication, Trust & Transparency related to the coronavirus pandemic to restore productivity and deliver on employee experience.

Covid 19-Pre and post strategies

- Health Organizations have to make a lot of adjustments to their implementation plans and the way of working post-COVID-19.
- They need more employee engagement than ever to get through this challenging period. The employees might struggle with **feelings of uncertainty, isolation, not being in the know, and more**.
- Thus, the Role of Change Agents that is of the Health professionals becomes crucial in this scenario. With social distancing being implemented and practiced, it is difficult to have standard methods of process, policies & engagements leading to a new challenge for Health professionals.

New role of Urban Health (HP) in Global Pandemic.

- **Counselling and collaboration-** Two way communication
- **Sense employees' need for support-** Employees don't want to be viewed as faceless cogs in a larger machine—they want to be recognized for the unique value each brings to the company.
- **Reinforcing Organisational values** - Work well-being has the greatest impact on feelings of psychological safety — an unpleasant employee experience can negatively impact psychological safety by up to 35%. To make matters worse, during periods of uncertainty, employee misconduct increases by as much as 33%.

- **Recognizing employee efforts -** As COVID-19 generates significant disruption, and undercuts employee engagement, Health and Hospital managers need to redouble their recognition initiatives & efforts. Effective recognition motivates the recipient and This reinforces the organization's commitment to the long-term success of the employee.
- **Educating and equipping the workforce**
- **Focus on Employee Wellness**
- **Employee upskilling-**According to a report by Deloitte, the "inability to learn and grow" is the top reason why employees leave their companies.
- **Framing New Age Policies-**workplace flexibility, remote working & contractual staffing

COVID 19 and UH

- A centurion Pandemic
- Disrupted "**World order of public health"**
- Present urban systems are not equipped for covid 19.
- Developed nations bleeded more

The Urban Health focus must be on solutions

- Appropriate health
- Consultative health process
- Emergency Protocols
- Service delivery, and
- Creation of a healthy and safe city for all.
- “Health for all”

THANK YOU FOR LISTENING